

AUDIT SECTION 1: SUMMARY

Of 17 endoscopy units in Northern Ireland, 4 are 'stand alone units'. This means that they provide only endoscopy services. The Stand alone units are in Belfast City Hospital (BCH), The Royal Victoria Hospital (RVH), Antrim Area Hospital and The Downe Hospital.

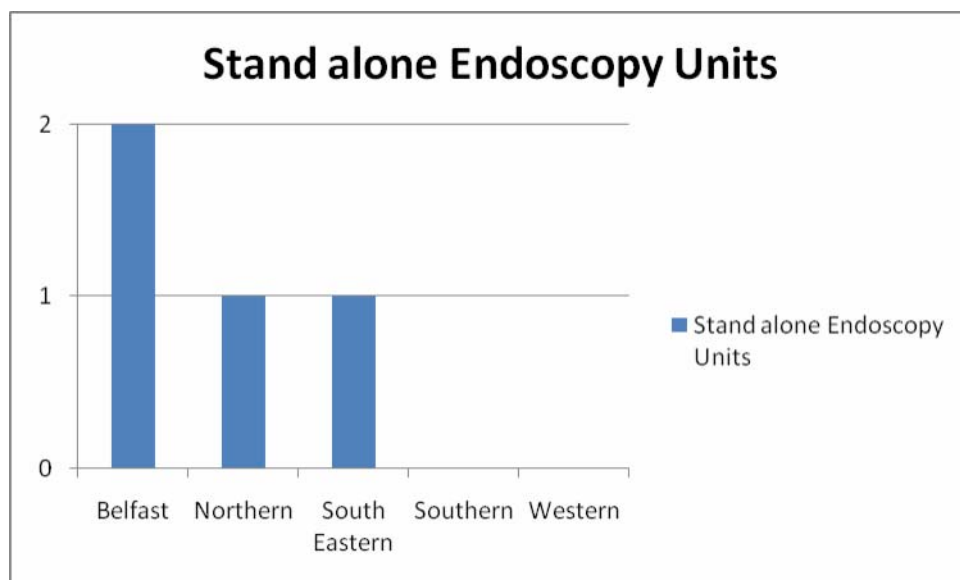


Table 1

Units that are not 'stand alone' are usually part of theatres or day surgery/day procedure units. Staff carry out other duties as well as those associated with endoscopy.

Generally, staff are not shared between endoscopy units, although in some cases this does happen. This may be due to the relatively recent merger of Trusts from 18 to just 5. The following endoscopy units share staff:

- Craigavon Area Hospital and South Tyrone;
- Tyrone County and The Erne;
- Antrim , Whiteabbey and Mid Ulster;
- RVH and Lagan Valley.

AUDIT SECTION 2: WORKFORCE

The audit asked about the numbers of each type of staff employed in the endoscopy service. The following table shows the main types of staff employed, by Trust. There was also a category called 'other' which included different job titles such as Consultant Physician, Consultant Radiologist, and Associate Specialist. These are not included because they were not common in all Trusts. Instead they are included in each Trust report.

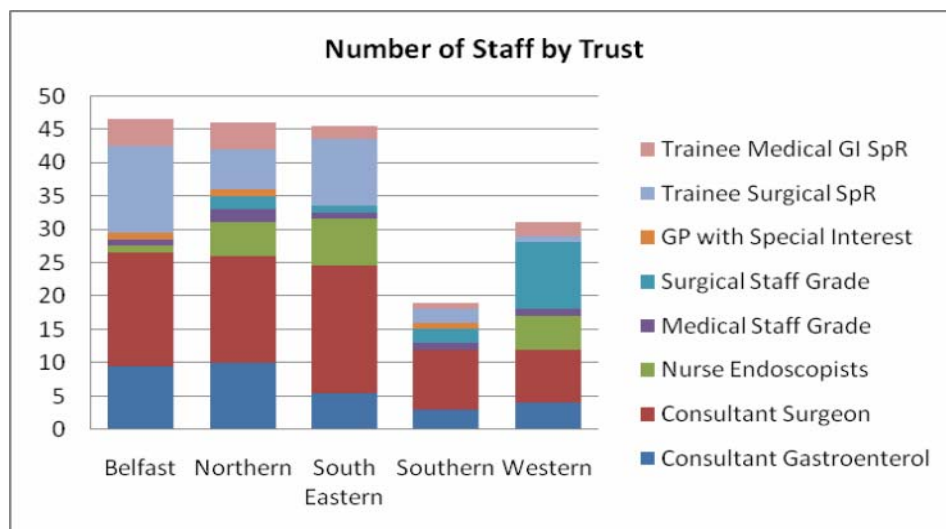


Table 2

This shows the number of sessions carried out per week by the staff in the table above:

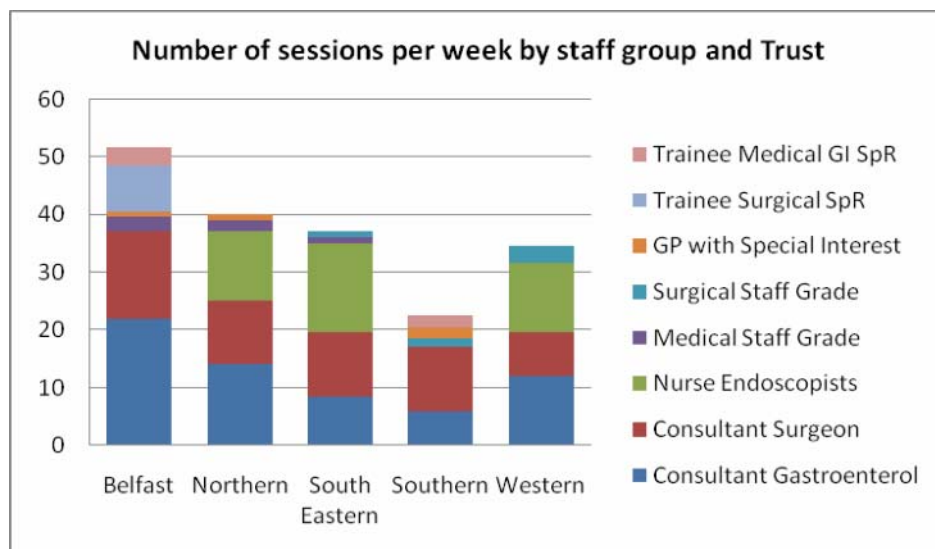


Table 3

The audit asked about other staff involved in delivering the endoscopy service. The table below shows the number of nursing staff, administration staff and endoscope cleaning staff by Trust. In some units, endoscope cleaning is carried out by the Hospital Sterilisation & Disinfection Unit (HSDU). In units which are not 'stand alone', nursing and administration staff are shared with other departments.

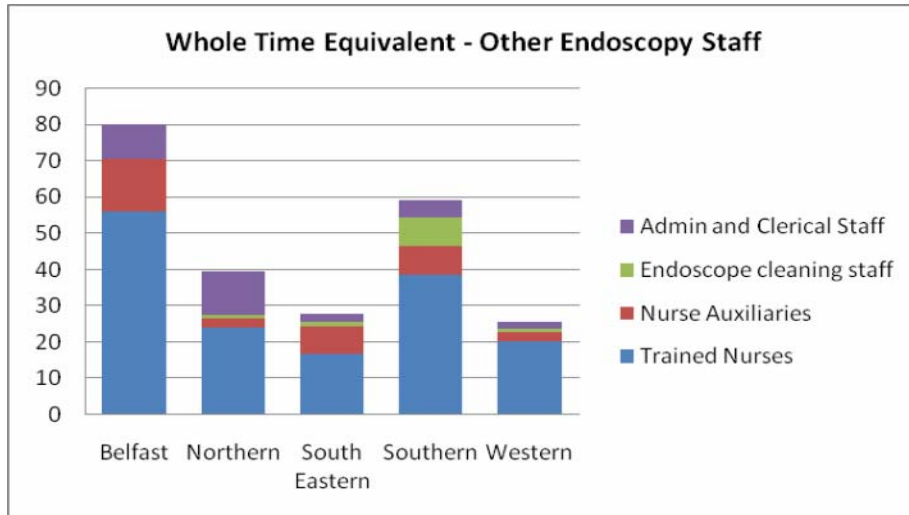


Table 4

Units were asked about the number of staff that have attended a Train the Trainer course:

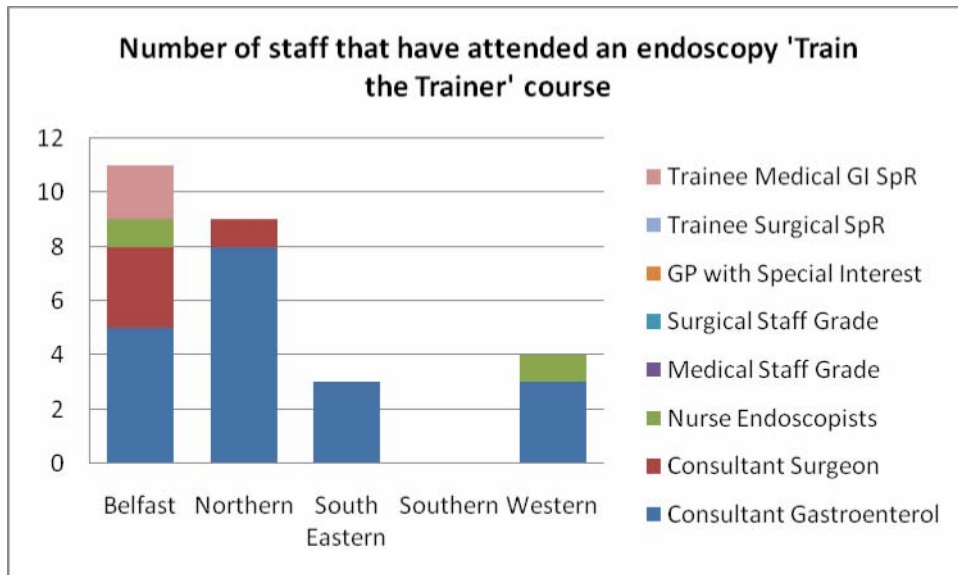


Table 5

All Trusts thought their staff would be attending endoscopy training in the near future, but noted the following factors as possible barriers to this:

- Cost
- Sickness and maternity leave
- Time constraints
- Staffing constraints and impact on daily lists
- Availability of relevant courses
- Location of the training – best if it is delivered locally

AUDIT SECTION 3: TRAINING LISTS

This diagram shows which units have lists set aside specifically for training:

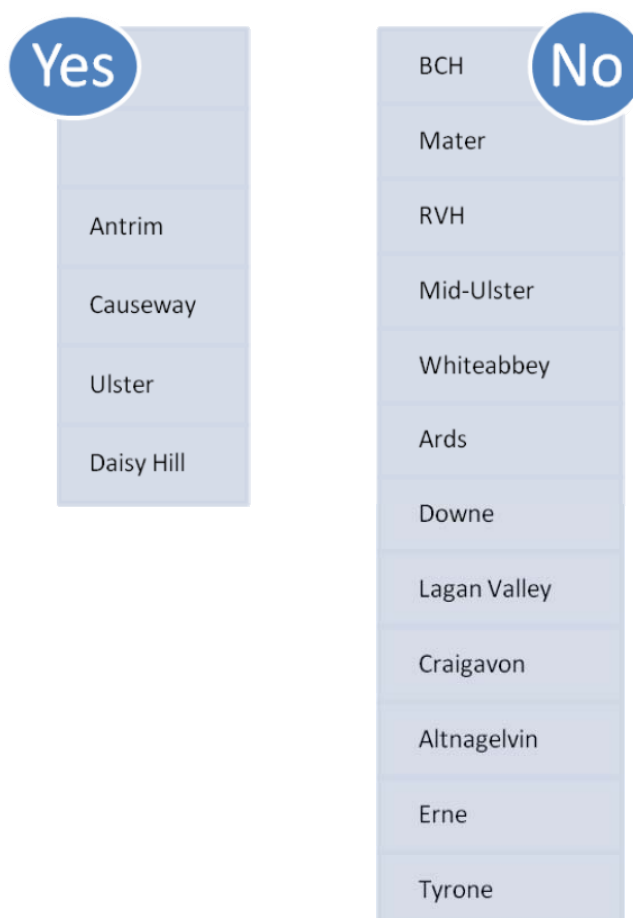


Table 6

Units which do set aside lists for training stated that they set aside the following number of sessions per week:

- Northern Trust: Antrim (1 per week) and Causeway (2 per week)
- South Eastern: The Ulster (0.69 per week)
- Southern: Daisy Hill (3 per week)

Training lists last between 3 – 3½ hours.

The audit asked for prospective data over the four week period from 15th October to 9th November. This showed that although units do not set aside lists specifically for training, training does take place. This is shown in the following table:

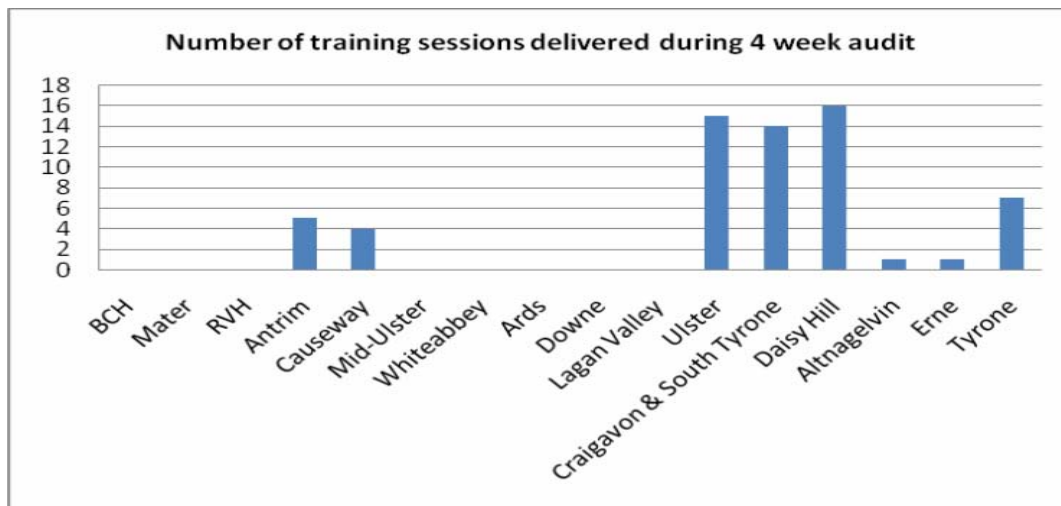


Table 7

Do trainees carry out endoscopy independently?

All units were asked if trainees carried out endoscopy independently; this table shows the responses.

Yes
<ul style="list-style-type: none"> •BCH •Mater •RVH •Antrim •Whiteabbey •Craigavon •Daisy Hill
No
<ul style="list-style-type: none"> •Causeway •Mid-Ulster •Ards •Lagan Valley •Ulster •Erne •Tyrone

Table 8

In most units where trainees carry out endoscopy independently, a tool is used to assess the trainees' competence, however in one unit Trainees performed gastroscopies independently out of hours, without assessment. In another, the GI Medical SpR is able to provide Gastroscopy and Flexible Sigmoidoscopy independently, but only if the Consultant Gastroenterologist is on site at the hospital. In another, only medical trainees are assessed while surgical trainees are not. The tools used are:

- JAG assessment tool -DOPS (Directly Observed Procedural Skills) for GI Trainees

- A consultant is present and supervises / assesses competencies

Units were asked to comment on what works well and what pressures or constraints were experienced in relation to training lists. Comments are summarized here:

- The time allocated for each procedure is greater in a training list; therefore less patients can be seen in a training list than in a non-training list;
 - Some units that say they don't set aside lists for training still provide training during regular lists, causing over runs and late starts;
 - There is conflict between service delivery and training requirements, with no capacity set aside for specific training lists due to pressures of work and meeting access targets;
 - Lack of space;
 - Lack of equipment or equipment being shared with other departments.
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