NIMDTA
Deanery Review of Emergency Medicine, Royal Victoria Hospital, Mater Infirmorum Hospital and Royal Belfast Hospital for Sick Children, Belfast HSC Trust
FINAL REPORT

Hospital Visited	RVH, MIH & RBHSC Belfast HSC Trust			
Specialty Visited	Emergency Medicine			
Type of Visit	Cyclical			
Trust Officers with Postgraduate Medical Education & Training Responsibility	Mr X (Medical Director) Dr X (Associate Medical Director) Dr X (Director of Medical Education; RVH/MIH) Dr X & Dr X (Deputy Directors of Medical Education; RVH/MIH)			
Date of Visit	7th October 2021			
Visiting Team	Dr X, Associate Dean for Deanery Visits (Chair) Dr X, Deputy Head of School for Emergency Medicine Mr X, Lay Representative Dr X, GP Representative Mrs X, Quality Manager, NIMDTA			
Rating Outcome	Red	Amber	Green	White[1]
	2	3	0	5

Purpose of Deanery Visits	The General Medical Council (GMC) requires UK Deaneries/LETBs to demonstrate compliance with the standards and requirements that it sets (GMC-Promoting Excellence 2016). This activity is called Quality Management and Deaneries need to ensure that Local Education and Training Providers (Hospital Trusts and General Practices) meet GMC standards through robust reporting and monitoring. One of the ways the NI Deanery (NIMDTA) carries out its duties is through visiting Local Education and Training Providers (LEPS). NIMDTA is responsible for the educational governance of all GMC-approved foundation and specialty (including General Practice) training programmes in NI.
Purpose of this Visit	This is a cyclical visit to assess the training environment and the postgraduate education and training of trainees in Emergency Medicine in RVH, MIH & RBHSC, Belfast HSC Trust.
Circumstances of this Visit	The Deanery Visiting Team met with educational leads, trainees and trainers in Emergency Medicine in RVH, MIH & RBHSC, Belfast HSC Trust.
Relevant Previous Visits	Cyclical Visit to Emergency Medicine in RVH, MIH & RBHSC, Belfast HSC Trust.
Pre-Visit Meeting	7th October 2021
Purpose of Pre-Visit Meeting	To review and triangulate information about postgraduate medical education and training in the unit to be visited.
Pre-Visit Documentation Review	Background Information Template from Emergency Medicine RVH, MIH & RBHSC Belfast HSC Trust Sept 2021. Previous visit report 19th Nov 2015 and subsequent Trust Action Plan 17th Feb 2016 BHSCT (RVH) EM visit/Placement Quality Survey Sept 2021 GMC National Training Survey 2017-2021
Types of Visit	Cyclical Planned visitation of all Units within 5 years Re-Visit Assess progress of LEP against a previous action plan Decision at Quality Management Group after grading of cyclical visit Reconfiguration of Service Problem-Solving Visit Request of GMC Request of RQIA Quality Management Group after review of submitted evidence sufficient to justify investigation and not suitable for investigation at Trust or Specialty School level.

This report reflects the findings from the trainees and trainers who were available to meet with the visiting team on the day of the visit and information arising from the pre-visit survey.

Please note the following recommendations from the Francis Report on Mid-Staffordshire NHS Foundation Trust Public Inquiry on Training and Training Establishments as a Source of Safety Information:

- **Recommendation 160: Proactive steps need to be taken to encourage openness on the part of trainees and to protect them from any adverse consequences in relation to raising concerns.**
- **Recommendation 161: Training visits should make an important contribution to the protection of patients. Obtaining information directly from trainees should remain a valuable source of information.**

[1] Risks identified during the visit which were closed through action planning by the time of the final report.

Trainees Interviewed										
Hospital Site	**RVH**				**MIH**			**RBHSC**		
Grade	**F2**	**GPST1**	**ST1**	**ST3+**	**F2**	**GPST1/ST1**	**ST3+**	**F2**	**ST1**	**ST3+**
Posts	8	7	1	13	6	0	0	0	1	8
Interviewed	2	1	1	6	3	0	0	3	1	4

Trainers Interviewed

Trainers x 11 (RVH/MIH) 6 (RBHSC)

Feedback provided to Trust Team

Dr X (Associate Medical Director)
Dr X (Director of Medical Education; X Johnston & Dr Andrew McAllister (Deputy Directors of Medical Education; RVH/MIH)
Dr X (Clinical Director; RVH/MIH)
Dr X (LEP lead, RBHSC)
Dr X (Associate Medical Director, RBHSC)
Dr X (Clinical Director; RBHSC)

Contacts to whom the visit report is to be sent to for factual accuracy check

Dr X (Director of Medical Education; RVH/MIH)
Dr X & Dr X (Deputy Directors of Medical Education; RVH/MIH)

Background

Organisation: Trainees are based in Emergency Medicine, Royal Victoria Hospital, Mater Infirmorum Hospital and Royal Belfast Hospital for Sick Children, Belfast HSC Trust. Trainees rotate shifts between Royal Victoria Hospital and Mater Infirmorum Hospital.

Staff: RVH/MIH: There are 27.28 WTE consultants; 0.92 Associate Specialist, 9.5 Specialty Doctor; 11.2 ST3+; 4.0 ST1 7.0 GPST1; 13.0 FY2; 0.2 GP; 1.0 Senior Clinical Fellow, 9.0 Junior Clinical Fellow.

Staff: RBHSC: 7 WTE consultants; 2.0 Associate Specialist/Specialty Doctor; 5.0 ST3+; 4.0 ST1; Paeds ST1 &GPST1; 0 FY2;

NTS 2021: RVH: Positive – induction, handover, adequate experience, curriculum coverage, reporting systems. Negative – workload, supportive environment, facilities. **MIH:** Positive - adequate experience, facilities. **RBHSC:** negative – handover, adequate experience, curriculum coverage, clinical supervision OOH, feedback.

Previous Visits/Concerns: Feedback; **Patient safety** due to overcrowding and staffing levels; **Practical experience** in paediatric emergencies; **Educational Supervision; Clinical Supervision** especially at nights and weekends.

Findings against GMC's Standards for Medical Education and Training (Promoting Excellence, 2016)

Theme 1: Learning Environment and Culture

S1.1: The learning environment is safe for patients and supportive for learners and educators. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers and families.
S1.2: The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in *Good Medical Practice* and to achieve the learning outcomes required by their curriculum.

Induction (R1.10, 1.13, 1.19) Trust induction is comprehensive, with supporting documents available on line. **RVH/MIH:** Unit induction involved digital information sent in advance and a walk around each unit. Offered to those starting out of sync. Issues with login passwords and ID badges encountered reported - trainees rotate between sites, ID badge do not allow access to both sites. RVH parking passes do not work in MIH.

RBHSC: Unit induction offers a short walk around, described as a 'whistle stop tour'. ID passes received late.

Clinical Supervision (R1.7-1.10, 1.12a, 1.13, 1.15) RVH/MIH: Excellent supervision daily on the floor.RVH 8am-1am Monday to Friday and 8am-5pm at weekends. MIH consultants are only present late to 10pm Monday and Tuesday and present to 5/6pm the rest of the weekdays. They do come back in if there is a major issue. MIH F2 & GPST1 OOH tend to contact the medical registrar on site. Consultant can be contacted directly and are easily accessible. Trainees never feel that they are working outside their level of experience.

RBHSC: Excellent supervision daily on the floor. All attendances checked every day in 'flimsy review' and feedback on cases offered to trainees. Only 1 ST1 Paeds/GPST1 or ST3 in EM present OOH after 2am. They tend to rely on medical registrar for support. Medical registrar however is frequently busy at ward level and not on the unit. Consultant's advice can be accessed OOH and will return to the department if there is a need.

Handover (R1.14). RVH/MIH: Occurs twice daily. Morning handover in RVH (8.00-8.30am) is formal and consultant led and offers a good learning opportunity. Informal handover, more 1 to 1, in the evening. Informal feedback offered regularly. MIH handover is also twice daily but less formal due to having fewer staff on the floor at any time.

RBHSC: No formal handover. No consultant present for handover. White board run down with registrar and most senior nurse on duty. This occurs a couple of times per shift, as doctors start at different times (consultants 8.00-9.00am; ST3+ 9.00am and junior grades 8.00am). Patients for admission are handed over to nurse in charge. Nurse to nurse handover does occur. Examples shared of patients transferred to a ward without the medical team receiving a handover. Difficulty encountered in accessing a phone within the department to bleep the medical registrar on call.

Practical Experience (R1.19) RVH/MIH: Experience gained through a wide case mix in **RVH**. Trainees try to rotate through all areas. Allocation is organised by consultants. Trainees encouraged to voice if they have been rotated too freqently to 1 area. With the high volume of cases more junior trainees have limited exposure to minor injuries and acutely ill patients as spend a significant portion of their time on ambulatory cases. Staff shortages are impacting on training opportunities as they are more frequently engaged in helping with nursing tasks and portering. 1 F2 acts in a supernumery capacity with a more senior trainee in the resus room. Plenty of opportunity to perform procedures under supervision within the unit.

MIH: less of a case mix recently. Majority of cases are respiratory. It tends to be COVID-19 heavy.

RBHSC: Excellent exposure to complex cases. Trainees rotate through all areas including resus and minor injuries.

Workload (R1.7, 1.12) RVH/MIH: Workload is variable during the week days. Workload can be intense OOH and at weekends**.** F2 trainees feel sheltered from the pressure, encouraged to work at a safe pace, not influenced by pressure building within the unit. In MIH the pace is slower and the trainees welcome this change in pace.
F2 rota is challenging with long stretches of unsociable hours. Trainees feel the need to use annual leave to break up long periods on shift. Only permitted to take annual leave on day shift, not when rostered OOH. Recruitment of clinical fellows has reduced the reliance on locums to fill gaps. There is a culture for trainees to get away on time at the end of each shift.

RBHSC: The registrar finds it difficult to leave on time especially at 2am as only 1 junior doctor left on site. Recently department has been extremely busy, resulting in EM and general medicine consultants (including those not on call) being called in from home to clear the backlog and identify patients for discharge to free medical beds. Unable to fulfil a middle grade rota 24/7.

EWTR Compliance (R1.12e) Compliant.

Hospital and Regional Specialty Educational Meetings (R1.16) RVH/MIH: There are regular teaching sessions (block of 4 hours/3 over each 4 month period). All junior grades attend. This teaching is on their shift rota and cover is organised to ensure trainee attendance. There is also a weekly journal club and simulation sessions. Opportunities for EM trainees to deliver teaching to other clinicians and to multi-disciplinary teams.

RBHSC: Local clinical teaching occurs every Thursday. Consultant present with junior trainees delivering the teaching. Feedback is received. Cover is arranged and protected time given.

Educational Resources, Internet Access, Simulation Facilities (R1.19, R1.20) No concerns.

Quality Improvement and Audit (R1.3, 1.5, 1.22) All trainees have been encouraged to be involved in QI projects. QiP training delivered by Trust QiP expert.

Patient Care (R1.1, 1.3, 1.4) RVH/MIH/RBHSC: There are concerns that the recent increase in attendances resulting in increasing waiting times and delays in patients accessing a bed for admission has the potential to impact on the quality of care.

Patient Safety (R1.1-1.5) RVH/MIH/ RBHSC: All trainees advised there are no issues in regard to patient safety. All are aware of the trust reporting system, but junior trainees had not been shown how to use Datix. Trainees feel supported when raising a concern.

Theme 2: Educational Governance and Leadership

S2.1: The educational governance system continuously improves the quality and outcomes of education and training by measuring performance against our standards, demonstrating accountability, and responding when standards are not being met.
S2.2: The educational and clinical governance systems are integrated, allowing organisations to address concerns about patient safety.
S2.3: The educational governance system makes sure that education and training is fair and is based on principles of equality and diversity.

Educational Supervision (R2.11, 2.14, 2.15) Trainees reported that their educational supervision was excellent, and that they had no difficulties completing WBAs or securing time to meet with their ES.

Theme 3: Supporting Learners
S3.1: Learners receive educational and pastoral support to be able to demonstrate what is expected in *Good Medical Practice* and to achieve the learning outcomes required by the curriculum.

Feedback on Performance, Development and Progress (R3.13) Feedback on performance is given on a regular basis at educational meetings. Informal feedback is generally good on the floor.

RVH/MIH: RVH handover offers a good educational opportunity with feedback.

RBHSC: informal feedback given regularly.

Trainee Safety and Support (R3.2) RVH/MIH: All trainees know who to approach if they wanted to discuss anything in confidence. Units aim to offer a supportive environment. Trainees feel concerned about their safety at night going to the car park (esp RVH). Pre-covid the security would have supported them getting to their cars. Abuse is witness frequently within the units. Significant threats have been received (often due to frustration of long waiting times). Trainees are not working alone in isolated areas. The trainees felt concern for their nursing colleague in triage being in the immediate firing line of patients and relatives.

RBHSC: There were no concerns raised.

Undermining (R3.3) RVH/MIH: No concerns reported. F2 trainees feel valued within the team (esp. in MIH where less staff means their presence is greater felt).

RBHSC: Very supportive consultants. Senior nursing described as being abrupt at times to trainees, even specialty trainees. Example given of repeatedly questioning ST3+ decision to admit a patient.

Study Leave (R3.12) There is no issue.

Theme 4: Supporting Educators
S4.1: Educators are selected, inducted, trained, and appraised to reflect their education and training responsibilities.
S4.2: Educators receive the support, resources and time to meet their education and training responsibilities.

Trainer Support (R4.1-4.6) Trainers felt supported by the Trust and NIMDTA. Their roles were included in their job plans and each underwent an annual educational appraisal.

Theme 5: Developing and Implementing Curricula and Assessments
S5.2: Postgraduate curricula and assessments are implemented so that doctors in training are able to demonstrate what is expected in *Good Medical Practice* and to achieve the learning outcomes required by their curriculum.

There were no concerns identified.

Summary of Conclusions

The below conclusions have been categorised as follows:

i) Educational governance (training)
ii) Clinical governance or patient safety issues

Comment (if applicable):

Current overcrowding and ongoing work pressures make this a challenging training environment. Despite this the trainees feel well supported in each department.

Areas Working Well

Good balance between service and training despite this being a demanding and pressurised clinical environment.

Areas of Good Practice (includes areas of strength, good ideas and innovation in medical education and training):

RVH/MIH:

- Induction is repeated regularly and continually updated
- Excellent opportunities for practical experience
- Regular weekly teaching sessions
- AUDIT/QI well supported
- Supportive environment

RBHSC:

- Excellent opportunities for practical experience
- Regular weekly teaching sessions
- AUDIT/QI well supported

Areas for Improvement (issues identified has a limited impact on a trainee's education and training, or the quality provision for the patient):

	Educational Governance	Clinical Governance	RAG
There were no areas identified.			

Areas of Concern (trainees are able to achieve required outcomes, but the quality of education and training is recognised as requiring improvement and/or patients within the training environment are receiving safe care but the quality of their care is recognised as requiring improvement):

	Educational Governance	Clinical Governance	RAG
1. **Induction: RBHSC:** Would benefit from a more robust unit induction with more time spent on orientation.	✓	✓	N/A
2. **Clinical supervision: MIH:** OOH trainees tend to rely on medical registrar rather than contacting EM colleagues.	✓	✓	Amber
3. **Workload**: **RVH/MIH/RBHSC:** Increase in workload across all units. **RVH/MIH:** F2 rota challenging with long stretches of unsociable hour shifts. **RBHSC:** ST3+ trainees have difficulty leaving at 2am.	✓		Red
4. **Handover: RBHSC:** No formal handover. White board meetings occur frequently through each shift. No consultant presence at handovers.	✓	✓	N/A
5. **Handover: RBHSC:** Challenges encountered in handover from EM ST3+ to med registrar.	✓	✓	N/A
6. **Practical Experience: RVH:** Limited exposure to minor injuries and acutely ill patients. Staff shortages limiting educational opportunities.	✓		Amber
7. **Patient Safety: RVH/MIH/RBHSC:** Some trainees not familiar with how to access and use Datix.	✓		Amber
8. **Undermining: RBHSC:** Examples of undermining of clinical decisions, by senior nursing colleagues.	✓	✓	N/A

Areas of Significant Concern (patients/trainees within the training environment are at risk of coming to harm and/or trainees are unable to achieve required outcomes due to poor quality of the training posts/programme):

	Educational Governance	Clinical Governance	RAG
1. **Clinical supervision: RBHSC:** Only 1 junior trainee in unit after 2 am. No direct 'shop floor' clinical supervision.	✓	✓	Red
2. **Trainee safety and support: RVH/MIH:** Concern of trainees going to car park at end of shift (esp. RVH). Car park pass does not work cross site. Trainees have received threats.	✓		N/A

Hospital Visited	Ulster Hospital Dundonald & Lagan Valley Hospital
Specialty Visited	Emergency Medicine
Type of Visit	Cyclical
Trust Officers with Postgraduate Medical Education & Training Responsibility	Dr X, Director of Medical Education Dr X, Medical Director Dr X, Associate Director Mr X, Medical Director's Office Dr X, College Tutor
Date of Visit	23 September 2021
Visiting Team	Dr X, Associate Dean for Deanery Visits (Chair) Dr X, Head of School for Emergency Medicine Dr X, Deputy Head of School for Emergency Medicine Dr X, Foundation Representative Dr X, GP Representative Mr X, Lay Representative Miss X, Placement Quality Executive Officer, NIMDTA

Rating Outcome	Red	Amber	Green	White[1]
	0	2	0	6

Purpose of Deanery Visits	The General Medical Council (GMC) requires UK Deaneries/LETBs to demonstrate compliance with the standards and requirements that it sets (GMC-Promoting Excellence 2016). This activity is called Quality Management and Deaneries need to ensure that Local Education and Training Providers (Hospital Trusts and General Practices) meet GMC standards through robust reporting and monitoring. One of the ways the NI Deanery (NIMDTA) carries out its duties is through visiting Local Education and Training Providers (LEPS). NIMDTA is responsible for the educational governance of all GMC-approved foundation and specialty (including General Practice) training programmes in NI.
Purpose of this Visit	This is a cyclical visit to assess the training environment and the postgraduate education and training of trainees in Emergency Medicine in Ulster Hospital Dundonald & Lagan Valley Hospital.
Circumstances of this Visit	The Deanery Visiting Team met with educational leads, trainees and trainers in Emergency Medicine in Ulster Hospital Dundonald & Lagan Valley Hospital
Relevant Previous Visits	Cyclical Visit to Emergency Medicine in Ulster Hospital Dundonald & Lagan Valley Hospital.
Pre-Visit Meeting	23rd Sept 2021
Purpose of Pre-Visit Meeting	To review and triangulate information about postgraduate medical education and training in the units to be visited.
Pre-Visit Documentation Review	Background Information Template from Emergency Medicine - Ulster Hospital & Lagan Valley Hospital September 2021 Previous visit report 11th Dec 2015 and subsequent Trust Action Plan 26th May 2016 Quality Placement Surveys May 2021 GMC National Training Survey 2017-2021
Types of Visit	Cyclical Planned visitation of all Units within 5 years Re-Visit Assess progress of LEP against a previous action plan Decision at Quality Management Group after grading of cyclical visit Reconfiguration of Service Problem-Solving Visit Request of GMC Request of RQIA Quality Management Group after review of submitted evidence sufficient to justify investigation and not suitable for investigation at Trust or Specialty School level.

[1] Risks identified during the visit which were closed through action planning by the time of the final report.

This report reflects the findings from the trainees and trainers who were available to meet with the visiting team on the day of the visit and information arising from the pre-visit survey.

Please note the following recommendations from the Francis Report on Mid-Staffordshire NHS Foundation Trust Public Inquiry on Training and Training Establishments as a Source of Safety Information:

- **Recommendation 160: Proactive steps need to be taken to encourage openness on the part of trainees and to protect them from any adverse consequences in relation to raising concerns.**
- **Recommendation 161: Training visits should make an important contribution to the protection of patients. Obtaining information directly from trainees should remain a valuable source of information.**

Trainees Interviewed				
	F1/F2	**GPST1**	**ST3+**	**ACCS**
Posts	3 UHD 2 LVH	11	10	
Interviewed	1 UHD LAT1 LVH	2 UHD	2 UHD	1 ST2 Anaesthetic Trainee UHD
Trainers Interviewed				
Trainers x 4				
Feedback provided to Trust Team				
Dr X, Director of Medical Education Dr X, Associate Director for Emergency Medicine Mr X, Medical Director's Office Dr X Foundation Programme Director Dr X, College Tutor Dr X, Educational Lead				
Contacts to whom the visit report is to be sent to for factual accuracy check				
Dr X, Director of Medical Education Mr X, Medical Director's Office Mrs X, Medical Education Manager				

Background

Organisation: There are 3 emergency units in the SEHSCT, sited at the Ulster Hospital, Lagan Valley Hospital and Downe Hospital. There are no trainees based in the Downe Hospital Emergency Dept. The Lagan Valley unit opens 08:00-20:00. The Ulster Hospital unit is open 24 hours a day, 7 days a week.

Staff: There are 23 consultants working across the 3 Trust sites (some working less than full time); 13 SAS grade; 10 ST3+; 11 GPST1; 5 FY2

Rotas: Consultant: 1 in 6 on call weekdays and weekends, SAS: 1 in 4 weekends, ST3+: 1 in 4 weekends and GPST1 and F2: 1 in 2.43 UHD and 1 in 8 weekends.

NTS 2021: UHD: Positive feedback for supportive environment, rota design and clinical supervision. Concerns regarding facilities and workload Previous Visits/Concerns: Practical experience - cross site working requested; workload – staffing levels.

Findings against GMC's Standards for Medical Education and Training (Promoting Excellence, 2016)

Theme 1: Learning Environment and Culture

S1.1: The learning environment is safe for patients and supportive for learners and educators. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers and families.

S1.2: The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in *Good Medical Practice* and to achieve the learning outcomes required by their curriculum.

Induction (R1.10, 1.13, 1.19) Trust induction is comprehensive.

UHD: departmental induction described as excellent. Induction is structured with a good overview, but also focuses on specific presentations.

LVH: 1 trainee started out of sync and did not receive a formal induction. As a trainee that graduated outside of the UK he reported the challenges encountered in the first days and weeks of the post.

No issues with login passwords and ID badges encountered on either site.

Clinical Supervision (R1.7-1.10, 1.12a, 1.13, 1.15) UHD: Senior supervison always available for F2 and GPST1 trainees. Registrar on site, with consultant staff in dept 08:00 to 23:00. OOH consultant on call can be contacted directly.

LVH: As consultants work cross site, they are usually not on site in LVH after 16:00. They do come back in if there is a major issue. There is a middle grade doctor, usually specialty doctor on site offering supervision. This was described as variable in quality, but clinical leads assured the visiting panel that middle grade doctors were required to have proof of the appropriate level of emergency medicine experience before being appointed to post. The department closes at 20:00.

Handover (R1.14) UHD: Handover occurs twice daily. Handover is at 8am (night registrar to day staff). Consultant present at morning handover. Second handover is at 10pm, again with consultant present. Designated area for handover not conducive to teaching, limiting the educational value of handover and opportunity for informal feedback. No computer available in the area designated for handover, adding to work load and risk of error as trainees write cases down to present.

LVH: Less formal in LVH, more on a 1 to 1 level.

Practical Experience (R1.19) UHD & LVH: Experience gained through a wide case mix. Trainees rotate through all areas. Allocation is organised by the consultant at handover. Plenty of opportunity to perform procedures under supervision.

Workload (R1.7, 1.12) UHD: Workload is variable, but generally manageable. Workload increases in intensity from midmorning to evening, easing after 02:00**.** No pressure for trainees to cover the gaps. There is a culture for trainees to get away on time at the end of each shift.

LVH: department closes at 20:00, workload is variable, but manageable.

EWTR Compliance (R1.12e) The EWTR is compliant.

Hospital and Regional Specialty Educational Meetings (R1.16) UHD: local teaching occurs regularly, with protected time allocated. Dissemination of FOAMED to all trainees via WhatsApp Group. Attendance depends on shift patterns. Local teaching is consultant led and there are no barriers to attending. Teaching was rated as good and relevant to their training.

LVH: No formal teaching, but informal bedside teaching is frequent. Specialty trainees are aware they should have Educational Development (8 hours protected time) time allocated; However, this is not included in their rotated timetable yet.

Educational Resources, Internet Access, Simulation Facilities (R1.19, R1.20) UHD: No designated educational space. Current department is not spacious enough to accommodate on site simulation training.

Quality Improvement and Audit (R1.3, 1.5, 1.22) F2/GPST1 Trainees have been encouraged to be involved in National QI projects x3 per year. Trainees are assigned to 1 of 3 teams. The ST3+ trainees are not generally engaged in audit/QiP, nationally or locally.

Patient Care (R1.1, 1.3, 1.4) UHD & LVH: patient care reported as excellent, despite current pressures and issues regarding space in the departments.

Patient Safety (R1.1-1.5) UHD: All trainees advised there are no issues in regard to patient safety.

LVH: Concerns raised in regard to limited range of hospital specialties on site and the delay in the transfer of patients to other hospitals for specialist care. Example: there is no paediatric inpatient care onsite, but children do attend the emergency department and when admission is required acutely they must be transferred to a paediatric unit off site.

All trainees are aware of the trust reporting systems. Trainees feel supported when raising a concern.

Theme 2: Educational Governance and Leadership

S2.1: The educational governance system continuously improves the quality and outcomes of education and training by measuring performance against our standards, demonstrating accountability, and responding when standards are not being met.
S2.2: The educational and clinical governance systems are integrated, allowing organisations to address concerns about patient safety.
S2.3: The educational governance system makes sure that education and training is fair and is based on principles of equality and diversity.

Educational Supervision (R2.11, 2.14, 2.15) Trainees reported that their educational supervision was good and that they had no difficulties completing WBAs or securing time to meet with their ES.

Theme 3: Supporting Learners

S3.1: Learners receive educational and pastoral support to be able to demonstrate what is expected in *Good Medical Practice* and to achieve the learning outcomes required by the curriculum.

Feedback on Performance, Development and Progress (R3.13) Feedback on performance is offered at educational meetings. Informal feedback is variable depending on individual consultants.

UHD: Handover currently does not offer a good educational opportunity with feedback.

Trainee Safety and Support (R3.2) Examples given of assaults made on staff. [redacted]

UHD: Security on site, but stretched as they cover the whole hospital site.

LVH: Until recently no security on site. There are plans to offer training on self-protection and de-escalation of a potential violent situation to all staff. All trainees know who to approach if they wanted to discuss anything in confidence.

Undermining (R3.3) There are no concerns reported.

Study Leave (R3.12) There is no issues reported.

Theme 4: Supporting Educators

S4.1: Educators are selected, inducted, trained, and appraised to reflect their education and training responsibilities.
S4.2: Educators receive the support, resources and time to meet their education and training responsibilities.

Trainer Support (R4.1-4.6) Trainers felt supported by the Trust and NIMDTA. Their roles were included in their job plans and each underwent an annual educational appraisal. Regular trainers meetings for discussion of any curriculum changes and regular review of all trainees with early identification of training needs or additional support required.

Theme 5: Developing and Implementing Curricula and Assessments

S5.2: Postgraduate curricula and assessments are implemented so that doctors in training are able to demonstrate what is expected in *Good Medical Practice* and to achieve the learning outcomes required by their curriculum.

There are no concerns identified.

Summary of Conclusions

The below conclusions have been categorised as follows:

iii) Educational governance (training)
iv) Clinical governance or patient safety issues

Comment (if applicable):
Despite being a busy clinical area the trainees feel well supported. Trainees that have not previously worked in NI, have required significant additional support.

Areas Working Well
1. Reasonable balance between service and training despite this being a demanding and pressurised clinical environment.

Good Practice (includes areas of strength, good ideas and innovation in medical education and training):
1. Sufficient opportunities for practical experience.
2. Good clinical supervision. Consultant present on site 08:00 – 23:00 UHD.
3. Regular weekly teaching sessions.
4. AUDIT/QI for F2/GPST1 well supported.
5. Supportive environment.
6. Workload although variable, trainees encouraged to leave on time.

Areas for Improvement (issues identified has a limited impact on a trainee's education and training, or the quality provision for the patient):

	Educational Governance	Clinical Governance	RAG
Induction: Out of sync trainees not always receiving full induction programme**.**	✓		N/A
Handover. More suitable environment should be identified for handover, with computer available for use UHD.	✓		AMBER
Quality Improvement & Audit. ST3+ trainees are not generally engaged in audit/QiP, nationally or locally.	✓		N/A
Regional Teaching. ST3+ Educational Development (8 hours protected time) not included in rotated timetable yet.	✓		N/A

Areas of Concern (trainees are able to achieve required outcomes, but the quality of education and training is recognised as requiring improvement and/or patients within the training environment are receiving safe care but the quality of their care is recognised as requiring improvement):

	Educational Governance	Clinical Governance	RAG
1. Educational Resources, Internet Access, Simulation Facilities. No designated educational space in UHD.	✓		AMBER
2. Trainee Safety. Examples of violence and assault shared.	✓		N/A
3. Trainee Support. Trainees starting out of sync especially those new to the region should be identified, and offered more support.	✓	✓	N/A

Areas of Significant Concern (patients/trainees within the training environment are at risk of coming to harm and/or trainees are unable to achieve required outcomes due to poor quality of the training posts/programme):

	Educational Governance	Clinical Governance	RAG
Patient Safety. Delayed transfers between LVH ED and other hospitals and sites.		✓	N/A

NIMDTA

Deanery Review of Emergency Medicine at Craigavon Area Hospital and Daisy Hill Hospital in the Southern Trust

FINAL REPORT

Hospital Visited	Craigavon Area Hospital and Daisy Hill Hospital, Southern Health & Social Care Trust
Specialty Visited	Emergency Medicine
Type of Visit	Cyclical
Trust Officers with Postgraduate Medical Education & Training Responsibility	Dr X, LEP Educational Lead Dr X, Director of Postgraduate Medical Education and Training Dr X, Associate Medical Director Clinical Directors - Dr X (CAH) and Dr X (DHH)
Date of Visit	Tuesday 8th June 2021
Visiting Team	Dr X, Associate Dean for Deanery Visits (Chair) Dr X, Associate Dean for Placement Quality Dr X, Head of School for Emergency Medicine Dr X, Deputy Head of School for Emergency Medicine Dr X, GP Representative Mr X, Lay Representative Mrs X, Quality & Revalidation Manager, NIMDTA

Rating Outcome	**Red**	**Amber**	**Green**	**White***
	0	2	0	4

Purpose of Deanery Visits	The General Medical Council (GMC) requires UK Deaneries/LETBs to demonstrate compliance with the standards and requirements that it sets (GMC-Promoting Excellence 2016). This activity is called Quality Management and Deaneries need to ensure that Local Education and Training Providers (Hospital Trusts and General Practices) meet GMC standards through robust reporting and monitoring. One of the ways the NI Deanery (NIMDTA) carries out its duties is through visiting Local Education and Training Providers (LEPS). NIMDTA is responsible for the educational governance of all GMC-approved foundation and specialty (including General Practice) training programmes in NI.
Purpose of this Visit	This is a cyclical visit to assess the training environment and the postgraduate education and training of trainees in Emergency Medicine in the Southern Trust.
Circumstances of this Visit	The Deanery Visiting Team met with educational leads, trainees and trainers in Emergency Medicine in the Southern Trust.
Relevant Previous Visits	Cyclical Visit to Emergency Medicine CAH and DHH, Southern Trust.
Pre-Visit Meeting	26th May 2021 and 8th June 2021
Purpose of Pre-Visit Meeting	To review and triangulate information about postgraduate medical education and training in the unit to be visited.
Pre-Visit Documentation Review	Background Information Template from Emergency Medicine in the Southern Trust. Previous visit report 26th November 2015 and subsequent Trust Action Plans 5th January 2016 and 8th February 2016 Quality Placement Surveys May 2021 GMC National Training Survey 2019
Types of Visit	Cyclical Planned visitation of all Units within 5 years Re-Visit Assess progress of LEP against a previous action plan Decision at Quality Management Group after grading of cyclical visit Reconfiguration of Service Problem-Solving Visit Request of GMC Request of RQIA Quality Management Group after review of submitted evidence sufficient to justify investigation and not suitable for investigation at Trust or Specialty School level.

This report reflects the findings from the trainees and trainers who were available to meet with the visiting team on the day of the visit and information arising from the pre-visit survey.

* Risks identified during the visit which were closed through action planning by the time of the final report.

Please note the following recommendations from the Francis Report on Mid-Staffordshire NHS Foundation Trust Public Inquiry on Training and Training Establishments as a Source of Safety Information:

- **<u>Recommendation 160</u>: Proactive steps need to be taken to encourage openness on the part of trainees and to protect them from any adverse consequences in relation to raising concerns.**

- **<u>Recommendation 161</u>: Training visits should make an important contribution to the protection of patients. Obtaining information directly from trainees should remain a valuable source of information.**

Trainees Interviewed

	F1/F2	Core	GPST1	ST3+
Posts	6	2	6	9
Interviewed	1	0	4	8

Trainers Interviewed

Trainers x 8

Feedback provided to Trust Team

Dr X, DME – Education & Training
Mr X, Assistant Director, MD office
Dr X, Specialty Education Lead/College Tutor
Dr X, FPD DHH
Dr X, FPD CAH
Dr X, Head of Department for Acute Medicine and ED
Mrs X, Medical Education Manager

Contacts to whom the visit report is to be sent to for factual accuracy check

Dr X, DME – Education & Training
Mr X, Assistant Director, MD office
Mrs X, Medical Education Manager

Background

Organisation: Trainees are based in EM in Craigavon Area Hospital and Daisy Hill Hospital.

Staff: There are 17 consultants across the 2 sites (1 in 10 CAH and 1 in 8 DHH), 8 SAS grade (1 in 6).

Rotas: F1/F2: CAH 1 in 7 nights/3 in 7 weekends; DHH 1 in 6 nights/3 in 6 weekends
GPST1: CAH in 7 nights/3 in 7 weekends; DHH 1 in 6 nights/3 in 6 weekends
Core: 1 in 7 nights/3 in 7 weekends
ST3: 1 in 7 nights/3 in 7 weekends
ST4: 1 in 7 nights/2 in 7 weekends

NTS 2019: N/A

Previous Visits/Concerns:
CAH: Handover; clinical supervision; practical experience (allocation), rota, induction; Ed resources (simulation and teaching room); potential patient safety (with delays due to excessive number of patients).

DHH: Handover; low staffing levels and reliance on locums.

Findings against GMC's Standards for Medical Education and Training (Promoting Excellence, 2016)

Theme 1: Learning Environment and Culture

S1.1: The learning environment is safe for patients and supportive for learners and educators. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers and families.
S1.2: The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in *Good Medical Practice* and to achieve the learning outcomes required by their curriculum.

Induction (R1.10, 1.13, 1.19) Trust induction is comprehensive. Departmental induction involved digital information being sent in advance and a walk around each unit. Invitations to the induction held on zoom were sent to Trust email accounts, so those previously not worked in the Trust did not have access. Trainees out of sync in both CAH and DDH did not receive a full induction. Some issues with login passwords and ID badges were encountered in CAH.

Clinical Supervision (R1.7-1.10, 1.12a, 1.13, 1.15) CAH: 2 registrars on duty at night, if the weekend is busy the consultant will normally remain on site to around 10pm - if not busy they usually leave around 5pm. F2 and GPST1 feel well supervised. From the ST3+ point of view, the educational element of clinical supervision is variable on the floor especially OOH and at weekends. There is always a named consultant to contact for advice OOH, and often there is a SAS doctor also available. **DHH:** no concerns regarding clinical supervision.

Handover (R1.14). **CAH**: In both units there is an 8am handover. In CAH at the weekends ST3+ trainees frequently feel the need to stay the extra hour from 8am to 9am to handover directly to the consultant (starts at 9am), especially following a busy weekend night. In both units' consultants are present on the evening handover. Variable learning opportunity reported.

Practical Experience (R1.19) Experience gained is good. Trainees are allocated to different areas. Good case mix in both units.

Workload (R1.7, 1.12) Workload is variable during the week days in both units, however it has recently become more intense OOH and at weekends**.** Staffing numbers are lighter at these periods. Balance between service/training – more service than training currently. The increased numbers of patients attending in recent times and the knock-on effect of limited flow out of the departments to admission beds has led to significant overcrowding adding to the intensity.

EWTR Compliance (R1.12e)
CAH: There is no rota monitoring ongoing. No issues raised about the rota.
DHH: A monitoring exercise has recently taken place. Compliant.

Hospital and Regional Specialty Educational Meetings (R1.16) Local teaching is on a Thursday morning at 9am, this doesn't clash with regional GP training study days that are held at the end of the month. ST3+ have no issue getting time to go to weekly (4hrs) regional teaching.

Educational Resources, Internet Access, Simulation Facilities (R1.19, R1.20) No concerns.

Quality Improvement and Audit (R1.3, 1.5, 1.22) Trainees have been encouraged in QI projects within the Trust.

Patient Care (R1.1, 1.3, 1.4) Trainees expressed concern that patient care was potentially being compromised due to the numbers of patients attending the departments, leading to lengthy waiting times and significant overcrowding within the department. Acute emergencies were prioritised appropriately and still seen promptly, despite the ongoing pressures on the service.

Patient Safety (R1.1-1.5) All trainees advised there are no issues. If they had a concern all are aware of the Trust reporting system.

Theme 2: Educational Governance and Leadership

S2.1: The educational governance system continuously improves the quality and outcomes of education and training by measuring performance against our standards, demonstrating accountability, and responding when standards are not being met.
S2.2: The educational and clinical governance systems are integrated, allowing organisations to address concerns about patient safety.
S2.3: The educational governance system makes sure that education and training is fair and is based on principles of equality and diversity.

Educational Supervision (R2.11, 2.14, 2.15) Trainees reported that their educational supervision was excellent, and that they had no difficulties completing WBAs.

Theme 3: Supporting Learners **S3.1:** Learners receive educational and pastoral support to be able to demonstrate what is expected in *Good Medical Practice* and to achieve the learning outcomes required by the curriculum.
Feedback on Performance, Development and Progress (R3.13) Informal feedback variable, dependant on individual consultants in CAH. Handover meeting not always used fully to offer feedback on cases. ST3+ received less feedback than more junior trainees. DHH more regular informal feedback received. **Trainee Safety and Support (R3.2)** No concerns raised. All trainees know who to approach if they wanted to discuss anything in confidence. Specialty trainees in particular expressed their appreciation in regard to their consultant colleagues who regularly went over and above to support them during the covid-19 peaks. Examples were given of consultants dropping off shopping to those that has to self-isolate. There is weekly access to a clinical psychologist within the department for all staff. **Undermining (R3.3)** No issues reported. **Study Leave (R3.12)** No issues.
Theme 4: Supporting Educators **S4.1:** Educators are selected, inducted, trained, and appraised to reflect their education and training responsibilities. **S4.2:** Educators receive the support, resources and time to meet their education and training responsibilities.
Trainer Support (R4.1-4.6) Trainers felt supported by the Trust and NIMDTA. Their roles were included in their job plans and each underwent an annual educational appraisal.
Theme 5: Developing and Implementing Curricula and Assessments **S5.2:** Postgraduate curricula and assessments are implemented so that doctors in training are able to demonstrate what is expected in *Good Medical Practice* and to achieve the learning outcomes required by their curriculum.
No concerns identified.

Summary of Conclusions

The below conclusions have been categorised as follows:

v) Educational governance (training)

vi) Clinical governance or patient safety issues

Comment (if applicable):
Busy units currently under extreme pressures. Trainees however feel valued and very much supported by their consultant colleagues. The ST3+ trainees did however come across as somewhat 'battle weary' to the panel, which raised concern of how long this level of pressure can be endured.

Areas Working Well
1. Induction is comprehensive and occurs at each change over period. **2.** Handover is frequent throughout the day and structured.

Good Practice (includes areas of strength, good ideas and innovation in medical education and training):
7. Good practical experience in both departments. **8.** Local teaching held regularly and of good quality. **9.** Protected time for regional teaching. **10.** Access to study leave. **11.** No undermining or bullying. **12.** No trainee safety issues. **13.** Trainees well supported by senior colleagues. Positive training environment. **14.** Weekly access to session with a clinical psychologist. **15.** No patient safety concerns.

Areas for Improvement (issues identified has a limited impact on a trainee's education and training, or the quality provision for the patient):			
	Educational Governance	**Clinical Governance**	**RAG**
1. Informal feedback: is variable in CAH especially with the specialty trainees. Handover and direct supervision on the floor could offer opportunities for this.	✓	✓	N/A

Areas of Concern (trainees are able to achieve required outcomes, but the quality of education and training is recognised as requiring improvement and/or patients within the training environment are receiving safe care but the quality of their care is recognised as requiring improvement):			
	Educational Governance	**Clinical Governance**	**RAG**
4. Induction: CAH & DHH. Induction not fully delivered to 'out of sync' trainees. Accessing personal login codes was slow at times. Invitation to online induction sent to trust emails prior to training receiving that address.	✓	✓	N/A
5. Handover: CAH. Consultant not always present for 8am handover. ST3+ trainees feel they need to stay an additional hour at weekends to handover to consultant directly. Limited learning opportunity offered.	✓	✓	N/A
6. Clinical Supervision: CAH. From the ST3+ point of view, the educational element of clinical supervision is variable on the floor especially OOH and at weekends.	✓	✓	Amber
7. Workload:CAH. Imbalance between service and training currently.	✓		Amber
8. Patient Care: CAH. Overcrowding and length waiting times have the potential to compromise patient care. **This item has been provided for information only.**	✓	✓	N/A

Areas of Significant Concern (patients/trainees within the training environment are at risk of coming to harm and/or trainees are unable to achieve required outcomes due to poor quality of the training posts/programme):			
	Educational Governance	**Clinical Governance**	**RAG**
There were no areas of significant concern identified.			

Hospital Visited	Altnagelvin Area Hospital, Western Health & Social Care Trust
Specialty Visited	Emergency Medicine
Type of Visit	Cyclical
Trust Officers with Postgraduate Medical Education & Training Responsibility	Dr X, ES (ST3+) and clinical lead. Dr X, Director of Postgraduate Medical Education and Training. Dr X, Medical Director Ms X, Head of Service, Medical and Dental Education and Training
Date of Visit	22nd June 2021
Visiting Team	Dr X, Associate Dean for Deanery Visits (Chair) Dr X, Head of School for Emergency Medicine Dr x, Deputy Head of School for Emergency Medicine Dr X, GP Representative, Western Trust Ms X, Lay Representative Dr X, Associate Dean for Placement Quality Mrs x, Quality & Revalidation Manager, NIMDTA

Rating Outcome	Red	Amber	Green	White[1]
	0	4	1	0

Purpose of Deanery Visits	The General Medical Council (GMC) requires UK Deaneries/LETBs to demonstrate compliance with the standards and requirements that it sets (GMC-Promoting Excellence 2016). This activity is called Quality Management and Deaneries need to ensure that Local Education and Training Providers (Hospital Trusts and General Practices) meet GMC standards through robust reporting and monitoring. One of the ways the NI Deanery (NIMDTA) carries out its duties is through visiting Local Education and Training Providers (LEPS). NIMDTA is responsible for the educational governance of all GMC-approved foundation and specialty (including General Practice) training programmes in NI.
Purpose of this Visit	This is a cyclical visit to assess the training environment and the postgraduate education and training of trainees in Emergency Medicine in Altnagelvin Area Hospital.
Circumstances of this Visit	The Deanery Visiting Team met with educational leads, trainees and trainers in Emergency Medicine in Altnagelvin Area Hospital.
Relevant Previous Visits	Cyclical Visit to Emergency Medicine in Altnagelvin Area Hospital.
Pre-Visit Meeting	22nd June 2021
Purpose of Pre-Visit Meeting	To review and triangulate information about postgraduate medical education and training in the unit to be visited.
Pre-Visit Documentation Review	Background Information Template from Emergency Medicine Altnagelvin Area Hospital June 2021 Previous visit report 14th May 2015 and subsequent Trust Action Plan 23rd June 2016 Quality Placement Surveys May 2021 GMC National Training Survey 2012-2020
Types of Visit	Cyclical Planned visitation of all Units within 5 years Re-Visit Assess progress of LEP against a previous action plan Decision at Quality Management Group after grading of cyclical visit Reconfiguration of Service Problem-Solving Visit Request of GMC Request of RQIA Quality Management Group after review of submitted evidence sufficient to justify investigation and not suitable for investigation at Trust or Specialty School level.

This report reflects the findings from the trainees and trainers who were available to meet with the visiting team on the day of the visit and information arising from the pre-visit survey.

[1] Risks identified during the visit which were closed through action planning by the time of the final report.

Please note the following recommendations from the Francis Report on Mid-Staffordshire NHS Foundation Trust Public Inquiry on Training and Training Establishments as a Source of Safety Information:

- **Recommendation 160: Proactive steps need to be taken to encourage openness on the part of trainees and to protect them from any adverse consequences in relation to raising concerns.**

- **Recommendation 161: Training visits should make an important contribution to the protection of patients. Obtaining information directly from trainees should remain a valuable source of information.**

Trainees Interviewed			
	F1/F2	**GPST1**	**ST3+**
Posts	3	3	8
Interviewed	2	1	5

Trainers Interviewed

Trainers x 5

Feedback provided to Trust Team

Dr X, ES (ST3+) and clinical lead.
Dr X ES & CS (F2/GPST1).
Dr X, Director of Postgraduate Medical Education and Training.
Ms X, Head of Service, Medical and Dental Education and Training.

Contacts to whom the visit report is to be sent to for factual accuracy check

Dr X, Director of Postgraduate Medical Education and Training.
Ms X, Head of Service, Medical and Dental Education and Training.

Background

Organisation: Trainees are based in EM in Altnagelvin Area Hospital.

Staff: There are 10 consultants; 3 SAS grade; 8 ST3+; 3 GPST1; 3 FY2.

Rotas: consultant: 1 in 9 on call weekdays and weekends
SAS: 1 in 5 weekends
GPST1 and F2: combined 12 person rota band 1A
ST3+: 1 in 3 nights/weekends, approx. 39 hours per week.

NTS 2019: N/A

Previous Visits/Concerns: Feedback; **Patient safety** due to overcrowding and staffing levels; **Practical experience** in paediatric emergencies; **Educational Supervision; Clinical Supervision** especially at nights and weekends.

Findings against GMC's Standards for Medical Education and Training (Promoting Excellence, 2016)

Theme 1: Learning Environment and Culture

S1.1: The learning environment is safe for patients and supportive for learners and educators. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers and families.

S1.2: The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in *Good Medical Practice* and to achieve the learning outcomes required by their curriculum.

Induction (R1.10, 1.13, 1.19) Trust induction is comprehensive, administered through an online training portal. Departmental induction involved digital information sent in advance and a walk around each unit. Various resources on SharePoint on Trust computers to access guidelines. Repeated at each change over date and offered to those starting out of sync. No issues with login passwords and ID badges encountered.

Clinical Supervision (R1.7-1.10, 1.12a, 1.13, 1.15) Senior supervison always available for F2 and GPST1 trainees. Registrar on site. Consultant can be contacted directly. Consultant usually not on site after 7pm week days or to 3-4pm at weekends. They do come back in if there is a major issue. Trainees have a list of senarios of when they should call the consultant in to the department. Trainees rarely called consultants to come in. ST3 may be the most senior doctor in the department overnight. Trainees never feel that they are working outside their level of experience.

Handover (R1.14) Handover is carried out twice daily. Handover is at 8am (night registrar to day staff) with Consultant starting board round with lead nurse at 9am. Consultant not present at morning handover. Second handover is at 4pm. This is a formal handover with consultant present. This is of educational value with teaching points highlighted. Informal feedback offered regularly. Supportive and comfortable environment.

Practical Experience (R1.19) Experience gained through a wide case mix. Trainees rotate through all areas. Allocation is organised by the registrar working on the 8am to 5pm shift. Plenty of opportunity to perform procedures under supervision.

Workload (R1.7, 1.12) Workload is variable during the week days. Workload is intense OOH and at weekends**.** F2/GPST1 rota results in unsociable hours with frequent changes between days and nights and a large number of weekends. No pressure for trainees to cover the gaps. There is a culture for trainees to get away on time at the end of each shift.

EWTR Compliance (R1.12e) The rota is compliant.

Hospital and Regional Specialty Educational Meetings (R1.16) There are weekly teaching sessions on Thursdays and Fridays. Thursday sessions are for the F2/GPST1 trainees. The Thursday session unfortunately clashes with GP regional training teaching days. Friday sessions are for the whole department, at 11am and lasting 1 hour. The trainees actively participate and receive feedback. External speakers invited. There is a plan to restart the Journal club.

Educational Resources, Internet Access, Simulation Facilities (R1.19, R1.20) Simulation training offered to F2/GPST1 trainees, not currently for specialty trainees.

Quality Improvement and Audit (R1.3, 1.5, 1.22) Trainees have been encouraged to be involved in QI projects. Audits and QIPs would be presented at the Thursday teaching session.

Patient Care (R1.1, 1.3, 1.4) Patient care reported as excellent. Adequate space now provided within the department. Supportive nursing team that promptly facilitate movement of patients when needed (e.g. into resus)

Patient Safety (R1.1-1.5) All trainees advised there are no issues in regard to patient safety. All are aware of the trust reporting system. Trainees feel supported when raising a concern.

Theme 2: Educational Governance and Leadership

S2.1: The educational governance system continuously improves the quality and outcomes of education and training by measuring performance against our standards, demonstrating accountability, and responding when standards are not being met.

S2.2: The educational and clinical governance systems are integrated, allowing organisations to address concerns about patient safety.

S2.3: The educational governance system makes sure that education and training is fair and is based on principles of equality and diversity.

Educational Supervision (R2.11, 2.14, 2.15) Trainees reported that their educational supervision was excellent, and that they had no difficulties completing WBAs or securing time to meet with their ES.

Theme 3: Supporting Learners **S3.1:** Learners receive educational and pastoral support to be able to demonstrate what is expected in *Good Medical Practice* and to achieve the learning outcomes required by the curriculum.
Feedback on Performance, Development and Progress (R3.13) Feedback on performance is given on a regular basis at educational meetings. Informal feedback is variable depending on individual consultants. Handover offers a good educational opportunity with feedback. **Trainee Safety and Support (R3.2)** No concerns raised. All trainees know who to approach if they wanted to discuss anything in confidence. Unit aims to offer 'wrap around supportive environment'. Trainees that had not previously worked in NI, have required significant additional support. Comments of pre-visit survey noted by the panel. Dealing with conscious and unconscious bias is a priority and training in this is being rolled out within the department. **Undermining (R3.3)** No concerns reported. **Study Leave (R3.12)** No issues.
Theme 4: Supporting Educators **S4.1:** Educators are selected, inducted, trained, and appraised to reflect their education and training responsibilities. **S4.2:** Educators receive the support, resources and time to meet their education and training responsibilities.
Trainer Support (R4.1-4.6) Trainers felt supported by the Trust and NIMDTA. Their roles were included in their job plans and each underwent an annual educational appraisal.
Theme 5: Developing and Implementing Curricula and Assessments **S5.2:** Postgraduate curricula and assessments are implemented so that doctors in training are able to demonstrate what is expected in *Good Medical Practice* and to achieve the learning outcomes required by their curriculum.
No concerns identified.

Summary of Conclusions

The below conclusions have been categorised as follows:

vii) Educational governance (training)

viii) Clinical governance or patient safety issues

Comment (if applicable):
Despite being a busy clinical area the trainees feel well supported. Trainees that had not previously worked in NI, have required significant additional support.

Areas Working Well
1. Good balance between service and training despite this being a demanding and pressurised clinical environment.

Good Practice (includes areas of strength, good ideas and innovation in medical education and training):
1. Induction is repeated regularly and continually updated. **2.** Excellent opportunities for practical experience. **3.** Excellent patient care. **4.** Regular weekly teaching sessions. **5.** AUDIT/QI well supported. **6.** No undermining or bullying. **7.** No trainee safety issues. **8.** Supportive environment.

Areas for Improvement (issues identified has a limited impact on a trainee's education and training, or the quality provision for the patient):			
	Educational Governance	**Clinical Governance**	**RAG**
Local Teaching: ST3+ would benefit from specific local teaching sessions. Simulation sessions would be welcomed.	✓		Green
Feedback: Frequency of informal feedback variable on the floor. Trainees would value regular feedback on their decision making.	✓		Amber

Areas of Concern (trainees are able to achieve required outcomes, but the quality of education and training is recognised as requiring improvement and/or patients within the training environment are receiving safe care but the quality of their care is recognised as requiring improvement):			
	Educational Governance	**Clinical Governance**	**RAG**
1. **Clinical supervision:** trainees on 4pm-12 midnight shift have limited on site consultant supervision		✓	Amber
2. **Rota Design**: F2/GPST1 rota results in unsociable hours with frequent changes between days and nights and a large number of weekends. Leads to missing a number of teaching sessions	✓		Amber
3. **Handover:** routinely no consultant at the 8am handover. Consultant starts at 9am.	✓	✓	Amber

Areas of Significant Concern (patients/trainees within the training environment are at risk of coming to harm and/or trainees are unable to achieve required outcomes due to poor quality of the training posts/programme):			
	Educational Governance	**Clinical Governance**	**RAG**
There were no areas of significant concern identified.			