NIMDTA
Deanery Review of Paediatric Surgery Specialty Programme
FINAL REPORT

Specialty Programme Reviewed	**Paediatric Surgery**
Type of Visit	**Cyclical**
Training Programme Director	**Mr Alistair Dick**
Date of Review	**Thursday 18 January 2018**
Visiting Team	Dr Richard Tubman, Associate Dean for Faculty Development & Deanery Visits (Chair) Mr Trevor Thompson, Head of School of Surgery Mr Mark Powis, Chair SAC in Paediatric Surgery, JCST (External Representative) Mr Jonathan Patton, Lay Representative Ms Emma Dickson, Quality Management Executive Officer, NIMDTA
Rating Outcome	**Summary Rating Outcomes**

Red	Amber	Green
0	0	3

Purpose of Deanery Visits	The General Medical Council (GMC) requires UK Deaneries and LETBs to demonstrate compliance with the standards and requirements that it sets (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 Northern Ireland Deanery (NIMDTA) carries out its duties is through visiting Local Education and Training Providers (LEPS) and Specialty Training Programmes. NIMDTA is responsible for the educational governance of all GMC-approved foundation and specialty (including General Practice) training programmes in Northern Ireland.
Purpose of this review	The purpose of this review is to assess the training environment and the postgraduate education and training of trainees in paediatric surgery. The visit team did not meet with GP or Foundation trainees who rotate through the first tier rota in the paediatric surgical department.
Circumstances of this review	The Deanery Visiting Team met with the Training Programme Director, Specialty trainees in the Programme and Clinical/Educational supervisors from Belfast Trust.
Relevant previous visits	01 December 2011
Pre-review meeting	08 January 2018
Purpose of pre-review meeting	To review and triangulate the information about postgraduate medical education and training in the programme to be visited.
Pre-visit documentation review	TPD Background information template 6/8/2017 LEP Background information template 19/12/2017 Trainee Survey Monkey questionnaire January 2018 GMC National Training Surveys 2017 Previous visit report December 2011 Trust action plan and updates 2011-2014
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:

- **<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.**

Educational Leads Interviewed		
Mr Alistair Dick, Training Programme Director and Educational Supervisor, Paediatric Surgery Dr Andrew Thompson, Specialty Lead for Paediatrics		
Trainees Interviewed		
	CT1-2	**ST3-8**
Total Posts	1	3
Interviewed	0	4 (2 LTFT)
Trainers Interviewed		
5		
Feedback provided		
Mr Chris Hagan, Divisional Chair, Specialist Services Women and Children Mr Ciaran Bradley, Service Manager, Specialist Services Women and Children		
Contacts to whom the visit report is to be sent to for factual accuracy check		
Mr Alistair Dick, Training Programme Director (TPD), Paediatric Surgery Mr Trevor Thompson, Head of School, Surgery <u>BHSCT Annex</u> Dr Cathy Jack, Medical Director Dr Una Carabine, Director of Medical Education		

Background

Trainees in Programme:
After their two years' core surgical training, of which 6 months may be in paediatric surgery, trainees undertake subspecialty training in Paediatric Surgery in ST3-8. Trainees are required by the Paediatric Surgery Specialty Advisory Committee (SAC) to have trained in at least two centres. Training centres are grouped into consortia, although Belfast is not currently formally part of a consortium. Training outside Belfast has therefore been arranged on an individualised basis for trainees to meet these requirements. Trainees sit an exit examination in the specialty after ST6.

Programme Training Sites:
The Paediatric Surgery training programme is based in Royal Belfast Hospital for Sick Children (RBHSC), with some sessions in the Ulster Hospital, Dundonald.

Staff:
There are seven consultant paediatric surgeons, two specialty doctors, three ST3-8 trainees in Paediatric Surgery (currently four trainees as two are LTFT) and 1 core trainee (usually CT2). The first tier is staffed by F2 and GPST trainees who follow a weekly rotation in paediatric medicine and surgery.
There are two educational supervisors, one for the ST5-8s and one for the ST3/4 core trainee. There are four clinical supervisors.

Rotas:
The specialty rota is 1:7 non-resident on-call (Band 3). The first tier rota is a 1:10 partial shift (F2 and GPST trainees).
Pre-visit Survey Monkey:
100% response rate: 4/5 trainees rated their overall training as good-excellent.

NTS
There were green indicators for Workload, Teamwork, Supportive Environment and Adequate Experience for all trainees in post in the 2017 Trainee survey. There was a green indicator for Handover for Specialty trainees in that survey.
There was a 75% response rate to the 2017 Trainer Survey. There were red indicators for Time for Training and Trainer Development.

Previous Visits or Concerns
There were a number of areas for improvement in the 2011 visit report. Most of these were related to the first tier trainees, and these issues have been substantially addressed since then, with removal of paediatric ST1 trainee from the rota and an improved rotation and experience for F2 and GPST trainees.

Annex for Belfast HSCT:

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)
Trainees reported that induction materials were provided in advance and that they obtained passwords, ID badges etc. without delay.

Clinical Supervision (R1.7-1.10, 1.12a, 1.13, 1.15)
Trainees reported that all consultants were easily contacted, were approachable and supportive at all times including at clinics and out of hours. The CT2 trainee acts up on the middle tier rota but is closely supervised particularly at the start of the post.

Handover (R1.14)
There are two handovers at 8.00am and 5.00pm, which take place at the nursing station in the surgical ward. A handover sheet is used and all patients, including outliers, are discussed. There is a safety brief. In the morning, the consultant on-call overnight hands over by phone to the consultant of the week. The 5.00pm handover is less formal. There is a team discussion on Friday mornings about any long-term ward patients.

Practical Experience (R1.19)
The ST3 trainee reported that they got good experience and their log book had been filled up very well compared to colleagues in other centres. There were lists in Ulster Hospital Dundonald (UHD) which were well supervised and particularly geared to core/ST3 level.
Weekly duties were split between being attached to the consultant of the week (emergency lists and ward work) and non-urgent work. There was a daily consultant ward round which the trainees also led.
The senior trainees reported that there was sometimes competition for index cases, particularly for the LTFT trainees, but that they tried to balance it out equitably amongst themselves. There was not normally so many very senior trainees in the programme at the same time.
Some of the more complex cases required two consultants in theatre which naturally reduced training opportunities. There were on average three theatre sessions per week. There were good opportunities generally to perform surgical procedures although laparoscopic surgery was performed less often compared to other centres in the UK.
Trainees attended on average 1-2 clinics per week; they saw a range of new and review patients and discussed their management with the consultant. Clinic space was said to be limited in UHD.
We did not meet with the CT2 trainee on the visit but were informed that the core training post in paediatric surgery was highly valued and there was always a keen interest in the post from core trainees.
Ward work is done by the F2/GPST trainees.

Workload (R1.7, 1.12)
Trainees reported that their workload was busy but manageable. They were called to see patients in the Emergency Department (ED) most nights, and would take phone calls after midnight. There was an emergency list each day except Mondays.
Trainees reported that their workload and continuity of care was greatly helped by the presence of an advanced surgical nurse practitioner who was currently on sabbatical.

EWTR Compliance (R1.12e)
The rota is Band 3, 24 hour non-resident on call. This is monitored every 6 months and fed back to the trainees for their agreement. Trainees reported that they preferred this because it allowed adequate training opportunities which would be lost by another shift pattern.

Hospital and Regional Specialty Educational Meetings (R1.16)
There is a weekly local teaching session from 10.00am - 12.00pm on Friday mornings and an X-ray meeting at 12.00pm. This is attended by trainees and consultants, and there are presentations by trainees and guest speakers. Trainees reported that this had become less well organised of late, with variable attendance by consultants. There had not been a journal club for a long time although one was planned for this month. Trainees also attended M+M/audit meetings.
There were meetings between Belfast and Dublin every 6-12 months.
Paediatric SAC had started a "boot camp" for new entrants to paediatric surgery although this was not mandatory and the ST3 trainee had not attended it.
Trainees reported that they received very good bedside teaching from the consultants.

Educational Resources, Internet Access, Simulation Facilities (R1.19, R1.20)
Trainees reported that they used the single computer in the theatre rest area but that it was often in use by other members of staff. There were other computers in the education room above the oncology outpatients department but this is at the far end of RBHSC and not quickly accessible between cases.

Quality Improvement and Audit (R1.3, 1.5, 1.22)
No difficulties accessing QI/audit.

Patient Care (R1.1, 1.3, 1.4)
Trainees reported that in their view patient care was good to excellent; however there were "never enough nurses in Barbour Ward" and that the layout of the ward was less than optimal.

Patient Safety (R1.1-1.5)
No individual patient safety concerns were raised. There is an open and positive culture of patient safety within the department.
Trainers reported that patient notes were often unavailable in outpatients. This was inefficient and potentially unsafe.

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 they were each allocated to a named Educational Supervisor (ES). They expressed some concern about the difficulty in arranging meetings with their ES, which were sometimes at the last minute before ARCP. They believed that this was because the ES was so busy.

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)
Trainees reported that they got regular feedback particularly as procedure-based assessments in theatre, and in clinics.

Trainee Safety and Support (R3.2)
No concerns reported.

Undermining (R3.3)
No concerns reported.

Study Leave (R3.12)
Trainees reported that study leave did not cover some of the advanced opportunities that were available to them, however trainees receive £1250 pa for study leave.
Trainers reported that "Training the Trainer" was mandated by SAC to achieve CCT, however, the courses provided by NIMDTA are sufficient to meet CCT requirements.

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 reported that they had all been able to access courses required for Recognition of Trainer status.
Their educational role was included in their job plans and funded.
There was some uncertainty about how they were appraised in their educational role and most were unclear about the Trust process of educational review.
One of the Consultants is salaried by South Eastern Health and Social Care Trust though works mostly in RBHSC. This has caused some difficulties accessing training opportunities via HRPTS, which were said not to be available in Belfast Trust.

Summary of Conclusions

The below conclusions have been categorised as follows:

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

Comment
The visit team did not meet with F2 or GPST trainees on this occasion.

Areas Working Well
1. Survey feedback from Trainees has been very positive.
2. Exam pass rates have been excellent.
3. Clinical supervision is good at all times.
4. There are good opportunities for operative experience.
5. Trainees are consulted about, and fed back with the results of EWTR monitoring every 6 months.
6. There is a positive patient safety culture in the department.

Good Practice (includes areas of strength, good ideas and innovation in medical education and training):
Continuity of care and trainee workload has been greatly helped by the presence of an advanced nurse practitioner in the department. This should be taken into account in workforce planning.

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. Local Teaching. The organisation of the Friday morning teaching programme should be reviewed.	✓		Green
2. Local Teaching. Trainees would benefit from a more regular journal club.	✓		Green
3. Trainer Support. Trainers were not clear about how the BHSCT process of annual review works.	✓		Green

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. Potential Patient Safety. Trainers reported that patient notes were regularly unavailable in outpatients. This was inefficient and potentially unsafe. This has been shared 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**
None identified.			N/A

Summary Rating Outcomes		
Red	**Amber**	**Green**
0	0	3