Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	28th January 2020	**Level(s)**	Foundation, core and specialty trainees
Type of visit	Triggered visit	**Hospital**	Inverclyde Royal Hospital
Specialty(s)	General Surgery	**Board**	NHS Greater Glasgow and Clyde

Visit panel	
Professor Clare McKenzie	Visit Chair - Postgraduate Dean
Dr Surinder Panpher	Foundation Programme Director
Dr Ron Coggins	Training Programme Director
Dr David MacPherson	Trainee Representative
Archie Glen	Lay Representative
Heather Stronach	Quality Improvement Manager
In attendance	
Claire Rolfe	Quality Improvement Administrator

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)	Mrs Jennifer Duncan	
Unit/Site Information		
Non-medical staff in attendance	4	
Trainers in attendance	5	
Trainees in attendance	5 foundation year 1 (FY1) trainees, 3 core trainees, 1 specialty trainee (ST)	

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

Date report approved by Lead Visitor	17th November 2020

1. Principal issues arising from pre-visit review:

At its meeting in August 2019, following a review of the available data, the Deanery's foundation quality review panel (QRP) decided to trigger a visit to general surgery at Inverclyde Royal Hospital and to undertake this in conjunction with a visit to trauma and orthopaedic surgery.

Below is a broad summary of the data from the General Medical Council's (GMC's) national training survey (NTS) and the Deanery's Scottish training survey (STS).

	Foundation Year 1 (FY1)	**Core**	**General Practice trainees**	**Specialty trainees (STs) in general surgery**
Overall satisfaction	NTS red	NTS pink (aggregated)		NTS pink (aggregated)
Induction	NTS red		NTS green	
Curriculum Coverage	NTS pink	NTS pink (aggregated)		NTS pink (aggregated)
Adequate Experience	NTS red	NTS pink (aggregated)		NTS pink (aggregated)
Workload	NTS red STS red			
Feedback				NTS pink (aggregated)
Handover	STS red	NTS pink (aggregated)		STS red (aggregated)
Reporting Systems	NTS red			
Rota Design	NTS red	NTS pink (aggregated)		NTS red (aggregated)
Educational supervision			NTS green	NTS pink (aggregated)
Educational governance	NTS red			NTS pink (aggregated)
Workload	STS red			

Prior to the visit commencing, the visit panel met with Dr Michael Brett, Associate Director of Medical Education for Clyde, Dr Carsten Bolln, General Surgery Lead and Dr Alison Winter, T&O Education Lead who provided a brief summary of the departments.

The general surgery unit comprises five consultants and six middle grade doctors. When the unit is fully staffed, there are four ST trainees and two junior trainees. The general surgery department has not been fully staffed for quite some time; at present there are two core trainees, two ST trainees, one locum service appointment, and one vacancy which they currently have a locum for but are not sure if this will continue. Vacancies within anaesthetics are impacting on access to operative surgical training in particular hernia repairs.

Due to the size of the hospital and the services it provides, it is perceived that gaps in staffing levels are felt to disproportionally affect training. Core and ST trainees are all on the same rota.

The visiting panel met with trainers and trainees in general surgery. The trainees we met with were foundation year 1 (FY1 trainees), core trainees and specialty trainees (ST). The visit panel also met with non-medical staff who supported both surgery and T&O hence their responses are the same in both visit reports.

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: Trainers said there are several elements to induction as follows: 1) an online NHS Greater Glasgow and Clyde induction which can be carried out before trainees start working, 2) induction on the first day of work and 3) 'Preparation for Practice' which is a shadowing period for FY1 trainees. Induction is well organised, and trainers did not feel that trainees would raise any concerns about induction. There is also an induction pack available to trainees which is very detailed and updated regularly covering items such as day-to-day working and out of hours working at the hospital. This was initially created by trainees for trainees and information is added as necessary.

Foundation trainees: Trainees reported that induction for them was variable. They said that induction was less effective for trainees who did not rotated through the Greater Glasgow and Clyde region as part of their undergraduate training. Trainees from Glasgow University already had 5 weeks experience at Inverclyde Royal Hospital, whereas those from other universities did not have this. All trainees had the same amount of time

shadowing. On the high dependency unit (HDU), there is a handbook that trainees can use. However, the escalation processes described is felt to be of little benefit to trainees in real life practice; it states to 'call the appropriate team' and identifying the appropriate team can be the problem.

Core and ST trainees: Core trainees could not remember receiving a hospital induction but could recall their induction to the general surgery department. They said it was effective. They recall it being personalised with a consultant walking them round to meet staff. For them, the most useful information came from talking to peers. The induction booklet was reported to contain useful information; however, it would be beneficial to receive it prior to starting work to fully digest the information and equipping them for practice.

Non-medical staff: Non-medical staff said that new trainees on the wards are not identified to them. However, sometimes they recognise trainees if they were previously a medical student in Glasgow. They felt that a photo board would be helpful for identifying staff. Non-medical staff consider that the induction programme provides trainees with the information they need.

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

Trainers: FY teaching takes place on a Tuesday lunchtime. Core regional teaching primarily takes place at the teaching hospitals in Glasgow or in the Deanery and is arranged by TPD. ST regional teaching is on Fridays. The time is protected so that all trainees can attend (unless scheduled to be on call).

Departmental meetings take place on Friday afternoons. There is no formal programme of departmental teaching, rather this is a rolling programme. Sometimes teaching is based on cases presented at morbidity and mortality (M&M) meetings, journal clubs or real-life cases that trainees have encountered during their acute receiving work. Trainers perceive that a lot of informal on the job teaching takes place because consultants frequently ask trainees what they picked up during the acute ward round take.

Trainers said that registrars take the bleeps of FY1s to ensure their time at teaching is protected. However, consultants acknowledged that this varies in effectiveness. The 1st on call for GP calls is the only trainee who would still get bleeped.

Regular mention was made through out of the term 'House Officers.'

Foundation trainees: Foundation trainees reported receiving on average 1 hour per week of locally delivered teaching. Regional teaching is usually delivered via videoconference (VC) from the Royal Alexandra Hospital. They said there had been several cancellations (approximately 1 in 5 sessions), which had not been

rescheduled. FY trainees said that it felt difficult to engage with teaching by VC because it rarely begins on time and is of poor quality, often associated with technical issues. Foundation trainees did not consider that teaching was bleep free as there was no one to hand over the bleeps to. Despite the difficulties, trainees considered that they would be on target for the 30 hours mandatory foundation teaching required by their curriculum.

Core and ST trainees: Core and ST trainees confirmed their regional teachings and the local Friday afternoon departmental teaching. They said the latter is organised by a ST trainee and is delivered by either the ST or core trainees 95% of the time. They perceived that teaching is mainly aimed at foundation trainees because it is delivered by core or ST trainees. Consultants attend teaching and may sometimes deliver the teaching. More consultant led teaching would be of benefit to core and ST trainees.

Core trainees confirmed that being on call or on nights prevents them attending teaching. Insufficient trainee numbers in the past had sometimes resulted in cancelled sessions. The situation has improved since the appointment of a short-term locum who is currently filling this gap. Core trainees are on call once every 3 weeks.

Trainees noted that fitting in teaching can be difficult considering the 1:30pm start time for weekday emergency theatre. If trainees are due in theatre by 1:30pm and they are on call, by the time they have finished responding to the call this leaves limited time left for teaching. Unfortunately, because some consultants are based at the Royal Alexandra Hospital, trainees said there is no scope to change the time teaching starts.

ST trainees reported being able to attend most of their teaching sessions. Trainees have to request study leave for regional teaching through the TURAS system – it is not timetabled into the rota. Study leave has been declined for regional teaching on one occasion.

Non-medical staff: Non-medical staff said that nurses know when trainees are going into teaching and try to minimise interrupting them. Only the trainee who is 1st on call for surgical receiving will receive any bleeps. Non-medical staff said that foundation trainees can handover their bleeps to the registrars.

2.3 Study Leave (R3.12)

Trainers: Trainers said that they are supportive of study leave but it can sometimes be difficult to accommodate due to the rota gaps. Clinics had been reduced in the past in order to accommodate study leave. Trainers were not aware of anyone who had been denied study leave.

Core and ST trainees: Core and ST trainees also said this was difficult because of rota gaps. Requesting study leave had been easier since the appointment of the short-term locum. The trainee who organises the rota and does their best to accommodate any requests. Usually if 6 weeks' notice is given, study leave requests can be granted. Certain days were observed to be more difficult than others.

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

Trainers: Trainers reported that formal supervision is split amongst consultants, with consultants allocated separate cohorts of trainees. One consultant attends the specialty training committee (STC) for general surgery to be aware of any changes to training.

All trainers have their education role reviewed as part of appraisal. Job plans were renewed last year. One session within job plans who provide formal supervision to different cohorts was felt to be insufficient.

Trainees: All trainees had been allocated educational supervisors and had met with them. Foundation trainees found this meeting to be useful and had agreed learning plans. Core and ST trainees reported that they meet frequently with their educational supervisors on an informal basis and did not feel that more regular formal meetings were required. Educational supervision was reported as good overall.

2.5 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 reported the curricula for foundation, core and specialty trainees are very clear on the requirements for each cohort. The intercollegiate surgical curriculum programme (ISCP) describes what competencies are required for trainees to be eligible to apply for ST3 interviews. Trainers said that when they are allocated trainees, they will look at a trainee's e-portfolio to determine what their training needs are. In the past, one consultant was responsible for ensuring that individual training needs were covered in the planning of the rota, but this now this is tasked to the trainee who writes the rota. Sometimes the availability of theatre lists, including endoscopy, has posed a problem in meeting these individual needs.

Trainers said that trainees know who to contact for support during the day and out of hours. Most of a trainee's activity in general surgery is directly supervised. ST trainees are on call with the same consultant so that operations occurring out of hours are directly supervised unless trainees are signed off as competent to do a procedure.

Foundation doctors are ward based and are not allocated to attend theatre. Trainees on the ward know who they can contact. Foundation doctors have been told that the registrar/consultant in theatre would rather be

contacted if someone is critically unwell. Other specialties can also provide support. For example, the anaesthetic registrar would be happy to help with peri-arrests. Sometimes the orthopaedic registrars are asked but this is an exception.

Trainers said that if there are times when foundation trainees have felt they have had to cope with problems beyond their competence. They perceived this could stem from issues arising within the high dependency unit (HDU). Surgical patients are reviewed first thing in the morning so any surgical issues should be dealt with. Trainers seek the views of foundation doctors after Friday afternoon teaching and were aware of a trainee who had felt unsafe on the HDU, but this seemed to be with respect to the medicine rota.

Foundation trainees: Foundation trainees reported that in general surgery, when on the surgical rotation for the HDU, they always know who to contact.

Foundation trainees said that obtaining an opinion when both the surgical registrar and consultant on call are in theatre is difficult and in these situations, they have to admit the patients as they are unable to make the decision about whether these patients can be discharged. Foundation trainees said that their senior colleagues are accessible and approachable.

Core and ST trainees: Trainees said they always know who to contact for supervision both during the day and out of hours. Trainees said they have never felt they have had to cope with problems beyond their competence. Senior staff are accessible and approachable. Trainees did however report a disparity in the behaviours of consultants in directly supervising cases in and out of hours.

Non-medical staff: Non-medical staff said it can be difficult for foundation trainees to seek support because the registrar is often in theatre with the consultant. While they can seek support by telephone, there is not always a senior doctor available in person. When this is the case, sometimes concerns are raised by foundation trainees to the service manager.

Some non-medical staff were aware that the trainees wear different coloured badges according to their training grade; however, they were unaware of the significance of the colour coding.

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

Trainers: Trainers reported that they are made aware of the various curricula requirements for specialty trainees via ISCP. For foundation doctors this information is available on TURAS.

Trainers reported that previously FY1s had an educational supervisor for the entire year but recently this was changed to a new educational supervisor every 4 months. Feedback from FY1 doctors will be sought.

Trainers said that FY1 competencies are easy to achieve. Trainers felt that for foundation trainees, work in the pre-assessment clinic could be perceived by trainees as having little educational value. Trainers felt it had educational value as it builds upon basic learning. Similarly, assessing whether a patient is fit for surgery or not is an important clinical judgement to make. Reporting back on CT scans is also valuable learning. Last year saw the implementation of phlebotomy support at weekends so that foundation doctors now spend less time taking bloods.

For core and ST trainees, trainers said that the learning opportunities such as clinic and theatres are maximised because they are incorporated into the rota design. Rotas are considered to be fairer this year.

For specialty trainees, appendicectomy requirements are difficult to achieve. There are low numbers of these cases at Inverclyde Royal Hospital when compared to other hospitals due to patient demographics. Additionally, the weekday emergency theatre starts at 1:30pm so by the time some cases are prepared and ready for theatre at around 5:30pm, core and ST trainees will have finished their day shift. Trainers reported that the rota staffing results in weekday out of hours working not being carried out by core or ST trainees, but by non-training grades. The STC is aware that it is difficult to obtain the required number of appendicectomy procedures.

In the HDU, there is a ward round by the consultant surgeon on call before 9am. The on-call registrar will take part in this ward round.

Specialty trainees and core trainees all work weekends. This means they are on the weekend shift once every 3 weeks.

Foundation trainees: Foundation trainees reported that airway and arrests are core competencies they can achieve during this placement. They estimate that about 80% of their work out of hours is carrying out electrocardiograms (ECGs) as there is no ECG technician. Foundation trainees also report being heavily burdened with discharge letters and routine tasks of limited educational benefit. Foundation trainees said that they typically struggle with obtaining direct observation of procedure (DOPs) assessments because there are so many discharges and ECGs to do first and that long-term locums are not able to sign off WBAs.

Core and ST trainees: Core and specialty trainees also reported that appendicectomy and hernia requirements are difficult to achieve. Theatre lists had been cancelled due to absences in the anaesthetic rota

with some hernia cases going to the Golden Jubilee. There are two lists, one on Tuesday morning which trainees feel they are too busy to attend, and one on a Thursday afternoon. Trainees believe that to be eligible for an ST job, you need a certain number of procedures. This creates anxiety if the numbers cannot be achieved. However, they reported that their overall procedure numbers are on track.

Trainees reported that endoscopy requirements are also difficult to achieve because the trainee list is shared amongst all trainees on the higher rota. Specialty trainees are not prioritised for endoscopy over core trainees. It was not clear if this was a requirement of their individual general training.

Trainees report being able to attend 2 – 4 clinics per week all of which provided appropriate learning opportunities. Trainees have time built into their rotas to complete administrative tasks.

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

Trainers: Trainers reported that there are no problems for trainees completing their assessments. The requirements around assessment are easy to understand. Trainers felt an aid memoire would be useful for Foundation training assessments. They encourage trainees to undertake these regularly.

Foundation trainees: Trainees reported that workplace-based assessments are easy to achieve, and they are fair. They said that they are unable to get sign off on assessments from some registrars because they are long term locums.

Core and ST trainees: Core and specialty trainees reported that some consultants' complete assessments more quickly than others and that it would be good if they were more consistent. ST trainees have raised issues about undertaking WBAs with their TPD as it is more difficult when they are experienced and undertaking activity independently.

Non-medical staff: Non-medical staff contribute to the assessment of doctors in training in this unit (for example, multi-source feedback).

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

Trainers: Not asked.

Trainees: All trainees reported some element of informal multi-professional learning from advanced nurse practitioners, pharmacists or dieticians. They reported that there was nothing formal.

Non-medical staff: Nurses informally contribute to teaching and support. They considered that they could offer to do more teaching. There is the opportunity for shared learning at M&M meetings.

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

Trainers: Trainers said that audit projects are encouraged.

Trainees: All trainees reported that there are quality improvement projects available. Core and ST trainees reported that the volume of administrative work makes it difficult to get time to do a quality improvement project.

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: Not asked.

Foundation trainees: Trainees reported that when they are first on for clerking patients, they get useful feedback from the registrar who will ask them what they think is going on with the patient. Foundation trainees perceive receiving less feedback when working day to day on the wards.

Core and ST trainees: Trainees reported receiving frequent informal feedback. Feedback is constructive.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: Trainers said they receive feedback from trainees at educational supervision meetings and from the service managers who report back what trainees raise. In the past, there were meetings with trainees to discuss issues with the rota however these are not ongoing. Trainers also acknowledged the NTS and STS surveys as feedback from trainees. They highlighted the Chief Resident as someone who gathers feedback. Trainers are aware of feedback about endoscopy training which has been impacted by the need to train up a new nurse endoscopist.

Foundation trainees: Trainees reported this deanery visit as their method of feedback. They were not aware of how to provide feedback about their regional teaching and were not provided with a link asking for their feedback.

Core and ST trainees Core and specialty trainees were aware of the chief resident role and described an upcoming meeting.

2.12 Culture & undermining (R3.3)

Trainers: Not asked.

All trainees: All trainees reported that consultants were accessible and approachable. They would speak to a clinical supervisor, educational supervisor or training programme director if they had concerns about bullying or undermining behaviours.

Non-medical staff: Non-medical staff said that team culture is supported through safety huddles and catch ups at ward rounds. Non-medical staff said it was important to be approachable and available for colleagues. Face to face discussions usually help to resolve any misunderstandings. Formal dignity at work policies are also in place at work.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Trainers reported that there was no FY1 vacancy in surgery at the moment. Two ST positions were unfilled at the start of August. Currently, one is filled by a service appointment and another by a locum. The longevity of this locum appointment is unknown.

Last year, there was a redesign of the rota because of the feedback received from foundation trainees. The FY1 on call for general surgery used to provide cover for the orthopaedic ward, but this is now no longer the case. Rota now allows a longer time on wards rather than being frequently moved around. This is felt to be better. Miss Winter (T&O) has been involved in rota development for foundation.

Annual leave requests had often left the unit feeling understaffed so FY1s now have annual leave allocated to them.

Foundation trainees: As a small unit, absences heavily impact on the team and workload can at times feel unmanageable. Foundation trainees report having to get on with things with no spare capacity in the system. The receiving ward is busy, and workload is even greater if they have to cover multiple other areas as well. Day care admissions can be difficult to manage especially during the winter period.

Foundation trainees appreciate the weekend support that the phlebotomist provides. No nurse practitioners are available to help with basic clinical assessments in pre-assessment which increases workload. Foundation trainees had not yet fed back these challenges to trainers.

Core and ST trainees: Trainees said that the gap in the middle grade rota was known in advance of August. The need to cover the vacancy did impact negatively from their training opportunities as core and ST trainees are on the same rota. An external locum has been filling this gap since November and was sourced by one of the trainees. It is not known how long the locum will be staying for. Trainees reported that there was an expectation from management that trainees themselves were responsible for filling the gap. As far as trainees were aware, the vacant post had never been advertised. They are not aware of a proactive plan to address the vacancy.

Non-medical staff: Non-medical staff reported that foundation trainees raised that they were not able to take their breaks. This has been addressed by the consultant who has spoken with trainees and advised of ways they can take them. A monitoring exercise had taken place but needs to be repeated.

It was felt that there has been a lack of clear communication to the service manager about whether to advertise the vacant middle grade surgical post as a substantive appointment. Historically, recruiting to Inverclyde has been challenging probably due to geographic location.

2.14 Handover (R1.14)

Trainers: Not asked.

Foundation trainees: Foundation trainees said that there is a 9pm handover to the hospital at night (H@N) team with 1st on call for surgery attending. H@N handover is led by medical registrar and is verbal rather than written. There are no handovers in general surgery in the morning from H@N. There is a 9am surgical ward round.

Core and ST trainees: This group of trainees also confirmed the handover to H@N at 9pm. They said there is also a verbal handover between 5pm and 5:30pm on weekday to the non-training grade specialists.

Non-medical staff: Non-medical staff have a huddle around the board at 8:30am followed by the ward round. If a patient deteriorating, they use a sticker system to identify these patients. This works effectively.

2.15 Educational Resources (R1.19)

Trainers: Not asked.

Foundation trainees: Foundation trainees had not accessed the library but said that there were computers available to them and they had not struggled to complete online assessments.

Core and ST trainees: Not asked.

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

Trainers: Not asked.

Foundation trainees: No trainees were less than full time. Foundation trainees perceived that trainers would be supportive of reasonable adjustments if they were required.

Core and ST trainees: Not asked.

Non-medical staff: Non-medical staff did not raise any concerns around support.

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

Trainers: Not asked.

All trainees: All trainees were aware of the junior doctor's forum led by the chief registrar and said that the main topic that had been covered was monitoring of the rota as this was raised with the British Medical Association. Trainees said the rota was monitored in October but that it came back as unrepresentative, so the exercise had to be repeated.

Trainees were unaware who the Director of Medical Education is for NHS Greater Glasgow and Clyde.

2.18 Raising concerns (R1.1, 2.7)

Trainers: Not asked.

Foundation trainees: Trainees reported that they would raise any concerns with their supervisor. Trainees were aware of Datix.

Core and ST trainees: Not asked.

Non-medical staff: Non-medical staff said that foundation trainees would always escalate to a registrar if faced with a deteriorating patient. They would speak to a trainee if they felt that there were issues about the trainee.

2.19 Patient safety (R1.2)

Trainers: Not asked.

Foundation trainees: Trainees said that the general surgery department was a safe environment for patients. They said that boarding from other specialties (for example, medicine) impacts on the surgery department as operations can be cancelled if there are no beds left for these patients.

Core and ST trainees: Not asked.

Non-medical staff: Non-medical staff said that currently there are boarded patients, and this is adding some pressure on FY1s because it is not just one consultant but 4 or 5 that they need to speak to. From a safety perspective, this means that priorities must alter in order to cope with patients who might be deteriorating medically. The impression is that foundation trainees are not as well supported in managing the medical boarder patients and they seek support from their own surgery consultant colleagues.
Non-medical staff said that currently there are 10/11 beds that are boarded patients, and this is adding some pressure on FY1s because it is not just one consultant but 4 or 5 that they need to speak to. From a safety perspective, this means that priorities must alter in order to cope with patients who might be deteriorating medically. The impression is that foundation trainees are not as well supported as they could be from medicine, so that they look to their own surgery consultant colleagues for support.

2.20 Adverse incidents & Duty of Candour (R1.3 & R1.4)

Trainers: Not asked.

Foundation trainees: Foundation trainees reported they would feel supported raising concerns with supervisors or nursing staff. They were also aware of reporting adverse incidents using the Datix system and aware of morbidity and mortality (M&M) meetings that take place although could not attend many.

Core and ST trainees: Not asked.

Non-medical staff: Non-medical staff mentioned the Datix system for reporting concerns. They felt that the department could do better at feeding back with clearer outcome and actions.

2.21 Other

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

- **Foundation trainees** Range = 6 - 7, Average = 6.5 out of 10
- **Core and ST trainees:** Range = 5 - 7, Average = 6 out of 10

3. Summary

Is a revisit required?	**Yes**	**No**	**Highly Likely**	**Highly unlikely**

Overall trainees were positive about colleagues at Inverclyde Royal Hospital. Foundation trainees enjoy working on acute receiving in particular and report receiving good feedback there. Foundation trainees can sometimes find it difficult seeking senior support when their registrar or consultant colleagues are in theatre. Escalation pathways are not clear when they need to seek support for patients who become medically unwell following surgery. Trainees report fluctuating between medical and surgical colleagues for advice and would benefit from a clear agreed policy.

Foundation trainees said that the rota in surgery remains an issue and they continue to be faced with a busy workload. Some tasks, such as taking ECGs and taking routine recordings in pre-assessment, were not seen as being educationally valuable for foundation trainees. The ANP role has worked well in T&O an could be considered in general surgery.

Core and specialty trainees have concerns about accessing enough clinical experience specifically in endoscopy, appendicectomies and hernias. This is worsened when there are gaps in their rota and when sessions are cancelled due to anaesthetic vacancies.

Positive aspects of the visit

- All trainees advised that they had supportive, approachable easily accessible consultants.
- All trainees recognised receiving feedback regularly from trainers, both informally and formally (although some consultants were reported as being slow at completing workplace-based assessments which was causing some anxiety to trainees).
- Trainers are aware of the differing needs of trainees and the different curricula.
- Trainees report good front line learning opportunities. Foundation trainees appreciate the experience of being the first point of call for GP referrals.
- Trainees described a good team atmosphere with mutual respect amongst medical and nursing colleagues.
- Trainers identify the individual trainees' learning needs and offer tailored sessions where possible.

Less positive aspects of the visit

- Foundation trainees said that the teaching by videoconference does not work well in terms of learning and interactivity and were concerned by the number of sessions that have been cancelled at the last minute.
- Teaching is not bleep free.
- Coloured badges were noted to be in use; however, the significance of the colour and the stage of training was not widely known to staff rendering it ineffective.
- There is no written handover between shifts and grades and no regular handover from H@N in the morning. Trainees report not being able to use Trakcare in the surgical specialties which reportedly works well in the medical specialties in the hospital.
- There must be named consultant involvement with all trainee rotas to ensure educational opportunities are appropriately distributed and to regularly review any issues with the rotas of both foundation and middle grade trainees. Views of the trainees should be formally sought in development of rotas and workload changes.
- Trainees are burdened by tasks of little educational benefit especially when on call e.g. performing electrocardiograms.
- Long term rota gaps on the middle grade rota should ideally be supported by a substantive appointment.
- Innovative review should be undertaken of the current middle grade rota to consider how trainees can maximise educational opportunities both in hours and out of hours.

4. Areas of Good Practice

Ref	Item	Action
4.1	Clinic opportunities and admin time built into rotas	

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	Induction	Seek trainee input into the HDU handbook.
5.2	Rota	Proactive management of rota gaps with substantive appointments should be considered.
5.3	Rota	Formal trainee input should be sought regarding rotas and consideration given to changes in daytime and out of hours of the middle grade rota.
5.4	Rota	There must be named consultant oversight of all trainee rotas to ensure that educational opportunities are appropriately rostered.

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	Handover arrangements, especially between H@N and day teams, must be reviewed and improved to ensure there is a safe, robust handover of patient care with adequate documentation of patient issues. This should be used as a learning opportunity.	Immediately	All trainees
6.2	Clarify escalation pathways for T&O and surgical patients who become medical unwell.	31st December 2020	All trainees
6.3	There must be robust arrangements in place to ensure the safe selection, tracking and management of all boarded patients. In addition, for boarded patients, there needs to be clarity which consultant and clinical care team are responsible, how often patients are reviewed and what the escalation policy is.	31st December 2020	All trainees
6.4	Tasks that do not support educational and professional development and that compromise access to formal learning opportunities must be reduced (for example, ECGs and recordings at pre-assessment).	31st December 2020	FY1 trainees
6.5	Trainees must have access to the appropriate procedures, including endoscopy, to enable them to meet the requirements of the curriculum.	31st December 2020	ST trainees
6.6	Regional teaching should be reviewed to improve the quality of the VC and interactivity as well as reduce the cancellation of sessions. There must be a system to ensure teaching is bleep-free.	31st December 2020	FY1 trainees
6.7	All references to “SHOs” must cease.	31st December 2020	All trainees
6.8	There must be a process that ensures trainees understand, and are able to articulate, arrangements regarding educational governance at both site and board level.	31st December 2020	All trainees