CORE SURGICAL TRAINING PLACEMENT QUALITY REVIEW 2020

Northern Ireland Medical and Dental Training Agency
REPORT COMPILED BY DR S.A.PHILLIPS & DR K.WALSH

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Executive Summary

In Northern Ireland, the percentage of doctors entering directly into GP/specialty training post-Foundation has fallen from 70.9% in 2011 to 34.3% in 2019.[1] Despite this decline, surgical training in Northern Ireland (NI) remains a competitive and attractive specialty with a competition ratio of 5.1 for entry to the Core Surgical Training (CST) programme in 2019.[2] This compares favourably to the 2019 national competition ratio of 2.93.[3]

The CST programme in Northern Ireland recruits into CT1 and is a two year programme, with trainees rotating between surgical subspecialty posts on a six monthly basis across all five Health and Social Care Trusts. The programme currently (Aug 2020) has 82 training posts across CT1 and CT2.

The Placement Quality (PQ) Review of Specialty Training Programmes started in August 2018. The aim of this work is "*To optimise patient-centred care though quality improvement of medical training posts within Northern Ireland, involving rigorous review of current placements, active engagement with trainees, trainers and providers, and the development and implementation of strategies to improve current practice within medical training*." The PQ review adds to the existing information available from NIMDTA deanery visits and the GMC National Training Surveys (NTS), providing a more detailed specialty specific assessment of the quality of training posts in Northern Ireland.

A PQ Review of core surgical training (CST) was completed in 2019/20. The first step in the process was to review the current training curricula and educational framework to confirm the requirements for training in core surgery.[4, 5] Feedback from the Head of School of Surgery and a number of surgical trainees was then used by the Placement Quality team to compile a detailed survey to assess the quality of training placements. This was approved by the Head of School and the Specialty School Board at NIMDTA. The survey was circulated to all trainees working in a core surgery placement between August 2019 and January 2020. The survey was open for three weeks in December 2019-January 2020. The response rate was 74% (62/84). The balance of respondents was 47% CT1 surgery trainees, 47% CT2 surgery trainees and 6% CT2R trainees.

Section 1 of this report summarises the results of the survey under the following headings:

1. Post Preferences, Rota Allocations and Induction
2. Educational Supervision, Clinical Supervision and Feedback
3. Clinical Workload
4. Formal Teaching and Educational Opportunities
5. Overall Opinions and Trainee Suggestions for Improvement

Section 2 highlights the identified good/transferrable practice and sets out the agreed local actions for improvement.

To ensure improvements are maintained and to assess the success of additional measures that have been introduced to further improve the training experience, the Placement Quality Team at NIMDTA will be conducting a further survey of all trainees in core surgery training placements in 2021.

Section 1: Analysis and Recommendations

1. Post Information, Rota Allocations and Induction

Post Information

Additional information about training posts prior to making placement preferences was requested by 80% of trainees. This included more information on rota patterns, banding, number of theatre sessions and out-patient clinics (OPCs), details of specialist services, unit demographics and protected training time (Table 1).

Table 1: Information requested prior to making posting preferences (% of trainees)

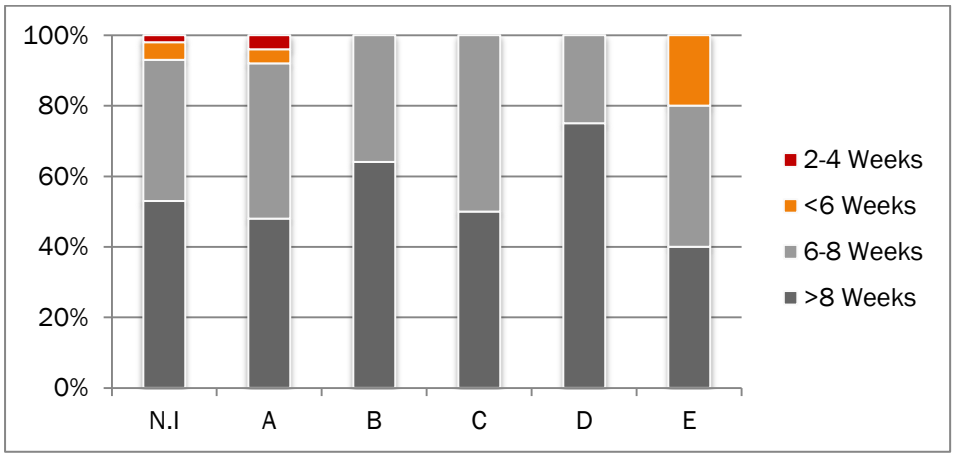
Rota Pattern	60%
Number of theatre sessions per week	65%
Number of OPCs per week	22%
Salary/Banding	42%
Amount of protected training time per week	52%
Specialist services offered in the unit	18%
Unit demographics	27%

Rota Allocations

It is a requirement of the Learning and Development Agreement between NIMDTA and Local Education Providers (LEPs) that information relating to the allocation of trainees within training programmes is provided to LEPs 8 weeks in advance of the changeover date.[6] Trainees are notified by NIMDTA of their post allocation at this time and Trusts are then required to inform trainees of their out of hours (OOH) rota allocation at least 6 weeks before the commencement of their post.[7]

The majority of trainees (93%) reported receiving notification from NIMDTA of the Trust where they would be working at least 6 weeks prior to starting their post, with 53% getting more than 8 weeks' notice. Regionally 1 trainee (2%) had less than 6 weeks' notice (Figure 1).

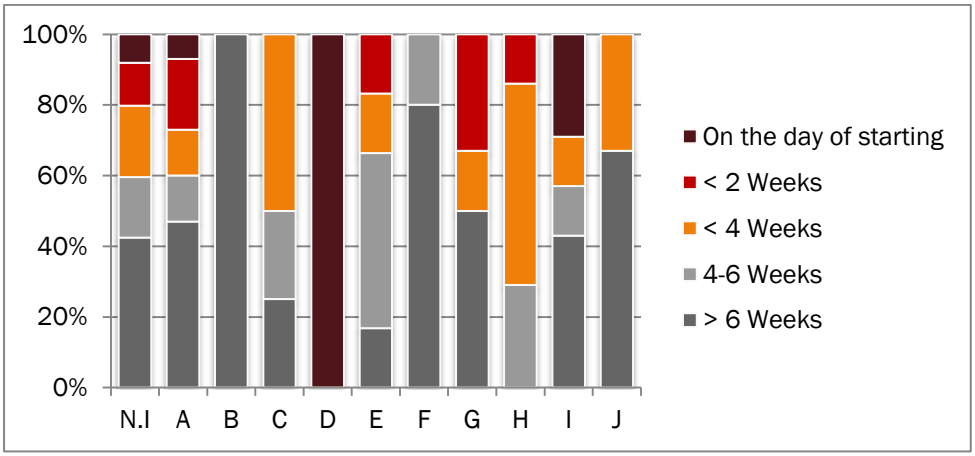
Figure 1: NIMDTA notification of training placement by Trust



Trainee feedback indicated that timely notification by Trusts of out of hours (OOH) rotas is an issue with only 42% of trainees receiving information about their OOH rotas at least 6 weeks prior to post commencement. A further 40% of trainees reported less than 4 weeks' notice of their OOH rota and half of these (20%) received less than 2 weeks' notice prior to starting their post (Figure 2).

There was some variation across hospital sites with earlier rota notification noted in sites B, F and J, where at least 6 weeks' notice of OOH arrangements was reported by 100%, 80% and 67% of trainees respectively. In contrast in hospitals C, G and H, less than 4 weeks' notice of OOH rota arrangements was reported by 50%, 50% and 71% of trainees respectively. In hospitals D and I, 100% and 29% of trainees respectively indicated that they had received notification of their OOH commitment on the day of starting their post. It was noted in hospital I that all trainees reporting notification of their OOH rota on the day of post commencement were from one unit within the site.

Figure 2: Trust notification of OOH rota by hospital site



Trainee free text comments

"Given less than 2 weeks prior to starting a new Trust/new job/new location. Unable to make any personal plans" - CT1 (Trust D)

"Notice for post location was enough, although it would be preferable to know the second year rotation as well, as it helps planning. The notice for rota allocation was not enough. We were informed 7 days prior to starting our rotation which is unacceptable and does not allow us to plan anything" - CT1 (Trust A)

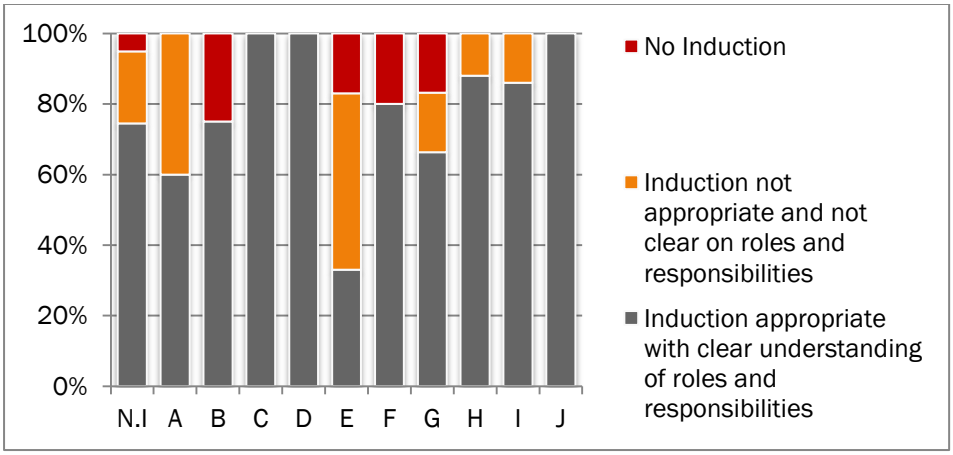
"I have children with Special Needs. My wife and I work. I need sufficient time to organise care when at work. I am yet to work in a Trust that has the manners to at least provide an outline of my working schedule" – CT2 (Trust A)

Induction

The GMC's Promoting Excellence sets out the requirements for Trusts to provide an induction at the start of a placement with clearly defined aims. [7]

The majority of trainees (73%) reported that their induction to their placement was appropriate, providing a clear understanding of their roles and responsibilities and two thirds received a handbook for their surgical unit. In hospitals C, D and J all trainees reported induction as appropriate. While in hospitals A, E and G induction was reported as unsatisfactory or did not occur by 40%, 67% and 33% of trainees respectively (Figure 3). Further analysis indicated that 67% of those who felt that their induction did not provide them with a clear understanding of their roles and responsibilities were CT1 trainees.

Figure 3: Departmental/Unit Induction by hospital site



Key Recommendations: Post Information, Rota Allocation and Induction

Development of a Unit Prospectus for all Core Surgery training sites

Trusts to provide all trainees with information of their OOH rota at least 6 weeks prior to start of post

2. Educational Supervision, Clinical Supervision and Feedback

Educational Supervision

Both quality of and access to educational supervision was rated very highly with 75% of respondents rating the quality of supervision from their Education Supervisor (ES) as excellent/above average. Regionally 73% indicated that they had met with their ES within the first 4 weeks of post commencement, with 98% reporting that this had resulted in the setting of clear objectives for the post (Figures 4 and 5).

In hospitals A and B however, 40% and 50% of trainees respectively and in hospitals G, H and I around a third of trainees reported that they had not had an initial meeting with their ES within the first 4 weeks.

Figure 4: Quality of Education Supervision by hospital site

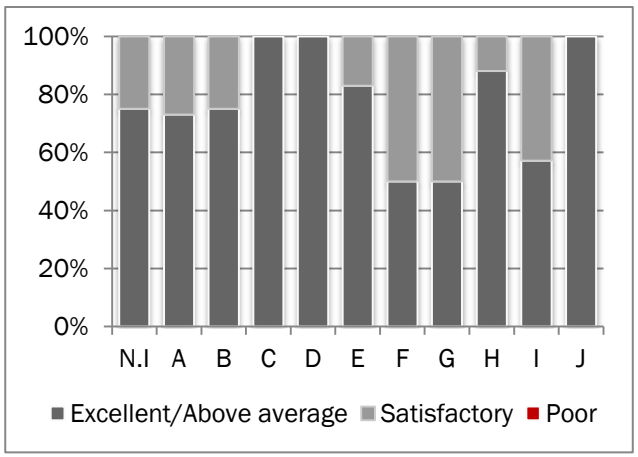
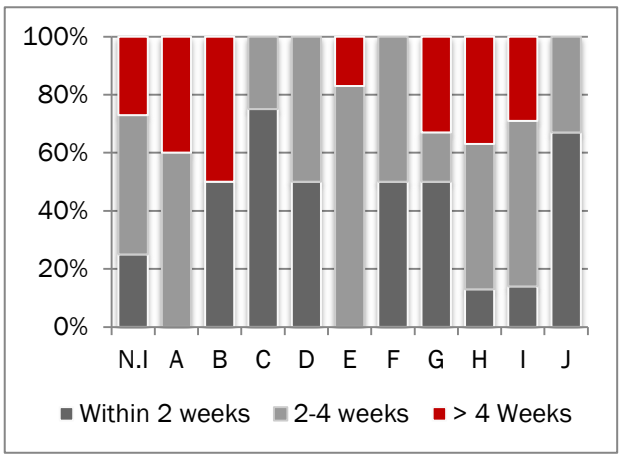


Figure 5: Initial meeting with Education Supervisor by hospital site



Clinical Supervision

When asked to rate the quality of senior clinical supervision during normal working hours the number of trainees reporting clinical supervision as acceptable was 91%, with 48% rating this as excellent/good. This level of supervision was maintained OOHs with 93% rating clinical supervision as acceptable and 26% as excellent/good (Figures 6 and 7).

In the majority of hospital sites the quality of senior clinical supervision remained high regardless of day time or out of hours working. In hospital I however the quality of senior supervision was reported as less than satisfactory by 43% of respondents during normal working hours and by 29% OOH. In hospital E less than satisfactory clinical supervision both during normal working hours and OOH was reported by 17% of trainees.

Figure 6: Clinical Supervision during normal working hours by hospital site

Figure 7: Clinical Supervision OOH by hospital site

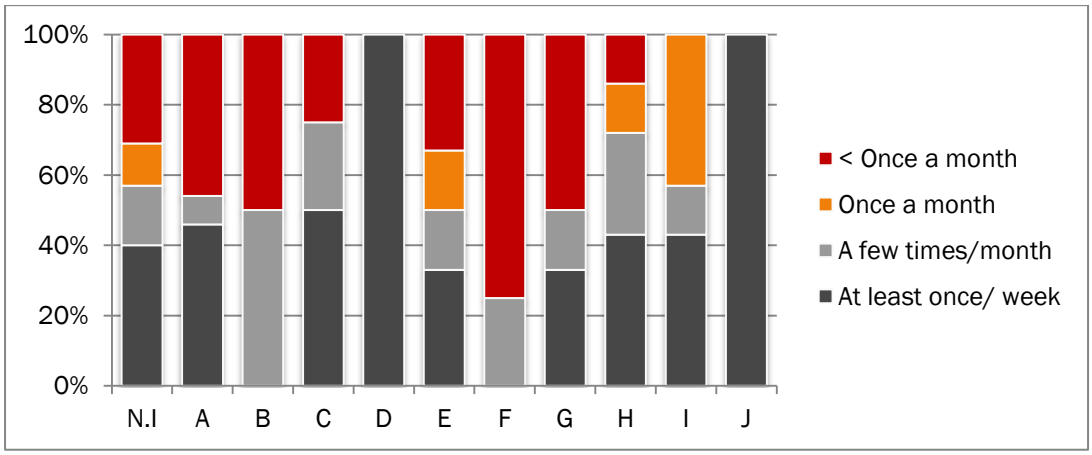
Feedback

The GMCs Promoting Excellence: standards for medical education and training [7] in its requirements related to supporting learners states in section R3.13 that
"Learners must receive regular, constructive and meaningful feedback on their performance, development and progress at appropriate points in their medical course or training programme, and be encouraged to act on it."

The Intercollegiate Surgical Curriculum Programme (ISCP) core surgery curriculum, in its definition of the role and responsibilities of the clinical supervisor also emphasises the requirement for the clinical supervisor to *'deliver feedback and validate assessments'.*

Regionally only 40% of core surgical trainees indicated that they had received feedback at least once a week on their performance with 31% of trainees reporting feedback less than once a month (Figure 8). There was however variation in results between sites, with hospitals D and J delivering feedback on performance at least once a week to all trainees, while in hospitals A, B, F and G results were significantly below the regional figures with 40%,50%, 75% and 50% respectively indicating they had received feedback less than once a month.

Figure 8: Frequency of trainee feedback by hospital site



Intercollegiate Surgical Curriculum Programme (ISCP) e-portfolio and Workplace based Assessments (WPBA)

At the start of their CT1 year, 66% of trainees regionally reported being given a clear understanding of how to use the ISCP e-portfolio to ensure that they meet the competencies required for ST3 application. At the time of the survey, 4 months into their post, 78 % indicated that they were confident in their ability to engage with the ISCP and to upload evidence when required. In hospital G however the results were below the regional figure with only a third of trainees reporting familiarity with and confidence in using the ISCP e-portfolio (Figure 9).

Regionally 92 % of core surgical trainees reported being aware of the WPBA requirements of their post, however 59% of respondents indicated that they had had issues getting the recommended number of WPBAs needed for progression. This issue was reported in all hospital sites (Figure 10). Feedback from trainee free text comments indicated that the main issue was obtaining consultant sign offs for WPBAs.

Figure 9: Confidence in using the ISCP e-portfolio by hospital site

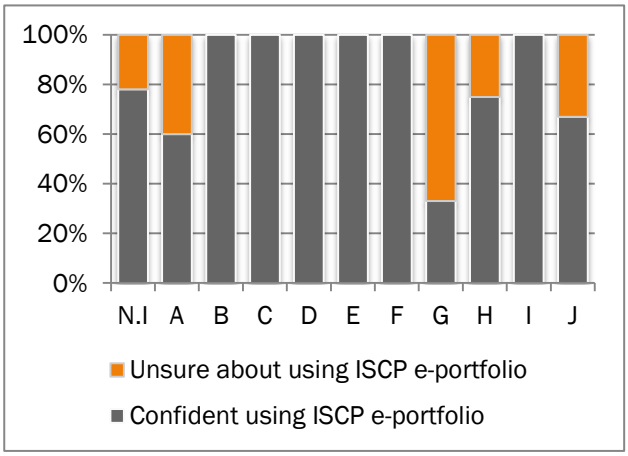
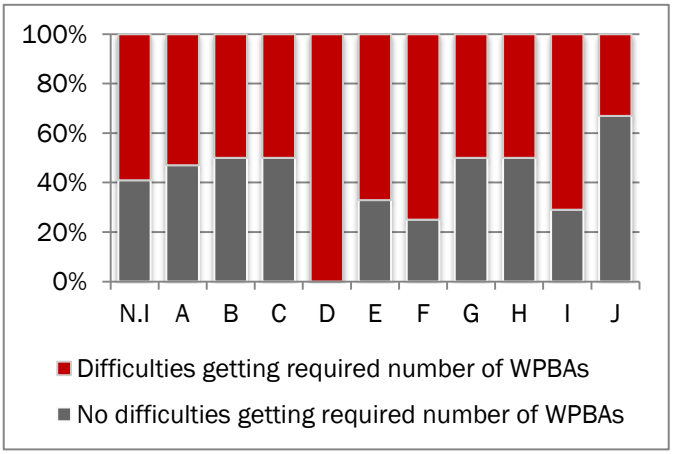


Figure 10: Issues getting WPBA by by hospital site



Trainee free text comments:

Education Supervision

"Clear and helpful. Good at being accessible" - CT1 T&O (Hospital A)

"Approachable and very supportive to trainees" - CT1 Gen Surgery (Hospital E)

"My ES is very receptive and takes every opportunity to train me" - CT2 T&O (Hospital D)

Clinical Supervision

"Only 1 registrar, so can be in a different hospital for clinics. Can be difficult to get in touch with a senior consultant at times "– CT2 ENT (Hospital E)

"Good if I get to theatre (rare) otherwise little supervision by consultant. Reg/Staff grade always available for advice"– CT1 ENT (Hospital G)

"I am in a post in which I do a daily consultant ward round, a daily consultant-led clinic followed by a consultant-led theatre session. Senior input is involved in all surgical decisions and clinics set very consultant-led formats" - CT2 T&O (Hospital D)

WPBA

"Consultants do not do ward rounds, very little consultant interaction and opportunities for WBAs" – CT2 ENT (Hospital I)

"Delay in them being filled out (have always discussed in advance before sending them)" – CT1 Gen Surgery (Hospital H)

"It has been difficult to complete WPBAs, even when appropriate tasks have been completed, to find the opportunity to discuss with supervisors and ensure completed forms." - CT1 Gen Surgery (Hospital E)

"Not enough supervised sessions to discuss cases with consultants. There is more access to registrars – CT1 Gen Surgery (Hospital F)"

Key Recommendations: Educational Supervision, Clinical Supervision and Feedback

An ongoing commitment to deliver high quality educational and clinical supervision to core surgical trainees is evidenced by trainee feedback across all training units in the School of Surgery. This is to be commended.

The need to ensure a timely initial meeting with Educational Supervisors to set out objectives for the post is noted in some areas. Adherence to the recently published Joint Committee on Surgical Training (JCST) quality indicators for core surgical training [5] which recommend that trainees should have signed up to a learning agreement with their ES within 6 weeks of commencing each post, is underlined.

The lack of regularly delivered feedback to trainees and difficulties obtaining the mandated WPBAs are highlighted as regional issues. Attention to the JCST Quality Indicators recommendations 10 and 11, that all core surgical trainees should have the opportunity to attend 5 consultant supervised sessions of 4 hours and at least one consultant led ward round each week, would provide the training opportunities required to facilitate more frequent trainee feedback and consultant WPBA sign offs.

All core surgery trainees to have an initial meeting with their Education Supervisor within 6 weeks of post commencement

Provide feedback to all core surgical trainees through clinical supervisors on average on a weekly basis

All cores surgery trainees should attend 5 consultant supervised sessions of 4 hours each and at least 1 consultant led ward round per week

Clinical Workload

Regionally over half of all core surgical trainees reported that clinical workload was just right during the day and at night, however there was significant variation across hospital sites (Figures11 and 12).

In hospitals A, D, and E, daytime workload was reported as very intense/excessive by 73%, 50% and 67% of trainees respectively, above the regional figure of 40%. In contrast in hospitals B, C, F and J all trainees indicated a well-balanced workload during the day. In hospitals B, C, D, I and J, the majority or all of trainees reported that the workload at night was appropriate but in hospitals E, F and H, 67%, 67% and 57% respectively reported workload at night as very intense/excessive, compared to the regional figure of 33%.

Figure 11: Daytime workload by hospital site

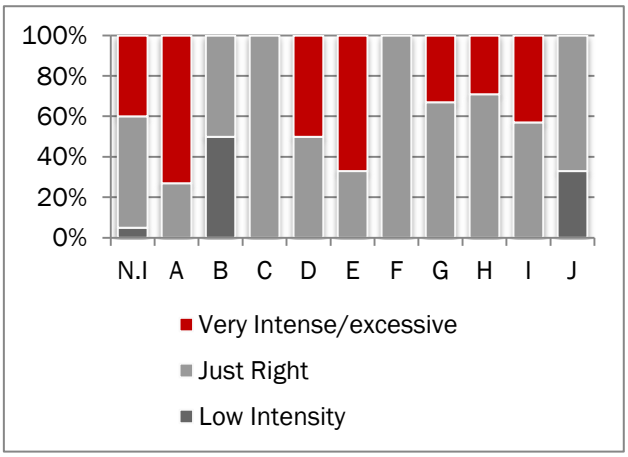
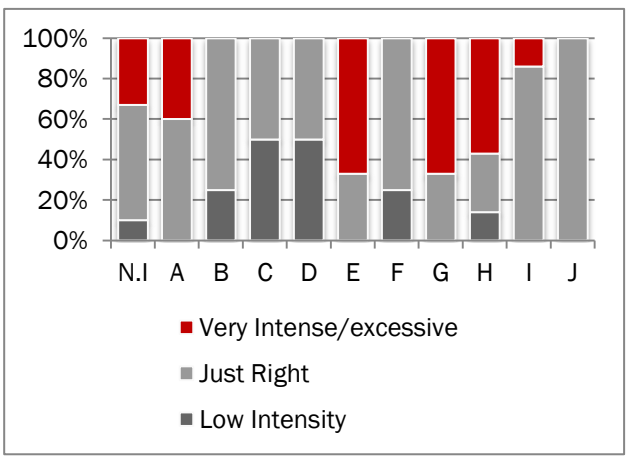
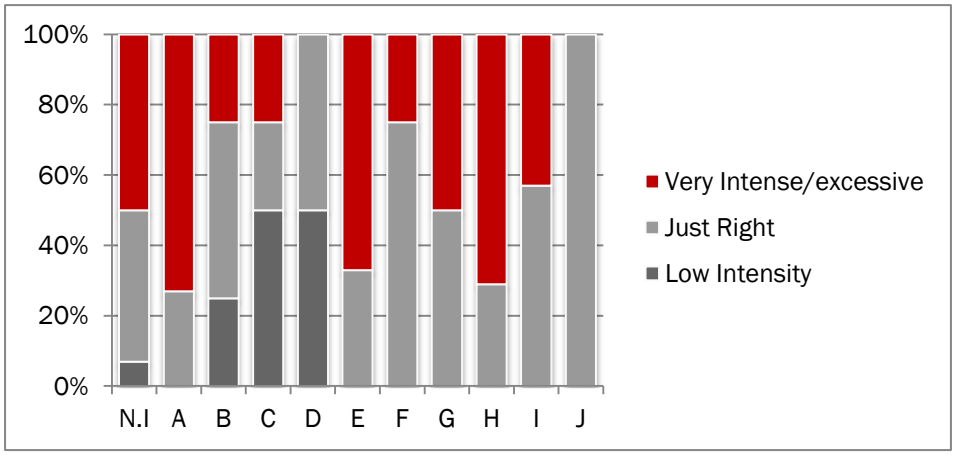


Figure 12: Workload at Night by hospital site



At weekends workload intensity was higher with 50% of trainees regionally reporting workload as very intense/excessive. In Trusts A, E and H the figures were above the regional average with 73%, 67% and 71% of trainees respectively indicating that the workload at weekends was very intense/excessive (Figure 13). It was noted, that in trainee free text comments, a high workload was identified by many trainees as providing good opportunities for gaining practical/theatre experience.

Figure 13: Workload at Weekend by hospital site



Trainee free text comments:

"Holding the bleep can be very/ excessively intense. Can require two trainees. Overnight/ weekends meant to be on call from home. Unable to do this as more often than not we are called into the hospital. CT1 is most junior member of the team- we are doing discharge letters, bloods, rewriting kardex (jobs that would seem to be of F1 level) as well as holding the bleep." – CT1 ENT (Hospital G)

"Very busy job, especially on call but that is expected." – CT1 T&O- (Hospital A)

"It is variable but the majority of the time the OOHs work is hefty- not a bad complaint though! Good training opportunities." – CT2 – Gen Surgery (Hospital G)

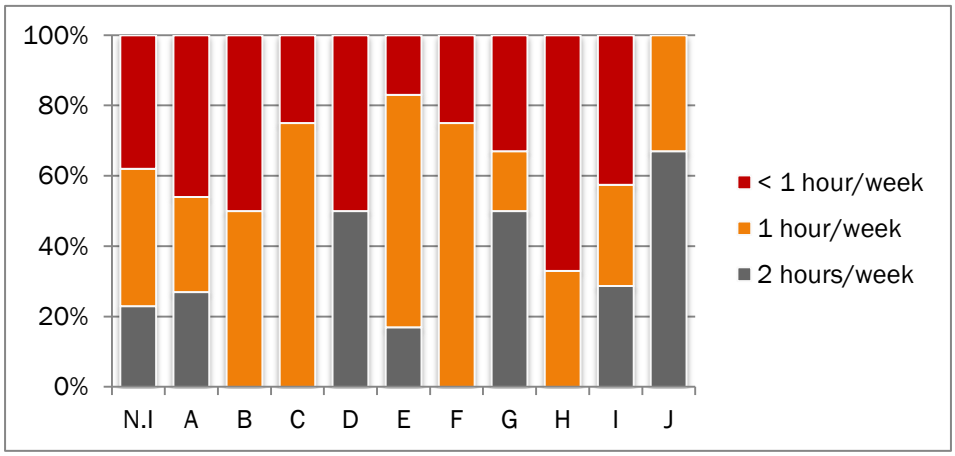
3. Formal Teaching and Educational Opportunities

The GMCs Promoting Excellence: standards for medical education and training [7] in its requirements related to supporting learners states in section R1.16 that
"Doctors in training must have protected time for learning while they are doing clinical or medical work, or during academic training, and for attending organised educational sessions, training days, courses and other learning opportunities to meet the requirements of their curriculum. In timetabled educational sessions, doctors in training must not be interrupted for service unless there is an exceptional and unanticipated clinical need to maintain patient safety."
Furthermore, the JSCT Quality Indicators for core surgical training [5], outline in QI.2 that
"Trainees in surgery should have at least 2 hours of facilitated formal teaching each week (on average). (For example, locally provided teaching, regional meetings, annual specialty meetings, journal clubs and x-ray meetings)".

Formal Teaching

Regionally, only 23% of trainees reported receiving 2 hours of facilitated formal teaching as recommended by the JCST [5], with 39% of respondents receiving 1 hour per week and a further 38% less than 1 hour per week (Figure 14). In hospitals D, G, and J, the results were above the regional average with 50%, 50% and 67% of trainees respectively indicating that they had received the recommended 2 hours of facilitated formal teaching per week. In hospitals B, C, F and H however, no trainees met the recommendation. It was noted in hospital I that all trainees reporting less than 1 hour per week of formal teaching were from one unit within the site.

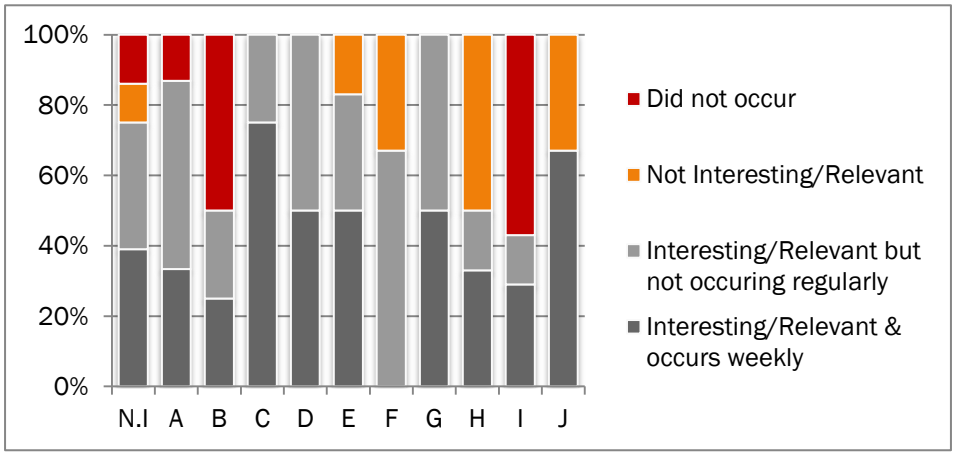
Figure 14: Facilitated Formal Teaching by hospital site



Regionally, the quality of departmental teaching was rated as interesting and relevant by 75% of respondents, however just over half this number 39%, reported that departmental teaching occurred weekly. A further 11% of respondents rated departmental teaching as neither interesting nor relevant with 14% of respondents reporting that local departmental teaching did not occur (Figure 15).

There was variation in results between hospital sites, with the results from hospitals C and J, being well above the regional average, with 75% and 67% of respondents reporting teaching as interesting/relevant and occurring weekly. In contrast, in hospitals B and I, 50% and 57% of respondents respectively indicated that departmental teaching did not occur.

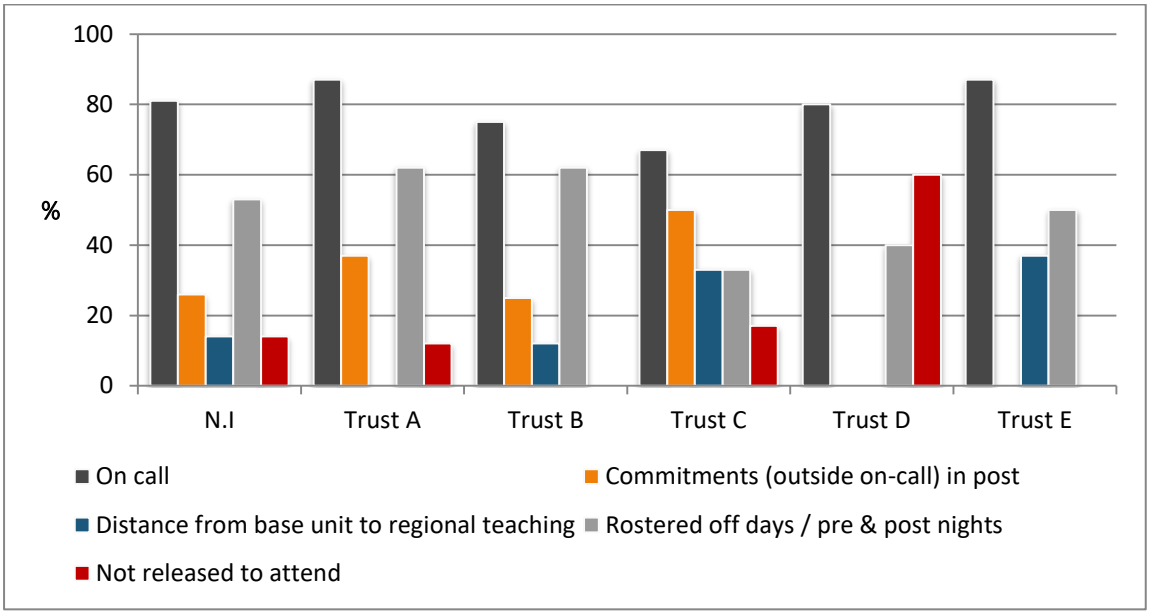
Figure 15: Quality of Local Departmental teaching by hospital site



Regionally, 86% of respondents reported having to attend regional teaching in their free time, with 70% experiencing barriers to attending these sessions. The main barriers to attendance at regional teaching were reported as on-call commitments, commitments in post, being rostered off pre or post-nights and the

distance from the base unit to the site of teaching (Figure 16). In Trust D it was noted that not being released to attend regional teaching was reported by 60% of respondents.

Figure 16: Barriers to attendance at Regional Teaching by Trust



Trainee free text comments:

"Teaching sessions relevant but quality questionable. A few day sessions cut to half day sessions. No practical teaching / training. Sessions a little outdated in terms of methods of delivery. I appreciate everyone is busy and has other commitments but bar one session (delivered by Orthopaedic Consultant from ALT), they have an air of throwing together a PowerPoint presentation 'that will do' or recycling old presentations. Make use of more interactive sessions. Give us prior learning objectives. Set up online modules. Look to counterparts in mainland UK partaking in pilot programme. Work to be done here and I am excited to see the teaching sessions evolve." CT2 – (Trust A)

"There has to be a core trainee to cover the ward. There are three of us - if one is off after being on call, only one may go to teaching, or none of others are on leave. I've missed all but one session so far for this reason. Senior admin staff should allocate staff grades (service provision doctors!) to cover the ward and allow us to attend our compulsory teaching!" – CT1 ENT (Trust C)

"Need to rotate between 3 core trainees as to who will cover the ward. I think the staff grades/reg should hold the bleep for this one day a month." – CT1 ENT (Trust C)

"Very difficult to attend teaching sessions." – CT2 (Trust B)

"Teaching only occurred during monthly audit meetings. No other formal opportunities."- CT2 (Trust A)

"Set up by registrar, weekly teaching was informative and useful"- CT1 (Trust B)

Educational/Training Opportunities (TOs)

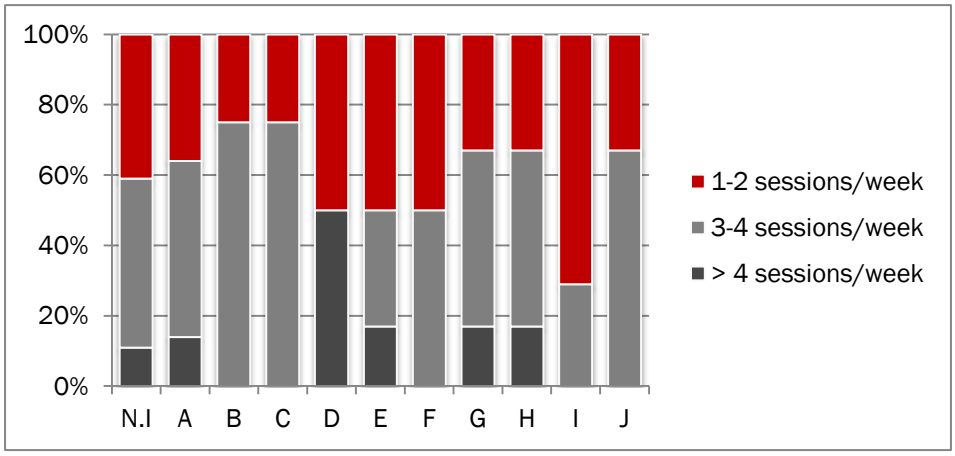
At the time of the PQ review, the core surgical curriculum requirements related to training and learning opportunities, advised that Educational Supervisors (ESs) should aim to provide at least one and no more than two clinic sessions and 3 to 4 operative sessions to all core surgical trainees in an average working week [4].

Operative Sessions - Theatre/ Day Procedure Unit (DPU)

Regionally, 59% of core surgical trainees reported achieving the recommended target of 3 to 4 operative sessions each week with 48% of respondents attending 3 to 4 theatre/DPU sessions, and a further 11% achieving more than 4 sessions per week. Overall however 41% of core surgical trainees reported not achieving the recommended target.

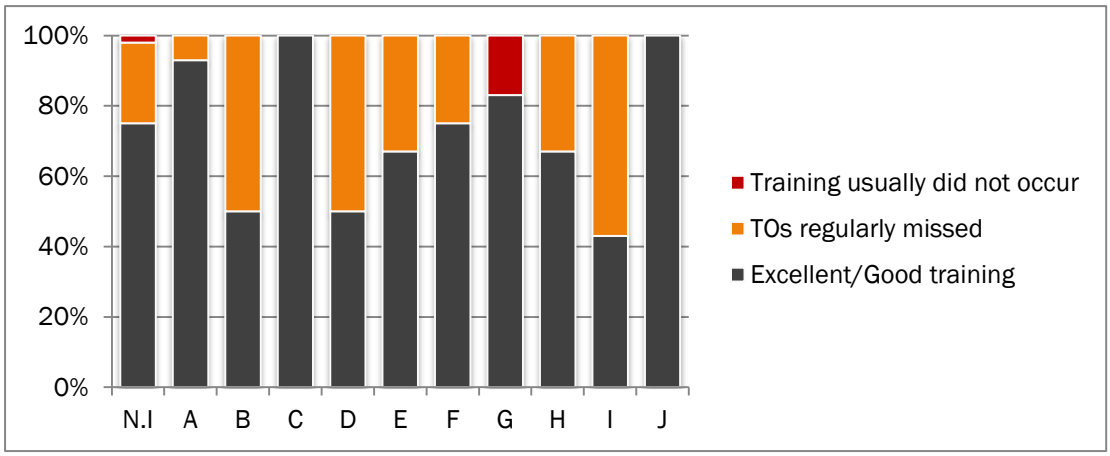
In hospitals B, C and J the results were above the regional average, with 75%, 75% and 67% of respondents respectively attending 3 to 4 operative sessions per week. In contrast, in hospital I only 29% of respondents reported achieving the recommended number of operative sessions per week (Figure 17).

Figure 17: Theatre/DPU attendance by hospital site



The quality of training received during theatre and DPU sessions was reported as excellent/ good by 75% of trainees (Figure 18). This may reflect the high level of direct consultant supervision in theatre/DPU reported in the survey, with 63% of respondents indicating consultant supervision for more than 75% of theatre/DPU sessions and overall, 88% reporting direct consultant supervision for over 50% of sessions.

Figure 18: Quality of training received in Theatre/DPU by hospital site



Trainee free text comments:

"Prevented from going to theatre because of lack of cover on ward- holding bleep and referrals takes the entire time and bleep is constant and relentless." CT2_ENT (Hospital E).

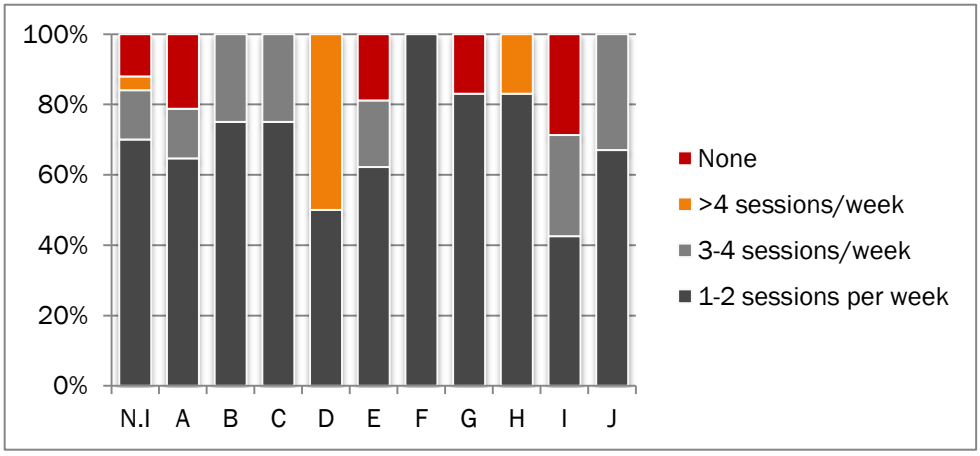
"We spend a lot of time on the ward doing ward work." CT1 – (Hospital H)

"DPU lists often have no trainee at them and prioritising attendance/making time for trainees to attend these lists would provide good training opportunities"

Outpatient Clinics (OPCs)

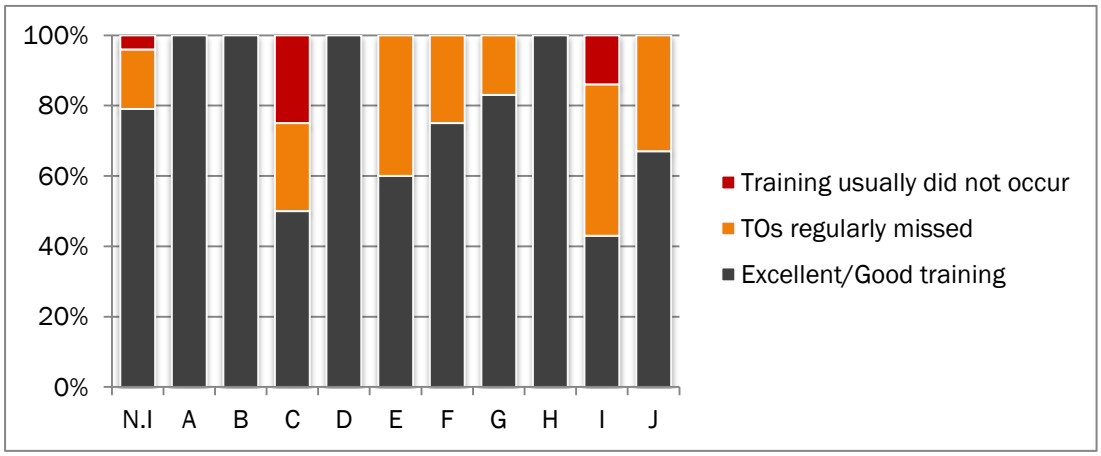
Regionally, 70% of core surgical trainees reported achieving the recommended target of 1-2 OPC sessions per week. A further 18% reported attending more than the recommended maximum of 2 OPCs per week. Only 12 % did not attain at least one OPC each week (Figure 19).

Figure 19: Attendance at OPCs by hospital site



Training opportunities in OPCs were rated highly with 79% of respondents regionally reporting the quality of training received at OPCs as excellent/good (Figure 20). Again, a high level of direct consultant supervision was reported, with 74% of respondents indicating direct consultant supervision for more than 75% of sessions. There was some variation between hospital sites, with all trainees in hospitals A, B and H, reporting the quality of training as excellent/good. In contrast in hospitals C, E and I, 50%, 40% and 57% of respondents respectively reported that training opportunities in OPCs were regularly missed or did not occur, above the regional figure of 21% (Figure 20).

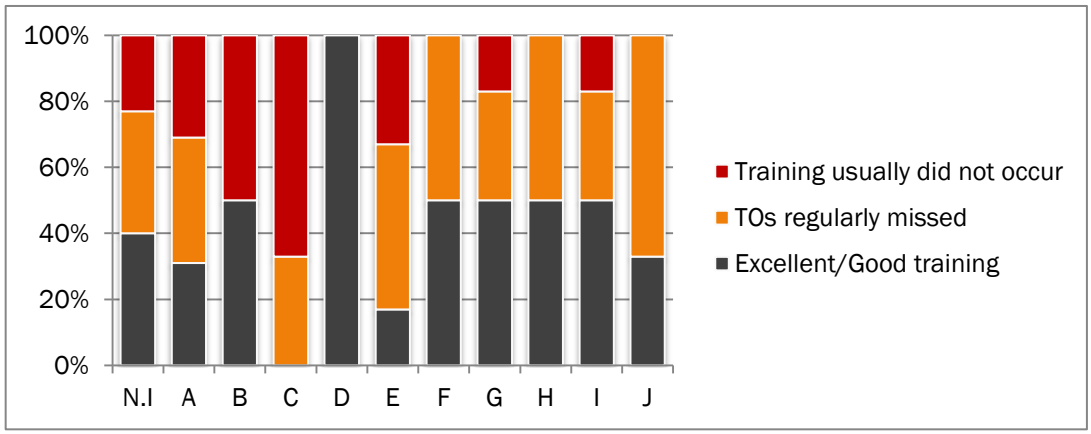
Figure 20: Quality of training received in OPCs by hospital site



Ward Rounds

Regionally all trainees reported attending at least 1 to 2 ward rounds per week, with 73% attending over 4 and 89% at least 3 to 4 per week. The quality of training on ward rounds was rated as excellent/good by only 40% of respondents, with 60% reporting that on ward rounds training opportunities were regularly missed or did not occur (Figure 21). In hospital D, all respondents reported the quality of training on ward rounds as excellent/good, but in all other hospital sites, at least half of core surgical trainees indicated that training opportunities were regularly missed, with 50% of respondents in hospital B and 67% in hospital C reporting that training opportunities did not occur on ward rounds. Regionally 56% of respondents reported that consultant supervision on ward rounds occurred less than 50% of the time.

Figure 21: Quality of training received on Ward Rounds by hospital site



Multidisciplinary Team Meetings (MDTs) and Radiology Meetings

Regionally, 43% of trainees reported being able to attend 1 to 2 MDTs each week, however 57% reported attending none. The figures for non-attendance were highest in hospitals C, E, F and H, where 75%, 83%, 100% and 83% reported attending no MDTs. In contrast, in hospital B, all trainees indicated attendance at 1 to 2 MDTs each week (Figure 22).

Figure 22: Attendance at MDTs by hospital site

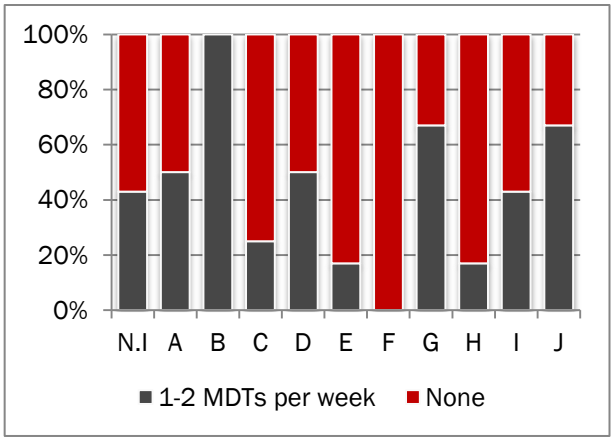
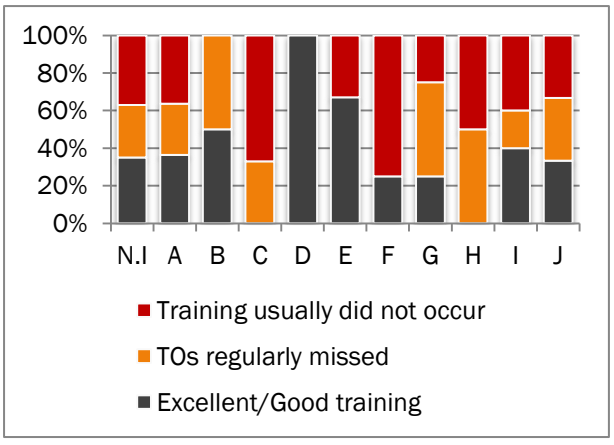


Figure 23: Quality of training received at MDTs by hospital site



Training opportunities at MDTs were reported by 65% of respondents as being regularly missed or rarely occurred, which may reflect the low attendance reported regionally. In hospitals B, D and E, 50%, 100% and 67% of trainees respectively reported good training in this area (Figure 23).

Regionally 59% of respondents reported attending at least 1 radiology meeting per week. No attendance at radiology meetings was reported by 41% of respondents. The quality of training opportunities at radiology sessions was reported by 68% of respondents as excellent/good.

Simulation (SIM) Based Training

The ISCP outlines the expectation that programmes will make use of simulation based training to augment workplace training and improve patient safety by allowing trainees to learn basic skills through repeated practice in a non-threatening environment. It states that "*Deaneries and LETBs should determine how they combine teaching methods, but it is expected that simulation based training will be one of the components used in order to ensure coverage of the full breadth of the syllabus.*"

A regional issue confirmed by the current survey is access to simulation based training, with 91% of core surgical trainees reporting that they do not feel they are receiving adequate exposure to simulation based training (Figure24). A similar number (89%) indicated that they would benefit from more frequent and regular exposure to simulation training.

Figure 24: Adequate exposure to SIM training by Trust

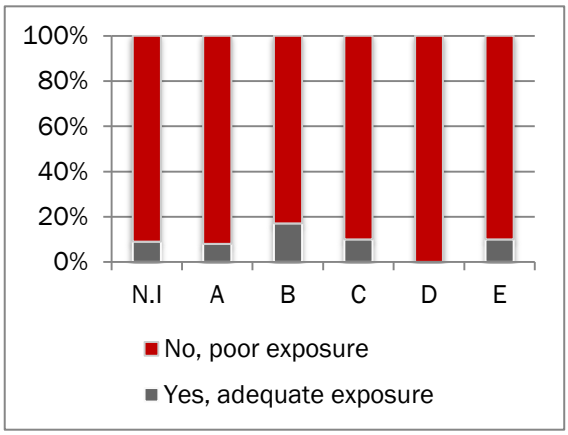
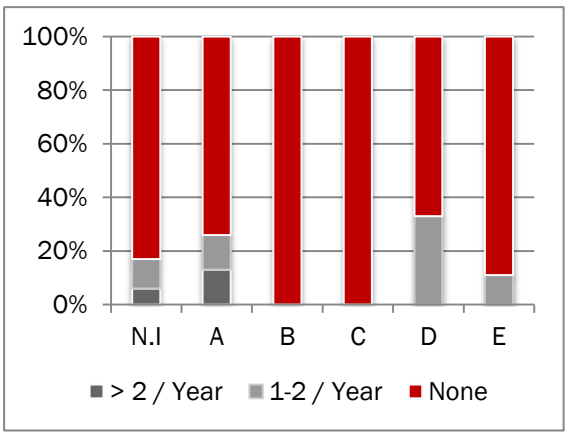


Figure 25: Number of WPBAs completed in a 'SIM based session', by Trust



The Enhanced Surgical Bootcamp at the start of core training was reported as beneficial by 89% of respondents with 86% reporting that this was the only simulation training that they had received. Only 17% of respondents reported having completed a WPBA in a simulated setting (Figure 25).

Trainee free text comments:

"I have received no simulation training during training (from NIMDTA or home units) apart from on courses I have attended (CCrISP, ATLS)"

"Would be keen to attend centrally delivered laparoscopic training sessions with real time Feedback"

"Exposure to simulation to allow development of skills/learning of new techniques in a controlled environment would be beneficial"

"I feel we should partake in multi-level human factors training in Northern Ireland. We tend to separate training into grades. I feel this actually exacerbated some of the issues that arise on this topic."

Key Recommendations: Formal Teaching and Educational Opportunities

Access to regular facilitated formal teaching within departments is highlighted as a regional issue. Adherence to the recently published Joint Committee on Surgical Training (JCST) quality indicators for core surgical training [5] which advises that trainees should have at least 2 hours of facilitated formal teaching each week (on average), is recommended.

The need to ensure access for core trainees to appropriate operative sessions is also noted, with over a third of trainees not currently achieving the recommended 3 to 4 operative sessions per week as set out in the ISCP core curriculum.

Poor attendance at MDTs is also highlighted, with over half of all trainees not attending any MDTs. Attention to the JCST quality indicator recommending the opportunity to attend one MDT meeting, or equivalent, per week is supported.

A lack of access to simulation based training is clearly demonstrated regionally by the current survey. The need for the development of increased opportunities for simulation training and consideration of new ways to deliver this against the limitations imposed by COVID –19 is required at both Deanery and Trust level to address this issue.

Access to 2 hours per week of facilitated formal teaching

All trainees to have access to a minimum of 3 operative sessions per week

All trainees to attend 1 MDT meeting per week

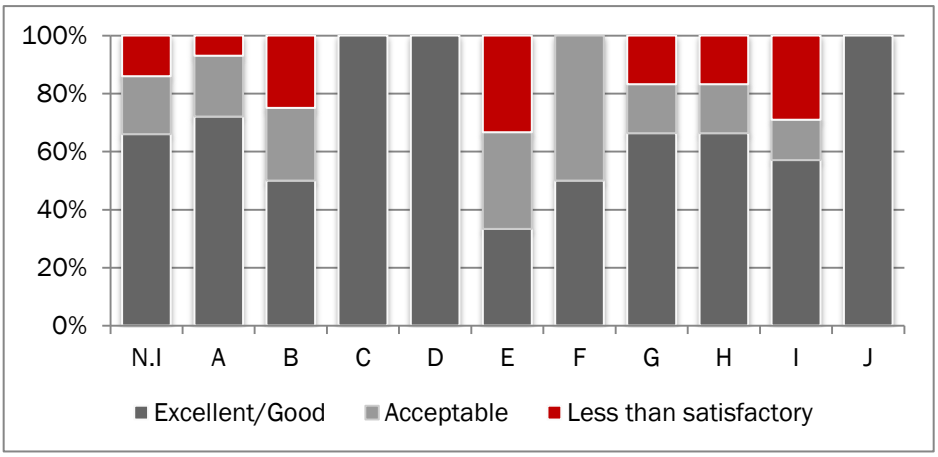
Review of the delivery of Simulation Training by NIMDTA and Trusts

4. Overall Opinions and Suggestions for Improvement

Overall Opinions

Feedback from trainees was largely positive across a wide range of areas surveyed and this is reflected in the overall global score for placements, where regionally 66% of respondents rated the training opportunities provided by their current placement as either excellent/good and 20% as acceptable (Figure 26). In hospitals B, E and I however, 25%, 33% and 29% of trainees respectively reported the placement as less than satisfactory, above the regional figure of 14%. Further development in these areas is required.

Figure 26: Global Score for placement as a training opportunity by hospital site



Trainee free text comments:

"Encouraging and approachable consultants and registrars. Feel like member of the team and when training opportunities happen the teaching is of high quality." CT2 Vascular (Hospital A)

"Busy department, wide range of exposure, overall good environment." – CT2 Gen Surgery (Hospital H)

"The clinical staff make my current post an excellent training experience. No knowledge is assumed and teaching is done with enthusiasm. I feel the consultants in my current post should be commended for their dedication to surgical education."- CT2 T&O (Hospital D)

Summary of Trainee Suggestions for Improvement

1) More day procedure lists
2) More hands on training during theatre sessions/DPU
3) Dedicated training lists
4) Dedicated theatre time for CT1/CT2
5) F1, F2 or physicians assistants on the ward to help cover ward duties
6) Less time spent on ward administrative tasks e.g. discharge letters, bloods, rewriting kardexes
7) More protected teaching time
8) More organised formal teaching targeted at CT level and delivered by consultants
9) More consultant led teaching

2: Good Practice and Actions Identified

Post Information

The need for improved information for trainees prior to making placement preferences and the suggested development of a surgical prospectus, outlining details of training opportunities within all training units, was outlined and discussed with the Head of School and TPD and with Educational Leads in each Trust, at visits conducted in March – August 2020.

Proposed Trust Actions

1) Each Trust to provide a draft surgical prospectus in late 2020 for publication on the NIMDTA website by January 2021.

Rota Allocation

There is a requirement for Trusts to inform trainees of their out of hours (OOH) rota allocation within 6 weeks of the commencement of their post. (7)

Proposed Trust Actions:

1) Trust to encourage Educational Leads to send out the OOH rota with gaps, rather than wait until gaps are filled, in order to give trainees earlier notification of their OOH duties.(A,E)
2) Trust to consider alternative rota design(A)

Induction

Good Practice

1) Provision of a surgical handbook (A,B,C,D, E)
2) Timetable for additional inductions required for trainees cross covering site (A)
3) Provision of one to one induction for trainees unable to attend the initial scheduled induction (A)

Proposed Trust Actions:

1) All trainees to be made aware at induction that the initial meeting with their Educational Supervisor will provide an opportunity to clarify their roles and responsibilities (C)
2) Trust to review their current generic surgical handbook and the information provided at induction to ensure that it provides all the relevant information needed by trainees at the start of their placement (E)
3) Trust to seek feedback from current trainees on 'things they would like to have known' at the start of their placement – so as to improve the information provided as part of the induction process (C)
4) Trust to identify a site lead to co-ordinate induction to ensure trainees receive all appropriate and relevant induction information (A)
5) Development of a handbook for trainees unable to attend induction (B)
6) Trust to consider options to reduce non-emergency clinical activity on changeover day to optimise trainee attendance at induction (B)

Educational Supervision, Clinical Supervision and Feedback

Good Practice

1) Majority of trainees meet with their ES within 4 weeks of post commencement, to set clear objectives for their post (A,B,C,D,E)

Proposed Trust Actions

1) Trust to reinforce to trainees when they are being given feedback[A,C]
2) Trust to run a senior trainee led teaching session on the use of ISCP and on the approach to completion of WPBAs at the start of each rotation [A,C,E]
3) Addition of information on the use of the ISCP to the surgical handbook[E]
4) Trust to seek clarification from trainees regarding their understanding of the ISCP at their initial meeting with the ES [A,C]
5) Trust to follow up on trainee progress with WPBA at the mid-point meeting with the ES [A,D]
6) Trust to put in place additional senior cover to provide trainee support on days when there are off-site clinics [B]

Proposed NIMDTA/School of Surgery Actions:

1) NIMDTA to discuss with Head of School and TPD the possibility of providing additional information for trainees on the ISCP e-portfolio e.g. newsletter/website article
2) NIMDTA to seek more specific information on feedback from clinical supervisors in the trainee re-survey

Clinical Workload

Good Practice

1) Additional core trainee on during the day to improve daytime workload [C,E]
2) Upskilling of nursing staff to take on clinical administration type roles in units without F1 cover to reduce day time workload [A]

Proposed NIMDTA/School of Surgery Actions:

1) Trust developing a Surgeon of the week model, with plans for a surgical assessment unit, new ambulatory and 'hot' clinics with additional consultant input during the day [B]

Education and Training Opportunities

Good Practice

1) 2 hours of formal facilitated teaching available each week [A,B,D, E]
2) Introduction of a regular 2 hour, dual site, teaching session delivered online [A]
3) A high level of consultant involvement in Theatre/DPU and OPCs [A,B,C,D,E]
4) Evidence of high quality training in Theatre/DPU and OPCs [A,B,C,D,E]

Proposed Trust Actions:

1) Attendance at regional teaching to be reviewed at the mid-point meeting with the ES[D]
2) Trainees to inform their consultant/rota organiser of the dates they plan to attend regional teaching to enable time off to be factored into the rota [D]
3) Trust to monitor attendance at scheduled departmental teaching to determine the reasons why trainees are unable to attend [C]
4) Trust to explore an alternative way of delivering departmental teaching to trainees who are unable to attend scheduled weekly teaching [C,E]
5) Trust to review the educational leadership in an identified area [E]
6) Trust to develop model for CT2 trainees where they would be given preparation time to lead a ward round to prepare them for stepping up to ST3 [C]

Simulation Training

Survey feedback indicates that SIM training provision and training opportunities are inadequate and that this remains a regional issue.

Good Practice

1) A SIM lead has been appointed to run 1-2 SIM based training sessions per week (B)

Proposed Actions:

1) Trust to explore possibility of using a simulator to deliver a local boot camp for core surgical trainees at the start of their placement (E)
2) Trust to set up a SIM Faculty to facilitate delivery of SIM based training courses (B)
3) NIMDTA to progress a proposed pilot scheme delivering Laparoscopic Simulation Training to CT1 core surgical trainees
4) Confirmed Trust commitment to be involved in a SIM pilot scheme for laparoscopic training (A,B,C,D,E)

References

1) UKFPO F2 Career Destinations Report 2019
2) NIMDTA Specialty Recruitment Competition Ratios (2019), Northern Ireland
3) Specialty Recruitment Competition Ratios (2019)
4) Intercollegiate Surgical Curriculum Programme (ISCP) 2017
5) JCST Quality Indicators for core surgical training (2019)
6) BMA Code of Practice Section 6.1: Employment Information
7) GMC Promoting Excellence: standards for medical education and training. (2016)

APPENDIX 1

SITE IDENTIFICATION KEY AND CONTACT DETAILS

KEY	SITE	CONTACT DETAILS	
	Belfast HSC Trust A	Dr Simon Johnston Dr Ruth Eakin Interim DMEs	simon.johnston@belfasttrust.hscni.net ruth.eakin@belfasttrust.hscni.net
A	Royal Victoria Hospital	Kate Crosbie Medical Education Manager	Kate.Crosbie@belfasttrust.hscni.net
B	Belfast City Hospital		
C	Mater Infirmorum Hospital		
D	Royal Belfast Hospital for Sick Children (RBHSC)		
	Northern HSC Trust B	Dr Kate Scott, DME	kate.scott@northerntrust.hscni.net
E	Antrim Area Hospital	Gail Kernohan Medical Education Manager	Gail.Kernohan@northerntrust.hscni.net
F	Causeway Hospital		
	Southern HSC Trust C	Dr Gail Browne, DME	gail.browne@southerntrust.hscni.net
G	Craigavon Area Hospital	Kelly Wylie Medical Education Manager	Kelly.Wylie@southerntrust.hscni.net
	South Eastern HSC Trust D	Dr Craig Renfrew, DME	Craig.Renfrew@setrust.hscni.net
H	Ulster Hospital	Esther Bell Medical Education Manager	Esther.Bell@setrust.hscni.net
	Western HSC Trust E	Dr Neil Corrigan, DME	Neil.Corrigan@westerntrust.hscni.net
I	Altnagelvin Hospital	Sinead Doherty Medical Education Manager	Sinead.Doherty@westerntrust.hscni.net
J	South West Acute Hospital		