Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	25th & 26th March 2021	**Level(s)**	FY/GPST/IMT/ST
Type of visit	Enhanced Monitoring re-visit	**Hospital**	Queen Elizabeth University Hospital
Specialty(s)	General Internal Medicine	**Board**	NHS Greater Glasgow and Clyde

Visit panel	
Professor Alastair McLellan	Visit Chair - Postgraduate Dean
Robin Benstead	General Medical Council - Principal Education QA Programme Manager (Devolved nations)
Marie Cerinus	Lay Representative
Dr Fiona Ewing	Associate Postgraduate Dean – Quality
Dr Marie Mathers	Associate Postgraduate Dean – Quality and Foundation Representative
Dr Nick Dunn	Associate Postgraduate Dean – Quality and GP Representative
Dr Duduzile Musa	College Representative
Alex McCulloch	Quality Improvement Manager
In attendance	
Claire Rolfe	Quality Improvement Administrator

Specialty Group Information	
Specialty Group	Medicine
Lead Dean/Director	Professor Alastair McLellan
Quality Lead(s)	Dr Alan McKenzie Dr Reem Al-Soufi Dr Greg Jones
Quality Improvement Manager(s)	Alex McCulloch and Hazel Stewart
Unit/Site Information	

Non-medical staff in attendance	6									
Trainers in attendance	33									
Trainees in attendance	FY1 x 15		FY2 x 6		GPST x 7		IMT x 14		ST x 11	
Feedback session: Managers in attendance	Chief Executive		DME	✓	ADME	✓	Medical Director	✓	Other	Clinical Service Managers, Business Managers, Quality Improvement Managers

Date report approved by Lead Visitor	19th April 2021 

1. Context

General Internal Medicine (GIM) at the Queen Elizabeth University Hospital (QEUH) has been under the General Medical Council (GMC) Enhanced Monitoring process since 2016. The site has been visited on several occasions over the past 6 years, as listed below:

- 27 October 2015 (new site visit)
- 13 May 2016 (triggered revisit)
- 02 December 2016 (enhanced monitoring visit)
- 21 February 2018 (enhanced monitoring revisit)
- 22 February 2019 (enhanced monitoring revisit)
- 04 February 2020 (enhanced monitoring revisit)

At the last visit to GIM on the 04 February 2020, the visit panel concluded there had been some improvements to the training experience since the previous visit in 2019. The Deanery acknowledges that since then, the QEUH has been under very significant service pressures and strain, particularly in the medicine specialties, in the context of the (ongoing) COVID-19 pandemic. As this visit has taken place during the 2nd wave of Covid 19 pandemic, the Deanery took the decision to produce an abbreviated report focussing on progress against the previous 2020 visit requirements.

The deanery would like to thank Dr Jacqueline Adams(Clinical Director, Glasgow South services) and Dr Colin Perry (Assistant Director of Medical Education) for the helpful and informative presentation which gave a detailed overview of work being done to address the 2020 visit requirements and was delivered to the visit panel during the management session.

2. Summary of the findings

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

The visit panel found that despite the significant challenges QEUH has faced as a result of the COVID-19 pandemic, a huge amount of work had gone into sustaining training during unprecedented service pressures. Despite the challenges there were positive aspects of the trainees' experience which are captured below.

2.1. The positive aspects of the visit were:

- Supportive, approachable, accessible and 'kind' consultants
- Leadership of Colin Perry with chief residents plus the support of trainers to address the trainees' concerns around the quality of their training
- Excellent learning environments within QEUH-medicine including – the 'ground floor' including in the Immediate Assessment Unit (IAU)/Special Assessment and Triage Area (SATA), respiratory medicine, cardiology, infectious diseases & rheumatology
- Improved organisational emotional intelligence that values doctors in training (reflecting the experience of all cohorts other than FY1s)

Other positives noted:

- The reconfiguration of medical high dependency unit (HDU) because of COVID – to ensure job-planned consultant presence all weekdays and with additional consultant input over weekends – providing substantial improvements to supervision and learning within this environment
- The engagement of the 3 chief residents in a range of activities, but of particular relevance during COVID, their provision for doctors in training of regular updates on COVID

Following agreement of the final visit report, correspondence will be sent to NHS GGC by the GMC to acknowledge the progress the site has made in resolving the previous patient safety concerns related to IAU.

2.2. Progress against requirements from February 2020 visit:

2.2.1. Requirements that have either been 'addressed' or for which 'progress towards resolution' was noted:

Req	Theme	Conclusion	Commentary
6.1	Measures must be implemented to build on the progress in addressing the ongoing patient safety concerns in relation to the IAU, described in this report.	**Addressed**	• The concerns around patient safety (and trainee safety) in IAU have been addressed. • All cohorts of trainees reflected confidence in the safety of patient safety in the IAU & SATA; those who had previous experience of training in the IAU commended the transformation that has been brought about in the safety of care. • This is partly a consequence of the introduction because of COVID-19 of 2 pathways into medicine for GP referrals – the SATA & the IAU. This has been supported by additional consultant staffing (both in headcount and extended hours of presence) • These measures have enabled improved flow of patients, better triage and identification of unwell patients, safer care. • These measures have also enabled excellent training opportunities – where doctors in training are well supported and well supervised by consultant trainers and receive excellent feedback on their management of acutely unwell patients.

6.2	The burden of tasks for all cohorts of doctors in training that do not support educational or professional development and that compromise access to formal learning opportunities must be significantly reduced.	**Progress noted**	• The panel heard of the benefits that provision of healthcare support workers (HCSWs) had brought to the FY1s' weekend roles. • The panel heard of plans to appoint a further HCSW per floor to cover the 'working week'. • Foundation year 1 doctors (FY1s) estimated that up to 80-90% of their time was consumed by their burden of non-educational tasks. • Non-educational tasks prevented FY1s accessing opportunities to develop as doctors including formal learning opportunities. While the latter are now available 'virtually' in hours the FY1s' workload limits access; additional COVID-related constraints include the availability of suitable rooms and IT. Access to recorded material out with working hours is theoretically possible but the expectation is that access should be within their working hours. Some FY1s, most notably in renal, cardiology and haematology, however, reported greater access to formal learning opportunities. • While more variable, other cohorts of trainees also reported significant amounts of time were spent on non-educational activities, e.g. General Practice Trainees (GPSTs) reported that up to 70-80% of their time, and internal medicine trainees (IMTs) reported that up to 50% of their time (perhaps even more so in the neurology post), was spent on such activities and was limiting access to training opportunities.

6.4	The scope of the ward cover and the associated workload for Foundation trainees at weekends and overnight (in the wards in 'the stack') must be reduced as currently they are not manageable and safe.	**Progress noted**	• The panel heard of the benefits that provision of HCSWs had brought to the foundation year 1s (FY1)' weekend roles. • The FY1s' weekend role remains very daunting, however, because this requires coverage of ~120 patients whose needs are greater than can be comfortably achieved by one FY1; the FY1s report that their workload is beyond their ability to manage well. • This poses a potential risk to safety of care, but we did not hear of actual harm; we did, however, hear of delays in the FY1s attending to patients and to tasks needing to be done because of their heavy workload. • Supporting the FY1s' weekend role, there is a senior available (usually busy elsewhere) to whom they can escalate their clinical concerns. This person is not available to help with the burden of tasks. • This FY1 workload challenge described applies to their role in covering floors in the stack at weekends. There is no longer an issue out of hours during weekday nights. • QI initiatives such as 'Friday tidy' and 'Think 5 x 5' have been beneficial.

6.5	There must be robust arrangements for both ongoing senior review of patients' care and ongoing supervision of the contributions of doctors in training to the management of their patients during times of Consultant absences (including leave and when on other duties) in the ward shared by Endocrinology/Diabetes and General Internal Medicine**.**	**Addressed**	• Improvements in consultant staffing and changes to the consultants' rota have addressed this concern.
6.9	Handover of care of patients transferred from the ED to Pods must be provided to support safe continuity of care and to ensure unwell patients are identified and prioritised.	**Progress noted**	• While some progress was reported, there was also noted to be concerning inconsistency in the practice of handing over of patients who were recognised as being unwell from ED to the pods.

2.2.2. Requirements still to be worked on:

Req	Theme		Commentary
6.3	Trainees must know how to engage in use of the Datix system and receive feedback on Datix cases.	**Little progress**	• There is variable awareness among foundation trainees of processes for reporting of incidents. • There is variable provision of feedback to doctors in training when they do report incidents. • There is little engagement of foundation trainees in processes supporting learning from incidents and adverse outcomes such as morbidity and mortality (M&M) meetings. • There appears little evidence of a culture of engaging foundation trainees in training in reporting and learning from incidents.
6.6	The training opportunities provided to GPSTs must meet the needs of the curriculum.	**Little progress**	• We heard of a commitment to tailor training posts for GPSTs to be more reflective of their training needs, but actual progress to achieve this outcome has been limited. • Access to outpatient clinic opportunities has been minimal. COVID has exacerbated the difficulties in accessing clinics. • GPSTs reported having a heavy burden of non-educational activities, that hindered access to learning opportunities. • The posts do offer exposure to the management of acutely unwell patients, with feedback on their input to inform their learning. • Some specialties e.g. cardiology were thought to offer more useful training opportunities than others.

6.7	The discontinuity of ward placements for GPST and 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. The duration of ward attachments for Foundation trainees must be increased to at least 4-weeks	**Little progress**	• GPSTs reported their perception that they are rota fillers, as reflected in the discontinuity of their ward attachments; they reported that it was common for them to be moved to other areas to plug gaps. • FY trainees continue to report their desire to have longer ward attachments.
6.8	Work must be undertaken to ensure that trainees are supported to attend clinics and other scheduled local learning opportunities without compromise because of service needs	**Little progress**	• We heard of local monitoring that had confirmed the continuing unmet needs of IMTs with regard to clinic access. • We heard that GPSTs and Foundation year 2 doctors, (FY2s) had next to no clinic opportunities. • COVID-19 has impacted on clinic opportunities in all training environments; the Joint Royal Colleges of Physicians Training Board (JRCPTB) has temporarily attenuated the curricular requirements for clinic experience for IMTs because of COVID. • We heard of doctors in training sitting-in on outpatient clinics rather than conducting consultations with patients; this is of little benefit to their training.

			• We heard of examples of good practice in some departments in actively pre-planning trainees engagement in outpatient clinics (e.g. in respiratory medicine – a consultant (Dr Martin Johnson) proactively plans trainees' participation in clinics) • We heard of plans to incorporate a new block of clinics for trainees rotating to Gartnavel General Hospital (GGH) from QEUH, and of plans to introduce a new app to support trainees to access outpatient opportunities.
6.10	Alternatives to doctors in training must be explored and implemented to address the chronic gaps in the rota that are impacting on training	**Little progress**	• We heard of on-going concerns regarding rota-gap management. • We heard of staffing changes among the rota team. • We noted staffing challenges have been greatly exacerbated by COVID-related absences of staff of all grades including doctors in training.

3. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
3.1	The burden of tasks for all cohorts of doctors in training that do not support educational or professional development and that compromise access to formal learning opportunities must be significantly reduced.	7th January 2022	FY1/FY2/ GPST/IMT
3.2	The scope of the ward cover and the associated workload for Foundation Trainees at weekends (in the wards in 'the stack') must be reduced as currently they are not manageable and safe.	7th January 2022	FY1
3.3	Handover of care of patients transferred from the ED to Pods must be provided to support safe continuity of care and to ensure unwell patients are identified and prioritised.	7th January 2022	FY1/FY2/ GPST/IMT/ ST
3.4	The site must foster a culture of learning that includes doctors in training both in reporting critical incidents using channels such as the Datix reporting system, but also in the consequent learning that comes from an effective system. Trainees must receive feedback on the incidents they raise and there must be a forum for learning from adverse events.	7th January 2022	FY1/FY2/ GPST/IMT/ ST
3.5	The training opportunities provided to GPSTs must meet the needs of the curriculum.	7th January 2022	GPST
3.6	The discontinuity of ward placements for GPST and 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. The duration of ward attachments for Foundation trainees must be increased to at least 4-weeks.	7th January 2022	FY1/FY2/ GPST
3.7	Work must be undertaken to ensure that trainees are supported to attend clinics and other scheduled local learning opportunities without compromise because of service needs.	7th January 2022	FY1/FY2/ GPST/IMT/ ST

3.8	Alternatives to doctors in training must be explored and implemented to address the chronic gaps in the rota that are impacting on training.	7th January 2022	FY1/FY2/ GPST/IMT/ ST