NIMDTA
Deanery Visit to Northern Trust
FINAL REPORT

Hospital Visited	**Causeway Hospital, Northern Trust**
Specialty Visited	**General Medicine**
Type of Visit	**Enhanced Monitoring Re-visit**
Trust Officers with Postgraduate Medical Education & Training Responsibility	Mr Seamus O'Reilly, Medical Director Dr Kate Scott, Interim Director of Medical Education Dr Wendy Anderson, Divisional Medical Director
Date of Visit	**22nd March 2018**
Visiting Team	Dr Richard Tubman, Associate Dean (Chair) Dr Jackie Rendall, Head of School, Medicine Dr Brian Bonner, GP Representative Ms Sinead Burns, Lay Representative Mr Robin Benstead, GMC Representative Ms Sophie Elkin, GMC Representative Dr Helen Groves, Trainee Representative Mrs Gillian Carlisle, Quality & Revalidation Manager, NIMDTA
Rating Outcome	**Red** 7 / **Amber** 2 / **Green** 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 Northern Ireland 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 Northern Ireland.
Purpose of this visit	This is an Enhanced Monitoring re-visit to assess the training environment and the postgraduate education and training of trainees in General Medicine training at Causeway Hospital.
Circumstances of this visit	The Deanery Visiting Team met with educational leads, trainees and trainers in General Medicine at Causeway Hospital.
Relevant previous visits	Enhanced monitoring visit to General Medicine, Causeway Hospital, 19th January 2017
Pre-visit meeting	8th March 2018
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	Previous visit report 19th January 2017 and subsequent Trust Action Plan Trust Background Information Template 7th December 2017 Pre-visit SurveyMonkey® January 2018 and March 2018 GMC National Training Survey 2017
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

Dr Charles Jack (Educational Supervisor)
Dr Fergal Dunn (Educational Supervisor)

Trainees Interviewed

	F1	F2	CT1/2, ST3+
Posts	9 (medicine)	6	3 CT1, 3 CT2, 2 ST3+
Interviewed	5 (medicine), 2 (surgery)	4	2 CT1, 2 CT2, 2 ST3+ (ST5 Nephrology in GIM post, ST7 AIM in cardiology post)

Trainers Interviewed

6

Feedback provided to Trust Team

Ms Jennifer Welsh, Deputy Chief Executive
Mr Seamus O'Reilly, Medical Director
Dr Wendy Anderson, Divisional Medical Director
Dr Fergal Dunn, Clinical Director Medicine and Emergency Medicine
Ms Wendy Magowan, Divisional Director of Medicine and Emergency Medicine
Ms Elizabeth Brownlees, Director Human Resources
Ms Karen Jenkins, Governance Manager
Mr Kevin McMahon, Assistant Director
Mrs Jayne McReynolds, Corporate Planning

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

Mr Seamus O'Reilly, Medical Director
Dr Kate Scott, Interim Director of Medical Education
Dr Wendy Anderson, Divisional Medical Director
Dr Karen Darragh, Education Lead, Medicine

Background

Organisation:
The Trust management informed us that they were changing the organisation of the wards, by trying to make them specialty-team based, and with two-weekly fixed consultant ward rounds. They had invested in an enhanced phlebotomy service seven days per week and pharmacy input six days per week, Monday-Saturday. A weekly microbiology ward round was being piloted, with rotational attendance by the consultant microbiologists from Antrim Area Hospital.

Staff:
There are 10 consultants. There are 5 specialty doctors, 3 of whom are recognised trainers. There are currently 2 ST3+, 6 CT1/2, 1 GPST, 6 F2 and 8 F1 posts in Medicine. There are also a variable number of locums across all levels.

Other Sites: N/A

NTS: 2017
There was a green indicator for educational governance for F1 trainees.
There were red indicators for overall satisfaction, clinical supervision, clinical supervision out of hours and reporting systems; and pink indicators for teamwork, handover, curriculum coverage and feedback for F2 trainees.
For the medicine specialty overall there was a recurrent red indicator for overall satisfaction, and red indicators for clinical supervision, clinical supervision out of hours, teamwork and local teaching.

We are aware that the 2018 NTS is currently open.

Pre-visit SurveyMonkey:
There were 16 responses across all grades to the January 2018 SurveyMonkey. There were seven responses to a repeat questionnaire sent out in March 2018 to foundation doctors only.
2/16 trainees responding to the January survey said that they had been undermined by managers, nurses, other trainees or consultants. 5/16 had raised specific concerns about patient safety. Neither of these concerns was raised in the March survey.

Previous Visits/Concerns:
The Enhanced Monitoring visit in January 2017 identified serious concerns about a range of issues, mostly related to the effects of how the medical wards were run, but also about undermining and potential patient safety. There were concerns about clinical supervision, induction, handover, workload and clinic attendance by CTs.

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)
F1: F1 trainees said that Trust induction was good, and that they had received a useful handbook. Local induction was very comprehensive and included an outline of their duties, cross-cover arrangements and a tour of the department. There was some delay in obtaining personal swipe cards due to a shortage (there was a transition to a new form of pass card at that time).

F2: F2 trainees said that the induction pack included information on the transition from F1 to F2, as well as practical information. They had no difficulty obtaining swipe cards.

CT/ST3+: CT trainees said that Trust and local induction were both good but that they would have appreciated getting a tour of the hospital.

Clinical Supervision (R1.7-1.10, 1.12a, 1.13, 1.15)
F1: F1 trainees said that supervision was good during the daytime and that they were very well supported by Hospital at Night (H@N) out of hours. There was always senior support available when needed.

F2: F2 trainees said that they were well supervised. Consultants would come in at night when called, but they sometimes seemed reluctant if called to see a problem that was not their subspecialty.
CT/ST3+: Trainees said that consultants were always available and responsive out of hours. They said that the

anaesthetics staff were helpful.
There was a lack of clarity about which consultant is responsible for patients when their named consultant is on leave.

Handover (R1.14)
There is an informal peer-peer handover between F1 trainees around 9am. All other trainees, consultants and the bed manager attend a formal 08.45 handover meeting. All the admitted patients are discussed and triaged for review. However, there is no discussion about patient management and no feedback to trainees.
There is a 9pm H@N handover attended by day and night teams including F1, the H@N team, bed manager and phlebotomist. This was said to be good with a focus on management, although consultants did not attend.

Practical Experience (R1.19)
F1: F1s carry out a range of jobs in the wards including insertion of cannulas, phlebotomy, writing up drugs and fluids, and discharge letters (up to 12/day particularly on Fridays). They can attend ward rounds in MAU, cardiology and rehabilitation if not busy but otherwise consultant ward rounds are very ad hoc. They rarely clerk in patients except out of hours if not otherwise busy. F1 trainees said that they should be able to get all of the required basic procedures completed in this post. There was good phlebotomy and pharmacy support.

F2: F2s were allocated by email on the preceding Sunday to a specific ward for a week at a time. F2 experience was variable depending on the ward that they were attached to. The attachment to Medical 1 was very busy as there were often many outlying patients. There was no regular schedule or structure for consultant ward rounds; they didn't know when the consultant was going to appear on the ward but would accompany them to see some patients when they did attend.
One F2 trainee had joined a scheduled consultant ward round in the week before the visit; they reported that this was a very good learning experience. F2s said that a structured ward round would improve patient flow and continuity of care, and would be an opportunity for feedback.
F2 trainees said that they didn't get many opportunities to perform practical procedures as these were done by CTs and staff grades. They said that the staff grades did the bulk of abdominal paracenteses and pleural procedures.

CT: Trainees described how they were assigned to a ward on a weekly basis, although sometimes they were in a ward for only 2-3 days. They did not know when consultant ward rounds were supposed to happen. There was a timetable in the ward but this was not followed. Consultant ward rounds seemed random. The exception to this was in cardiology.
CT trainees said that it was not clear what their role was in the ward, and that communication between them and consultants was not good. They described their post in Causeway as being "very different" to other CT posts that they had worked in.
They reported that they could do some procedures under supervision by the ST3+ trainee but that it was difficult to get consultants to supervise procedures. CTs said that they had only attended 1-2 clinics each so far in their posting, and just in cardiology. They were unable to get to most clinics because they were busy in the wards and because there was no space for them in clinic (there was room for a consultant and a staff grade). They thought that there might be scope for the staff grades to cover the wards to allow them to get to clinic. They said that this post could not be relied upon to allow them to get to the number of outpatient sessions required by the curriculum.

ST3+: The ST5 trainee said that their placement was not particularly helpful for their training, as their role was similar to that of the CTs. This placement should be reviewed by the School of Medicine.
The ST7 trainee was in a bespoke placement, so only did cardiology. They were able to do echos and DCCs and were very happy with their experience to date.

Workload (R1.7, 1.12)
F1 & F2: Workload was said to be busy but manageable by day but particularly heavy at the weekends. There were fewer F1 trainees than normal at the present time.

CT and ST3+: Workload is busy but trainees usually get away on time at the end of a shift.

EWTR Compliance (R1.12e)
Rotas are compliant but require locums to fill in gaps.
Hospital and Regional Specialty Educational Meetings (R1.16)

There is local teaching four days per week. This was said to be usually good. All staff from F1 to consultant have the opportunity to present at these sessions, and they receive feedback. Trainees were not often bleeped out of teaching. There was regular bedside teaching in MAU.
There were no reported difficulties accessing regional teaching.

Educational Resources, Internet Access, Simulation Facilities (R1.19, R1.20)
There is a lumbar puncture simulator but no regular simulation drills or human factors training.

Quality Improvement and Audit (R1.3, 1.5, 1.22)
No issues where relevant.

Patient Care (R1.1, 1.3, 1.4)
Trainees reported that patient care was in their view good in cardiology and rehabilitation and of average quality elsewhere. They were reluctant to be more specific about the latter.
There was reduced continuity of care because of their frequent changes between the wards.

Patient Safety (R1.1-1.5)
There were no specific issues raised, although F2 were concerned that medical outliers in the surgical wards might not be seen by a consultant for several days. Trainees were told about Datix at induction.

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)
All trainees have a named educational supervisor and have met with them to agree educational objectives. There are no difficulties accessing workplace based assessments.

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)
There is a monthly F1/F2 trainee forum. F1 trainees said that this was a very good opportunity to bring up issues, which were responded to by senior staff. CT and ST3+ trainees said that they would like to take part in a trainee forum.

Trainee Safety and Support (R3.2)
We were told that one F2 trainee carried out an ambulance transfer of a renal patient, having been asked by a locum consultant to do this.
Trainees wear lanyards to identify their grades. They said that this has been a helpful initiative.

Undermining (R3.3)
X

Study Leave (R3.12)
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 reported that they had been supported by the Trust to complete STATUS training.
Their educational role was still not formally recognised in job planning and they had not received their additional supplement for training.

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 limited opportunities for simulation.

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)

The visit team were encouraged to hear that the Trust have taken some initial steps to respond to the issues raised at the last visit. In particular, we were pleased to learn of the monthly foundation trainee forum, the weekly microbiology rounds and the increased investment in phlebotomy and pharmacy support. We welcome their approach to re-organisation of the model of care in the medical wards, but caution that there is still work to be done to finesse the model and ensure its sustainability. There remain significant challenges for core medical trainees attending regular outpatient clinics and this must be resolved in the immediate short term so that core trainees can to meet their mandatory curriculum requirements.

Areas Working Well

1. Trust induction is good.
2. Local induction is comprehensive.
3. Trainees are generally well-supervised clinically by day and out of hours.
4. The H@N handover is effective and F1 are supported well by the H@N team.
5. There is a well-run regular local teaching programme.
6. There is good phlebotomy and pharmacy support.
7. Educational supervision is good.
8. The pilot of a weekly microbiology ward round has been well received and has provided a beneficial educational opportunity for trainees.

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

1. The monthly Foundation trainee forum is a good opportunity for trainees to raise concerns to senior medical and management staff. Issues are responded to in a timely fashion.
2. Trainees' grades are identified by specific coloured lanyards.

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. Induction. The walk-round at induction should include all trainees at all grades who have not worked in Causeway Hospital before.	✓	✓	Amber
2. Handover. F1 do not take part in the morning handover meeting. Attendance would be beneficial to their training and be an opportunity for feedback.	✓	✓	Amber
3. Practical Experience. Core trainees (and preferably F2) should get more access to practical procedures, which are mainly done by the specialty doctors.	✓		Red
4. Feedback on Performance, Development and Progress. The trainee forum should be extended to include all grades of trainee.	✓		Green
5. Educational Resources, Internet Access, Simulation Facilities. Simulation is limited to task training. There are opportunities for multidisciplinary team simulation drills and human factors training.	✓	✓	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. Practical Experience. F1 trainees attend consultant ward rounds infrequently (apart from MAU, cardiology and rehabilitation). F1 trainees rarely clerk-in patients, apart from occasionally during out of hours. **The Deanery QM group have agreed to merge items 1 and 2 (as listed on the interim report) as all relate to F1 practical experience.**	✓	✓	Red
2. Practical Experience. Trainees are allocated to wards at very short notice and for short periods of not more than a week. This prevents continuity of care.	✓	✓	Red
3. Practical Experience. Although there have been initial moves to make consultant ward rounds more efficient, the majority of these are still ad-hoc. This hinders communication between consultants and trainees and is disruptive.	✓	✓	Red
4. Patient Safety. Trainees were concerned that there were delays in outlying patients being seen by a consultant.		✓	N/A
5. Clinical Supervision. There was a lack of clarity about which consultant is responsible for patients when their named consultant is on leave.	✓	✓	Red

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. Undermining. X	✓	✓	Green
2. Trainee Safety and Support. We were told that one F2 trainee carried out an ambulance transfer of a renal patient, having been asked by a locum consultant to do this. All staff must be reminded that F2 trainees must not do ambulance transfers.	✓	✓	Green
3. Practical Experience. Core medical trainees do not get enough exposure to outpatient clinics. This is a mandatory part of their training and must be rectified immediately; otherwise it could bring into question the suitability of the CMT posting to Causeway Hospital.	✓		Red
4. Trainer Support. The additional funding for recognised trainers has not yet been allocated.	✓		Red

Summary Rating Outcomes		
Red	**Amber**	**Green**
7	2	4