Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	24 September 2019	**Level(s)**	FY, GP, Core and ST
Type of visit	Revisit	**Hospital**	St John's Hospital
Specialty(s)	General Internal Medicine	**Board**	NHS Lothian

Visit panel	
Geraldine Brennan	Visit Chair - Visit Lead and Associate Postgraduate Dean for Quality (Foundation)
Yatin Patel	Foundation Programme Director
Timothy Jagelman	Trainee Associate
Bob Kemp	Lay Representative
Heather Stronach	Quality Improvement Manager

Specialty Group Information		
Specialty Group	Foundation	
Lead Dean/Director	Professor Clare McKenzie	
Quality Lead(s)	Dr Geraldine Brennan and Dr Fiona Drimmie	
Quality Improvement Manager(s)	Ms Jennifer Duncan	
Unit/Site Information		
Non-medical staff in attendance	5 non-medical staff	
Trainers in attendance	12 trainers	
Trainees in attendance	9 FY1s, 2 FY2, 2 GPST, 2 CMT, 4ST	

Feedback session: Managers in attendance	Chief Executive		DME		ADME	x	Medical Director	x	Other	x

Date report approved by Lead Visitor	10/12/2019

1. Principal issues arising from pre-visit review:

General internal medicine at St John's Hospital has been visited on the following occasions:

- 16 March 2016 (scheduled visit)
- 15 May 2018 (triggered visit).

The last visit demonstrated that 11 requirements, that is aspects where General Medical Council's (GMC's) standards were not being met, were identified as needing to be addressed. The 11 requirements were:

1. There must be a clear pathway for who is responsible for the day to day review of patients boarding out with their usual ward including an expectation of frequency of consultant review.
2. There must be clear lines of supervision within the Medical Assessment Unit (MAU) at all times with easy access to consultant support when required.
3. Clarity of consultant cross-cover arrangements for management of patients is required when their usual consultant is on leave.
4. All trainees must be assigned to a ward/unit for a minimum of a 4-week continuous period. The discontinuity of ward placements for all trainees must be addressed as a matter of urgency as it is compromising quality of training, feedback, workload and the safety of the care that doctors in training can provide.
5. The department must review and reduce the volume of non-educational tasks that Foundation Year 1 (FY1) trainees undertake in order to maximise their potential to attend educational opportunities including wards rounds.
6. General Practice Specialty Trainees (GPSTs) must have equitable access to clinics and be able to attend sufficient numbers to achieve their curriculum competencies.
7. A formal structured handover with input from senior team members must be established for the Foundation trainees.
8. Induction to the unit must be provided in a timely manner and prepare the trainees for their role in the unit. This should include practical information on protocols and ways of working in the department.

9. The department must review and reduce the volume and intensity of daytime work for Specialty trainees when working in acute admissions.
10. Opportunities to feedback to all trainees in the ward setting must be created.
11. There must be review of the arrangements for attendance at Hospital@Night handover to ensure that patient care and trainee workload within MAU is not compromised.

Prior to the visit commencing, the visit panel met with Dr Helen Gillett (Clinical Director), Dr Karen Adamson (Training Lead) and Dr Hannah Monaghan (Associate Director of Medical Education for NHS Lothian) who presented an update of site progress against the requirements identified at the 2018 visit. Their presentation covered the following areas:

1) The implementation of a clear boarding policy that identifies ownership of boarders, tracking of boarders and expectations of frequency of consultant review.
2) Improved supervision in the MAU: This includes on-call and post-take consultants splitting ward rounds, a named consultant in the Primary Assessment Area (PAA) identified both in the rota and at the daily safety huddle, and daily safety pauses that occur 2-3 times daily.
3) Continuity of ward placements particularly for FY1 trainees remains challenging, however the unit has identified some solutions by using the Professional Compliance Analysis Tool (PCAT). There is an aim is to increase the ancillary support over the next few months (refer to point 4 below).
4) Changes implemented to reduce non-educational tasks for FY1s included the introduction of abbreviated electronic immediate discharge letters. Work has also been done to identify the competencies of nursing staff to encourage top of the band working. Other measure planned include an increase in phlebotomy support and approval of funding to employ 3 Physician Associates (PAs) in Summer 2020.
5) Introducing clinics within the GPST rota.
6) A formal structure to FY1 handover at 4:30pm with support from the FY2 on late shift.
7) Changes to induction based on feedback received from trainees.
8) Increased opportunities for feedback to doctors in training

9) Reduction in workload intensity for middle grade rota to support evening shift in MAU. Five additional Clinical Fellows have been appointed.
10) Changes to the Induction programme now mean that Hospital and Department of Medicine induction run on the same day. A tour of the hospital site is also included.

The panel then met with trainers and non-medical staff as well as the following groups: FY1 trainees, FY2 trainees, GPSTs and specialty training registrars (STs) working in general internal medicine. No CMT trainees were available for interview due to a clash with a training day and this cohort was interviewed on 26 November 2019.

A summary of the discussions has been compiled under the headings in section 2 below. This report is compiled with direct reference to the GMC's Promoting Excellence - Standards for Medical Education and Training. Each section heading below includes numeric reference to specific requirements listed within the standards.

2.1 Induction (R1.13):

Trainers: Hospital induction is provided on the first day that trainees start work. A tour was given around the hospital so that trainees were given an entire overview of the hospital and the services available on the site.

Induction to the medicine department was delivered the same afternoon as hospital induction and included an initial welcome with presentations. Trainers said there is a MAU handbook available to trainees that provides information on who the team is, available teaching events and other resources. Trainees have access to additional information provided by trainees about working on the wards via the medicine St John's Hospital intranet site. Anyone who is unable to attend the unit induction is met with individually. Feedback is also sought from trainees about how to improve induction.

Trainers reported that induction materials are available to trainees on the medical education website.

FY1s: FY1 trainees reported that they had a week long FY1 induction which included a series of lecture-based sessions and information on the hospital and local protocols. They spent 4 – 5 days shadowing in the wards so they could find out more about what to expect when working there. FY1s confirmed receiving an induction about the medicine department on their first day of work. FY1s said that a lot of useful information was received via the induction pack, but they indicated they would have benefitted from receiving this earlier because there is so much information to absorb.

FY1 trainees felt that the hospital and medicine department inductions were good but did not prepare them for all of their roles. They indicated that induction to ward areas would have been helpful. An example was provided of the Friday deep vein thrombosis (DVT) clinic. FY1s see patients referred by their GP and need to arrange relevant investigations and chase up results. Trainees said that they had encountered some scenarios during the DVT clinic shift that they did not know how to respond to. They phoned a FY2 for support, however the FY2 also did not know what to do. They thought that a potential solution might be to shadow a senior member of staff at the start of their week.

FY1 trainees reported that some of the shift information within the induction pack is out of date. They said that information on the FY1 role in MAU, PAA and Hospital@Home could be improved with a greater emphasis on how these areas work on a day-to-day basis. In particular, there was confusion around the role of FY1 trainees on the late evening into night shift on the observation ward.

FY2, CMT, GPST: This cohort of trainees confirmed receiving induction and said that induction was one of the best they had had. However, they also expressed a similar view to the FY1 trainees that better information on the responsibilities of each cohort on the different shifts could be provided. For example, induction information could explain that the PAA is covered by one FY1, one GPST trainee and the acute medicine consultant. Trainees could not recall whether on-call working was explained and no trainees had received ward inductions. However those who had missed original induction talks had received a catch up induction.

ST: ST trainees confirmed receiving induction. They said that induction was good but that the practical aspects of induction are missing, for example, what type of patients the PAA takes, what the DVT clinic does, and how consultants divide ward rounds. They also said that ward level inductions were absent and these would have been helpful to have.

Nursing and Non-Medical staff: Nursing and non-medical staff felt that induction is effective in preparing doctors to work and that shadowing is an excellent way of learning. They said that the local ways of working are learned on the job.

2.2 Formal Teaching (R1.12, 1.16, 1.20)

Trainers: Trainers confirmed that weekly unit teaching takes place on a Tuesday lunchtime and this is supported in the rota. Foundation teaching takes place on a Wednesday afternoon and rotates across the 3 sites in NHS Lothian. There is a morbidity and mortality (M+M) teaching that takes place every quarter and was due in early October.

All cohorts of trainee confirmed that department teaching takes place on Tuesday between 1pm and 2pm and that regional foundation teaching takes place on Wednesday lunchtimes. There are grand rounds on Thursdays.

FY1s: FY1s said they can usually attend teaching when working on the wards but that it is difficult to do so when working in the DVT clinic or when assigned to MAU.

FY1 trainees had not yet completed the immediate life support course. Two sessions are scheduled in 2020 but trainees were not sure whether they could book onto these yet. Trainees thought it would make more sense to receive this training as soon as possible from starting in post since they are required to carry the crash bleep from day one.

FY2, CMT, GPST: This cohort of trainees confirmed their teaching arrangements and said there were no barriers to attending teaching. If clinics are booked to start at 1pm this can prevent trainees from attending teaching but they had not yet raised this with trainers. When doing first on call medical registrar duties they would also be unable to attend teaching because of the volume of patients to see. Attendance at local teaching by this group of trainees is therefore variable, but attendance at regional teaching is built into the rota.

ST: ST trainees said that local department teaching is excellent and confirmed they can access regional teaching which is built into their rota.

All trainees rated the quality of teaching provided at St John's Hospital as being excellent.

Nursing and Non-Medical staff: Nursing and non-medical staff confirmed that they help facilitate local teaching.

2.3 Study Leave (R3.12)

There were no problems accessing study leave.

2.4 Formal Supervision (R1.21, 2.15, 2.20, 4.1, 4.2, 4.3, 4.4, 4.6)

Trainers: The clinical director allocates educational supervisors to trainees. Educational supervisors are allocated the same grade of trainee(s) each time to ensure familiarity with the requirements of individual curricula. All educational supervisors are recognised trainers, and all have appropriate time in their job plans (1 hour per trainee per week) and are appraised for this role. There is a consultant meeting that takes place on a monthly basis which provides an opportunity to discuss how trainees are progressing.

Trainees: All grades of trainees confirmed having educational supervision and there were no concerns raised in this regard.

2.5 Adequate Experience (opportunities) (R1.15, 1.19, 5.9)

Trainers: Trainers said that there are now more doctors on the ward. Overall, things feel better since the last deanery visit, such as the evening on call shift. Ward rounds were noted to have improved because consultants are using this as an opportunity to complete case-based discussions. Workload for FY1s has improved following the issue of guidance for improving the content of electronic immediate discharge letters for short stay patients. This new guidance has resulted in fewer errors and has reduced the time taken by trainees to complete immediate discharge letters. This change has been well received by trainees and by the GP interface group.

Clinic experience is mandatory for ST and CMT trainees and trainers told the visiting panel that trainees can book themselves into clinics. At stroke clinics trainees are supernumerary so this would be a good opportunity for trainees to complete workplace-based assessments. Trainees can also attend rheumatology clinics to learn knee aspiration. Trainees know that clinic attendance is mandatory and if trainees have difficulty attending clinics, they have been told to escalate this to the clinical director.

FY1s: FY1 trainees continue to perceive that they are burdened with discharge letters and prioritise completing these over attending ward rounds with a consultant. They said that they frequently move wards (sometimes up to 3 times per week) and this causes a number of difficulties for them as follows:

- They frequently complete immediate discharge letters for patients they have not been involved in the care of.
- Nursing staff ask them questions about patients they have no idea about.
- If they make a referral (by email) they are often no longer working in the ward when the response is received and they need to find someone from the relevant team to forward the response to.
- FY1 trainees are very concerned that consultants do not know who they are on the wards and they perceive this makes it difficult for them to request team assessment of behaviour (TABS) assessments.
- FY1 trainees do not feel they are part of a team in the general wards.

By contrast, the FY1s report that MAU and PAA provide valuable learning experiences for them as they switch between being post take and on call. Here FY1 trainees feel well supported stating that it is very supervised.

FY2, CMT, GPST: CMT trainees are rostered to attend clinics but FY2s and GPSTs are not. If there is a specific clinic that trainees wish to attend, trainees concede that they can ask to do so, and it is usually permitted. Trainees who are not rostered to attend clinic felt that clinics are difficult to attend due to their workload.

Trainees reported that knee aspiration, cardioversion and pleural procedures are competencies which are more difficult to achieve at St John's Hospital. Although specific clinics are set up to provide this opportunity, in reality they are very busy and have difficulty prioritising this. Trainees therefore thought it could be helpful to have this rostered into their timetables or provided as dedicated teaching sessions.

On average, CMT trainees attend one clinic per week.

On the whole trainees felt that the experience and learning at St John's Hospital was good. However, this group of trainees felt that more could be done to support their training. Out of all of the NHS Lothian hospitals, trainees perceive St John's to be the site where trainees have to do more routine tasks - for example, bloods, cannulas and electrocardiogram (ECGs) - than in other NHS Lothian hospitals. Trainees thought that perhaps there was only one nurse in MAU who can take bloods. Phlebotomy provision was also felt to be lacking on the wards, but trainees perceive that their work on the wards is much more appropriate to their grade than what it is on MAU.

ST: ST trainees said they work on the acute on call rota and have no difficulty achieving acute medicine competencies. Access to other learning opportunities, however, such as going to endoscopy lists, is much harder when they are on acute weeks - although these are more easily accessed when they are working on the wards. ST trainees confirmed they are prompted to go to pleural and cardioversion clinics by consultants. ST trainees report that they are meant to be rostered into clinics once per week where they are not supernumerary, and that clinics have good supervision. However, in 2 months so far, on average ST trainees doing general medicine have only attended an average of 3 clinics (although those doing specialty work have accessed more).

Senior trainees are unclear about the available pathways to support the discharge of patients within acute areas including how to make referrals to the DVT clinic and ambulatory care facilities in order to improve patient flow.

2.6. Adequate Experience (assessment) (R1.18, 5.9, 5.10, 5.11)

Trainers: Trainers said that they are aware of the assessments that trainees need to complete because they are familiar with their curricula. They consider that trainees can achieve their portfolio assessments without any issues.

FY1: FY1s report that they rarely work with the same consultant for more than a day or 2 on the general wards which makes it difficult to complete TABS and other workplace assessments.

FY2, CMT, GPST: This cohort of trainees reported that completing workplace assessments at St John's Hospital is easier than elsewhere. They reported that they see the consultants a lot and that consultants are proactive about completing their assessments.

ST: ST trainees said consultants proactively offer workplace-based assessments. ST trainees reported not knowing FY1 trainees sufficiently well to be able to assist with completing their TABS.

Nursing and Non-Medical staff: Nursing and non-medical staff confirm having completed workplace-based assessments for trainees including for FY1 trainees and did not raise any concerns.

2.7 Adequate Experience (multi-professional learning) (R1.17)

Trainers: Trainers said that each medical ward has a medicine for elderly (MoE) consultant who carries out multi-disciplinary teaching (the exception is ward 9). This is an opportunity to learn from multi-professional staff including physiotherapists, occupational therapists and other allied health professionals. Tuesday unit teaching may also involve nurse practitioners. Occasionally, externally invited speakers deliver the teaching and an example given was of the prison service nursing team who have done this.

FY1s: FY1 trainees were unsure about multi-professional learning opportunities.

FY2, CMT, GPST: This cohort of mentioned that ward 25 (GIM/GI) has a good safety brief which includes occupational therapists and dietitians.

ST: ST trainees recognised multi-disciplinary learning in the MoE setting.

Nursing and Non-Medical staff: Nursing and non-medical staff aware of the department teaching and one volunteered that as a new member of staff they were encouraged to attend the teaching.

2.8 Adequate Experience (quality improvement) (R1.22)

Trainers: Trainers gave examples of quality improvement projects led by trainees such as antibiotic prescribing and ECG upload. There is an intranet site with a list of quality improvement projects that are available. These are discussed at a quality improvement team meeting.

FY1s: FY1 trainees confirmed that they were aware of the availability of quality improvement projects.

FY2, CMT, GPST: This cohort of trainees were aware of Dr Gillett's list of quality improvement projects. One trainee said they have become involved in a quality improvement project from a routine circulation that was distributed to all trainees. While most trainees were aware of the quality improvement projects they could undertake, they felt that there was little time to do them. It was also suggested that there could be a teaching session on the practicalities of how to begin carrying out a quality improvement project.

ST: None of the ST trainees were actively doing a quality improvement project. They said it would be accessible if needed but it would be difficult to maintain momentum for a quality improvement project in the absence of continuity of staff. They also stated that it would be difficult to fit this in around their current workload.

2.9 Clinical supervision (day to day) (R1.7, 1.8, 1.9, 1.10, 1.11, 1.12, 2.14, 4.1, 4.6)

Trainers: Trainers advised that everyone has coloured name badges to identify between different levels of staff. Everyone knows who new trainees are because they are a small unit. Trainees have a very open relationship with trainees and can discuss how trainees are progressing at their consultant meeting. Consultants are not aware of any instances where trainees have felt they have had to cope with problems beyond their experience or competence because they are always there for support.

FY1s: Trainees said they always have access to clinical supervision and always know who to contact both during the day and out of hours. At weekends trainees can feel they are pushed to their level of competence due to the busy workload and limited staff but confirmed that they are always able to seek advice from the registrar.

FY2, CMT, GPST: This cohort of trainees really enjoy the step up in training of being second on in the MAU post take. While expectations are high, the role is well supported and provides valuable hands on learning within reasonable levels. Trainees said there was an exceptionally good escalation protocol at St John's Hospital and they always know who to contact for support.

ST: ST trainees said consultants are extremely contactable and happy to be contacted.

Nursing and Non-Medical staff: Nursing and non-medical staff said that sheets are printed in every doctor's room showing how to differentiate between medical members of staff. They were not aware of trainees having to cope with problems beyond their competence, and they were always able to point them in the right direction for support. Nursing and non-medical staff said that senior support if available, but it depends on the time of the shift as to what this is and felt that support at weekends was stretched.

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: Trainers said they offer frequent informal face to face feedback to trainees out with the formal feedback opportunities.

FY1s: FY1 trainees did not recognise any formal feedback opportunities when working in the main wards, but said they receive feedback in the MAU, in the observation ward at weekends, and in the PAA. The lack of continuity for FY1s on their base ward results in FY1 trainees not feeling part of the team. FY1s perceived that after almost 2 months in post no-one really knew them sufficiently well to be able to provide any meaningful feedback.

FY2, CMT, GPST: This cohort of trainees said that within MAU feedback is received less frequently. They said it is useful if trainees can follow the patient onto the ward to observe whether the plans they had formulated were continued as part of the patient's ongoing care. Trainees were, however, confident that if their plans fell short this would be fed back to them.

This cohort of trainees said that on the wards they see the consultant at the beginning, or end of the week and can carry out ward rounds with them because they know when the ward rounds will take place. They can get feedback if they ask. Drs Amanda Barugh and Scott Ramsay were noted to provide excellent teaching and feedback during ward rounds. Trainees are also aware that they are generally discussed by the consultant body, and this is often informally fed back to the trainee along the lines of 'we've spoken as a team and you're good.' For some trainees, typing up an account of the ward round discussion into patient's record on behalf of consultants is challenging. They report missing out on the potential learning available from the next case as they need to concentrate on doing this and are often interrupted by nurses to answer questions during this time. They rarely receive feedback on what they have recorded unless they actively request this.

The Hospital@Home was noted as an exemplary environment for trainees receiving feedback.

ST: ST trainees do on call followed by post take days which is extremely useful for receiving feedback. They also confirmed doing ward rounds with the consultant where they get feedback.

2.11. Feedback from trainees (R1.5, 2.3)

Trainers: Trainers said there is an associate director of medical education focus group and a chief resident in the hospital who is responsible for the junior doctor forum meetings. There is also a ST within medicine who was trying to set a meeting up specifically for medical trainees to provide feedback.

FY1s: FY1 trainees were not aware of any formal mechanisms for providing feedback on their training. They said that they were asked for formal feedback on the teaching delivered.

FY2, CMT, GPST: This cohort of trainees said they would simply email if they wanted to provide feedback to trainers about training. One trainee said that their supervisor was proactive in setting a mid-October review.

To formalise feedback about training, trainees thought it might be helpful if there was a dedicated time for example a half day per month, to hold a junior doctor forum. Some trainees felt that when things have been queried in the past, adequate explanations were not always provided and it would be good to formalise the junior doctor forum structure to be able to effect real change.

2.12. Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Trainers said they have tried to adjust the rotas to meet each cohort's individual training needs where possible. This continues to be disrupted by rota gaps. A reduction in the numbers of GPSTs allocated by the deanery had made it incredibly difficult and stressful for the department to cover rotas this year.

FY1s: FY1 trainees reported difficulties with their working patterns in 2 main areas:

1. <u>The DVT clinic</u>

   This is covered by an FY1 for a consecutive 5-day period once in their rotation. The shift starts at midday although patients attend for assessment from around 8am or 9am and so trainees come in to a backlog of work. They have a few hours to see patients, organise investigations and chase results before the day unit nursing staff finish around 4pm. On most days there is work left over and patients are moved to the PAA if tasks are not completed in this time which can cause problems. Their shift continues until 9pm but between 4 and 5pm this trainee is also expected to cover the observation ward. The FY1s are unclear about their roles and responsibilities when they start working in the DVT Clinic. The current working pattern gives them a relatively short window to carry out the required tasks before the end of the working day.

2. <u>The observation ward adjacent to the emergency department</u>
   This is covered by a medical FY1 trainee from the department who starts at 8am with a ward round with the surgical consultant and finishes at 4pm. Between 4pm and 5pm there is a lack of cover. This is because the FY1 who is due to take over does not start there until 5pm. FY1s said that when there is no doctor physically covering the observation ward, it falls onto medical FY trainees to look after the patients – even those who are waiting for surgical reviews. They confirmed that they can ask the emergency medicine consultant in accident and emergency for support, if required. Trainees reported that if the observation ward shift was changed, for example, to 9am – 5pm, this would ensure there are no gaps in cover. They have previously raised this issue with the clinical lead.

FY2, CMT, GPST: FY2 trainees, CMT trainees and GPST trainees all work on the same rota at St John's Hospital. This cohort of trainees said that there is inadequate cover in the PAA between 5pm until 7pm. Until 5pm there is a nurse practitioner who helps to triage admissions from GP/community referrals into PAA. After 5pm, the receiving doctors in the MAU are not aware of the list of patients in the PAA and these patients can be left waiting to be seen without basic investigations (bloods/ECGs) being carried out. This responsibility is left to the receiving doctors in the MAU who are busy seeing patients in the MAU and this causes anxieties about patient safety.

The visiting panel were told that Dr Adamson manages the general medical rota which has slots for MoE trainees to fulfil. The MoE rota is managed by registrars and has no administration support. Difficulties sometimes arise when an MoE trainee's allocated shift is changed within the general medicine rota without that information being formally communicated to the MoE rota team. This has occasionally resulted in a trainee being double booked for on calls and other clinical duties.

This group of trainees felt that the rota needs an overall redesign to resolve the lack of continuity in FY1 support as that has knock-on consequences for them. Firstly, they have to rely on FY1s whose competence they have no idea about as they may not have worked with them before. They are also often left wondering if tasks allocated to

FY1s earlier in the week were completed before the FY1 was rotated to another unit and all of this causes some anxiety.

Trainees report feeling that the issues with the rota have been raised on several occasions but that little has been done to address the matter effectively.

By contrast, trainees reported that the stroke unit has excellent continuity. Consultants are aware of any tasks that have been delegated because the unit is well staffed and they are kept well informed through handover.

ST: ST trainees said that the rotas are variable due to the lack of continuity of junior medical staff. They also said that weekend staffing is not ideal, with FY2-ST7 acting as the second registrar. STs felt that this should ideally be another ST3+ trainee.

Nursing and Non-Medical staff: Nursing and non-medical staff said that FY1s are moved around frequently and volunteered that this may impact on the well-being of junior medical staff.

2.13. Handover (R1.14)

Trainers: Trainers said that FY1 handover is much more structured now there is input from a senior trainee. They also described a number of safety pauses within the MAU as being very effective for supporting handover.

FY1s: FY1 trainees reported that FY to FY handover takes place at 5pm each day. They confirmed that initially a middle grade doctor attended handover to support them. However, after 2 weeks this no longer happened as the FY1s felt they no longer required that support.

FY1s confirmed that there is no formal electronic record of this handover and that they are responsible for their own record keeping. Tasks to be followed up are put on workbenches. Overall, this handover was felt to work well for patients, although it was noted that FY1s finish their shift at 4:45pm but needed to stay on for handover which they said routinely takes place at 5pm.[1]

FY2, CMT, GPST: This cohort of trainees felt that overall handover works well for patients but is not used as a learning opportunity. The MAU morning handover to the day team always has consultant oversight. CMT trainees do not start their MAU shift until 10am, therefore the 8am handover from the Hospital@Night team does not include them and so they are unaware of ill patients in the department.

The on call medical registrar afternoon handover was not felt to work well. Trainees reported that this is not well structured and the information shared is person-dependent. The handover is often rushed and stressful due to the number of patients waiting to be seen.

When asked if the medical registrars support FY1 handover, this group of trainees said that a medical registrar is supposed to be at FY handover but as no one is specifically named, this often does not occur.

ST: STs confirmed that the MAU handover from the Hospital@Night team is given to the consultant on call at 8am. This is then fed back to the clinical fellow at 9am who then feeds this information to the registrar when they start their shift at 10am. There is no learning opportunity at handover but trainees reported that handover was effective. There are safety briefs with consultant presence but these are focused on sick patients and helping to maintain patient flow.

Nursing and Non-Medical staff: Nursing and non-medical staff had no concerns about handover and said they are effective to ensure that information about sick patients is passed to the next team.

[1] NHS Lothian has advised that FY handover is scheduled for 4.30pm to allow for a 4:45pm finish time.

2.14. Educational Resources (R1.19)

Trainers: Trainers told us about a simulation lead on the site and a skills lab for pleural procedures and lumbar puncture. There are also mess facilities.

Trainees: Trainees had no concerns about educational resources aside from reporting that computers can be slow.

2.15 Support (R2.16, 2.17, 3.2, 3.4, 3.5, 3.10, 3.11, 3.13, 3.16, 5.12)

Trainers: Trainers said there is a foundation programme director and associate postgraduate dean working in the unit. Both have expertise in managing doctors in difficulty, so the department benefits from this. Trainers also said there is good career support available.

Trainees: All groups of trainees raised no issues about the ability to receive additional support if required.

Nursing and Non-Medical staff: Nursing and non-medical staff said that they would approach a clinical supervisor or consultant on the ward if the performance of a trainee gave rise to potential concern.

2.16 Educational governance (R1.6, 1.19, 2.1, 2.2, 2.4, 2.6, 2.10, 2.11, 2.12, 3.1)

As a small unit, trainees feel comfortable raising any concerns about their training with consultants directly. Trainers told us that there is a chief resident who is in the initial stages of setting up junior doctor forum meetings, however this was noted to be in its infancy. No trainees interviewed on 24 September were aware of the junior doctor forum, but trainees we spoke to on 26 November were aware of the junior doctor forum and one meeting had taken place so far.

2.17 Raising concerns (R1.1, 2.7)

Trainers: All staff are aware of how to raise concerns and are comfortable doing so.

Trainees: FY trainees receive specific teaching on whistleblowing. Trainees said they would approach their consultants, or the charge nurse. if they had any concerns.

2.18 Patient safety (R1.2)

Trainers: Trainers commented that workload pressures have not lessened. The number of admissions has increased year on year and there are currently 30/40 admissions per day. The appointment of 5 new clinical fellows has had a positive impact on assisting with the workload for ST trainees in medical receiving. Trainers acknowledged that the Hospital@Night team is a small team looking after a lot of patients and that weekend staffing is at minimum. They felt that this raises questions about staffing at St John's Hospital compared to staffing at the other NHS Lothian sites where there are more staff available for a smaller complement of patients, for example, Western General Hospital. Work is currently being undertaken to attempt to match staffing levels to peak clinical activity. Additional locums are being employed for the winter ward and there is funding available for 2 more junior staff. There are plans to remodel medical admissions however these are phase 2 and currently phase one to remodel the emergency department are taking place.

Trainees: Trainees said that medicine at St John's Hospital is safe for patients, but at times the MAU can feel unsafe due to it feeling very busy. Trainees said that there is pressure to board patients, but this is not worse than at any other hospital. They were aware of a formal boarding policy being in place which they considered is effective for patients. TRAK is used to identify these patients and which consultant is responsible for ownership of the boarded patient is recorded on TRAK. Trainees said that safety could be improved by naming not just the consultant but the responsible ward and the bleep number to call. This idea progressed as trainees were voicing ideas and all trainees said it would be fantastic if a designated bleep number for contacting the relevant team looking after boarded patients could be implemented.

Nurses and non-medical staff: Nurses and non-medical staff talked about patient flow in the MAU. They said patients triaged by the PAA team now wait in the waiting room of MAU (they are not left in PAA anymore). Although the room is small, this was felt to be much better for patients than before. If a patient has a high (national early warning score), this is seen as priority and a bed is found more quickly for these patients.

2.19 Adverse incidents (R1.3)

Trainers: Trainees are aware of datix. Datix submissions are reviewed monthly with feedback provided by the medical director. These are also discussed at quarterly M+Ms.

FY1 Trainees: FY1 trainees mentioned teaching about datix and the foundations of safety programme. Trainees were not aware of M+M meetings.

FY2, CMT, GPST, ST Trainees: All trainees were aware of datix. This group of trainees considered that they would definitely receive feedback on the outcome of an incident report in the MoE unit, but were not sure whether this would apply in the MAU.

2.20 Duty of candour (R1.4)

Trainers: Trainers said they led by example.

Trainees: All trainees were aware of the duty of candour.

2.21 Culture & undermining (R3.3)

Trainers: Trainers felt that there was a good team spirit at St John’s Hospital and the consultant team has a WhatsApp group. Trainers said there was a zero tolerance of bullying. A specific incident of alleged undermining behaviour displayed by an individual member of staff was described.

Trainees: Overall, the impression from trainees is that St John's Hospital is a friendly hospital and a nice place to work. However trainees advised witnessing a junior doctor becoming upset after an encounter with a member of staff. Trainees alleged that this type of behaviour from this staff member has occurred previously and is known about by most trainees.

Further details of the specific incident have been shared with the clinical director and associate director of medical education out with this report and NHS Lothian has been asked to investigate and address this incident in accordance with local NHS Lothian policy.

2.22 Other

All groups of doctors were asked to rate their overall satisfaction' with their placement and the average scores are presented below:

- **FY1:** Range = 5 - 8, Average = 7 out of 10
- **FY2/GPST/CMT:** Range = 6 - 10, Average = 7.7 out of 10
- **ST3+:** Range = 7 – 8, Average = 7.5 out of 10.

3. Summary

Is a revisit required?	Yes	No	Highly Likely	Highly unlikely

The visit panel noted the ongoing commitment of site leads to improve the educational environment.

Progress against previous requirements recorded as 'addressed', 'significant', 'some progress', 'little or no progress'.

Ref	Issue	Progress noted at 2019 visit
1	There must be a clear pathway for who is responsible for the day to day review of patients boarding out with their	**Addressed**

	usual ward including an expectation of frequency of consultant review.	
2	There must be clear lines of supervision within the MAU at all times with easy access to Consultant support when required.	**Addressed**
3	Clarity of consultant cross-cover arrangements for management of patients is required when their usual consultant is on leave.	**Addressed**
4	All trainees must be assigned to a ward/unit for a minimum of a 4-week continuous period. The discontinuity of ward placements for all trainees must be addressed as a matter of urgency as it is compromising quality of training, feedback, workload and the safety of the care that doctors in training can provide.	**No progress**
5	The department must review and reduce the volume of non-educational tasks the FY1 trainees undertake in order to maximise their potential to attend educational opportunities including wards rounds.	**Some progress**
6	General Practice trainees must have equitable access to clinics and be able to attend sufficient numbers to achieve their curriculum competencies.	**Some progress**
7	A formal structured handover with input from senior team members must be established for the Foundation trainees.	**Initial progress – not sustained**
8	Induction to the unit must be provided in a timely manner and prepare the trainees for their role in the unit. This should include practical information on protocols and ways of working in the department	**Some progress**
9	The department must review and reduce the volume and intensity of daytime work for Specialty trainees when working in acute admissions.	**Addressed (improvement made with the appointment of 5 Clinical Fellows)**

10	Opportunities to feedback to all trainees in the ward setting must be created.	**Some progress – FY1 still perceive little to no feedback**
11	There must be review of the arrangements for attendance at H@N handover to ensure that patient care and trainee workload within MAU is not compromised.	**Addressed**

Aspects that are working well:

- Engagement - we commend the engagement of site leads and consultant trainers in improving the educational environment since the last visit. Notable improvements are:
  1. clear boarding policy with clear consultant ownership
  2. clear lines of educational and clinical supervision
  3. the positive impact achieved following employment of 4 clinical development fellows to support the workload of STs in particular
  4. no concerns were raised on this occasion relating to Hospital@Night handover (or the location of this).
- Trainees all described extremely supportive consultants, who are easy to contact, and there appears to be high levels of morale amongst most grades of doctors in training within the medicine department.
- While acknowledging the department is busy with an increasing volume of admissions over the years, trainees did not report working out with their competence.
- The weekly unit teaching on Tuesday was rated highly by all trainees. FY trainees also spoke highly of local FY teaching.
- Attendance at mandatory teaching for all grades is supported by the rota.
- Trainees commended the educational facilities available on site.
- There are no barriers to study leave.
- Trainees receive regular feedback both formal and informal and acknowledged MAU working as particularly good for this.
- Guidance for improving the content of electronic immediate discharge letters for short stay patients has reduced time taken for completion and has been well received.

Aspects that are working less well:

- Lack of continuity for FY1s on their base ward remains an issue. As a result, FY1 trainees report not feeling part of the team and perceive that after almost 2 months in post no-one knows them.
- More senior trainees reported not knowing FY1 trainees sufficiently well to be able to assist with completing TABS for them.
- Ward rounds do not appear to be perceived as a vehicle of learning for FY1 trainees. FY1 trainees prioritise completing electronic immediate discharge letters over actively taking part in ward rounds and spend much of the rest of their time doing jobs whilst working on medical wards.
- Arrangements for the DVT clinic require review. FY1s are unclear about their roles and responsibilities within this area and report that it is not fully covered by their induction.
- The working day of FY1s providing cover to the DVT clinic does not fully align to the workload involved. This leaves a relatively short window to carry out the required tasks before the Day Unit closes and nursing staff leave.
- The PAA staffing is suboptimal between 5pm - 7pm after the nurse practitioners depart. Patients arrive via the flow centre and no triage or basic investigations are done during this time.
- Cover for the emergency department observation ward is provided by a medical FY1 trainee. There is a gap in cover between 4pm - 5pm which trainees perceive as unsafe for patient care and nursing staff are unaware of who to escalate concerns to during this time. However no specific examples of harm were quoted.
- Handover in general functions well, however the 5pm handover between FY trainees currently has no senior input or educational focus.
- Senior trainees remain unclear about pathways to support discharge of patients within acute areas including referral to DVT clinic and ambulatory care facilities in order to improve flow.
- On average ST trainees had only attended 3 outpatient clinics in the first 2 months of post due to commitments to the medical receiving rota.
- GPST and FY2 trainees are not rostered to do clinics, although GPSTs can request this.

4. Areas of Good Practice

Ref	Item	Action
4.1	Guidance for improving the content of electronic immediate discharge letters for short stay patients has reduced time taken for completion and has been well received.	None required
4.2	The work undertaken to identify the competencies of nursing staff and encouragement of top of the band working to increase nursing support of routine tasks currently done by doctors in training (for example, bloods, cannulas and ECGs). We commend this activity and suggest that this work continues.	None required

5. Areas for Improvement

Areas for Improvement are not explicitly linked to GMC standards but are shared to encourage ongoing improvement and excellence within the training environment. The Deanery do not require any further information in regard to these items.

Ref	Item	Action
5.1	NHS Lothian should investigate whether the Hospital@Night team and weekend staffing arrangements are sufficient (see 2.12 and 2.18).	
5.2	Clarity needs to be provided to ST trainees about pathways to support discharge of patients within acute areas including referral to DVT clinic and ambulatory care facilities in order to improve patient flow.	

5.3	Information regarding shift patterns should be updated in the medicine department handbook and the health board should consider circulating this to FY1s earlier during shadowing week in advance of their formal induction.	
5.4	Review the role of middle grade junior staff on ward rounds to shift focus from the current scribing activities towards involvement in decision making.	
5.5	Formalise time for the junior doctor forum within the rota as a vehicle for formal trainee feedback.	
5.6	Improve the communication around changes occurring in the medical receiving rota that affect the MoE trainees.	
5.7	Review start times for trainees to attend clinics when there is a timetable clash with local teaching.	
5.8	Facilitate attendance at learning opportunities for example knee aspiration and pleural clinics by timetabling these activities into the rota.	

6. Requirements - Issues to be Addressed

Note that the work to address the requirements listed under section 3 from the 2018 visit must continue to ensure these are resolved and that resolution is sustainable. A complete list of requirements from both visits is outlined below.

Ref	Issue	By when	Trainee cohorts in scope
6.1	Allegations of undermining behaviour must be investigated, and if upheld, put in place an appropriate action plan must be instigated to address them.	**Immediately**	All cohorts

6.2	The scope of cover and the associated workload of the DVT Clinic requires urgent review. (See 2.12).	**Immediately**	**FY1**
6.3	The scope of cover and the associated workload for both the MAU/PAA between 5 and 7pm and the observation ward between 4 and 5pm must be reviewed as the work within these areas does not feel manageable and safe for trainees or patients. (See 2.12).	**Immediately**	**FY2, CMT, GPST**
6.4	Induction to all ward areas, including the DVT clinic, must be provided in a timely manner and prepare the trainees for their roles. This should include practical information on protocols and ways of working on the wards.	24 June 2020	**All cohorts**
6.5	All trainees must be assigned to a ward/unit for a minimum of a 4-week continuous period. The discontinuity of ward placements for all trainees must be addressed as a matter of urgency as it is compromising quality of training, feedback, workload and the safety of the care that doctors in training can provide. *(This 2018 requirement is particularly relevant for FY1 trainees who reported to be struggling to feel part of the wider team with the current arrangements).*	24 June 2020	**FY1/All**
6.6	The department must review and reduce the volume of non-educational tasks undertaken by trainees to allow them better access to educational opportunities). *(This 2018 requirement*	24 June 2020	**FY1, CMT**

	now mainly applies to FY1 trainees within the DVT Clinic and to CMT trainees when working on call within the MAU).		
6.7	Trainees must have equitable access to clinics and be able to attend sufficient numbers to achieve their curriculum competencies. *(This 2018 requirement is now noted to be applicable to all trainees who are required to attend clinic as part of their curriculum).*	24 June 2020	**GPST/CMT/ST**
6.8	A formal structured handover with input from senior team members must be established for the Foundation trainees. *This 2018 requirement must be sustained and the handover must be scheduled within the rostered hours of work of the trainees.*	24 June 2020	**FY1**
6.9	Handover for the on call medical registrar must be formalised and structured to ensure safe handover and continuity of care. (See 2.12).	24 June 2020	**FY2/CMT/ST**
6.10	There must be a process that ensures trainees understand, and are able to articulate, arrangements regarding Educational Governance at both site and board level.	24 June 2020	**All cohorts**

Action undertaken by NHS Lothian to address requirements can be found by accessing NHS Lothian's Medical Education Directorate website. See Action Plan – located at the bottom of the webpage.