Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	Thursday 18 November 2021	**Level(s)**	Foundation/Specialty
Type of visit	Enhanced Monitoring Revisit (virtual)	**Hospital**	Dr Gray's Hospital
Specialty(s)	General Surgery & Anaesthetics	**Board**	NHS Grampian

Visit panel	
Professor Adam Hill	Lead Dean Director (Chair)
Miss Kate Bowden	GMC Education QA Programme Manager (Scotland & North East)
Dr Reem Al-Soufi	Associate Postgraduate Dean (Medicine/Surgery)
Dr Mo Al-Haddad	Associate Postgraduate Dean (EM/Anaesthetics)
Dr Nick Dunn	Associate Postgraduate Dean (General Practice)
Dr Andrew Docherty	Foundation Programme Director
Mr Neil Logue	Lay Representative
Professor Lorna McKee	Lay Representative (shadowing)
Ms Vicky Hayter	Quality Improvement Manager
In attendance	
Mrs Ashley Bairstow-Gay	Quality Improvement Administrator

Specialty Group Information	
Specialty Group	Surgery
Lead Dean/Director	Professor Adam Hill
Quality Lead(s)	Dr Kerry Haddow, Mr Phil Walmsley, Dr Reem Al-Soufi
Quality Improvement Manager(s)	Ms Vicky Hayter
Unit/Site Information	
Trainers in attendance	2
Trainees in attendance	Foundation Anaesthetics/Surgery 3 Core/Higher all Surgery 3
Feedback session: Managers in attendance	16
Date report approved by Lead Visitor	13th December 2021

1. Principal issues arising from pre-visit review

Following the previous visit held on 28th September 2020 Dr Gray's was placed on enhanced monitoring by the GMC therefore a virtual revisit was scheduled.

Previous Visit

The previous visit highlighted recommendations listed below:

- There must be sufficient substantive consultant trainers to support the supervision and training of the doctors in training in General Medicine and General Surgery
- Hospital and departmental induction must be provided which ensures trainees are aware of all of their roles and responsibilities and feel able to provide safe patient care.
- A process must be put in place to ensure that any trainee who misses their induction session is identified and provided with an induction.
- The morning and/or evening handover must be scheduled within the rostered hours of work of the trainees
- All consultants, who are trainers, must have time within their job plans for their roles to meet GMC Recognition of Trainers requirements
- All staff must behave with respect towards each other and conduct themselves in a manner befitting Good Medical Practice guidelines.
- Doctors in training must not be expected to work beyond their competence.
- The level of competence of trainees must be evident to those that they come in contact with and all references to 'SHOs' and to 'SHO rotas' must cease.
- The Board must provide sufficient IT resources to enable doctors in training to fulfil their duties at work efficiently and to support their learning needs.
- Trainees must be able to access learning opportunities to meet curricular objectives including, for example, outpatient clinics.
- Lack of continuity on wards creates a barrier to training and compromises quality of care of patients.
- Initial meetings and development of learning agreements must occur within a month of starting in post for Medicine trainees.
- The department must develop and sustain a local teaching programme relevant to curriculum requirements of higher Surgical trainees including a system for protecting time for attendance.

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.

The panel met with the following groups
Foundation Trainees
Core/Specialty Trainees

The Deanery would like to thank Professor Duff Bruce (Clinical Director for Surgery) and Mr Jamie Hogg (Hospital Clinical Director) for the helpful and informative presentation which gave a detailed overview of work being done to address the 2020 visit requirements across the Anaesthetic and General Surgery departments. The presentation highlighted the recent action plan, ongoing challenges, and future improvements.

2.1 Induction (R1.13)

Trainers: Trainers advised there is no formal induction for surgery it is currently under development. The induction for HDU OOH is not adequate and it is not defined who is responsible for undertaking this.

Foundation Trainees: Trainees advised they did not receive hospital or departmental induction but were given an induction booklet for orthopaedics. Trainees would have preferred a face-to-face induction with a tour of the department and hospital.

Core/Higher Trainees: Trainees did not receive hospital or departmental induction this include one trainee who was on nights following changeover date. Trainees were given a handbook for the orthopaedic department but were unaware of guidelines for surgical departments or the high dependency unit.

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

Trainers: Trainers reported no formal surgical teaching programme but are currently liaising with middle grade staff to facilitate them to teach. Anaesthetics have regular teaching sessions aligned with the curriculum, but trainees do not handover their bleeps when they are on long days in the high dependency unit. Foundation trainees have teaching via teams with ARI.

Foundation Trainees: Trainees reported attending weekly deanery teaching which is not bleep free. Departmental teaching has started recently via teams with ARI which is helpful and informative.

Core/Higher Trainees: Trainees advised there is no local teaching programme. Regional teaching is available but is not bleep free.

2.3 Study Leave (R3.12)

Trainers: Trainers advised that study leave can sometimes be challenging due to staffing levels, but no requests have been rejected.

Core/Higher Trainees: Trainees reported no issues taking study leave, but they had to arrange the rota swaps themselves.

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

Trainers: Trainers reported direct supervision in clinical care. If trainees have a special interest, they can request to change supervisor.

Foundation Trainees: All trainees have been allocated an educational supervisor. One trainee advised they had only recently met their supervisor despite being in post since August, this was due to the supervisor having several commitments.

Core/Higher Trainees: Not all trainees were allocated an educational supervisor and did not have a meeting to discuss their learning plan. Clinical Supervisors are not formally assigned. Trainees reported Consultants were approachable and helpful.

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 advised that staff could differentiate between grades of staff using the new colour coded lanyards. Trainees always know who to contact during the day and out of hours. Trainees have access to the doctor's room which lists all the consultants on-call and their mobile numbers. Trainers give an immediate response when contacted with verbal help initially and inform trainees who to contact in the interim. Trainers can drive in from home which usually takes between 3-10 minutes. Trainees are always encouraged to call consultants.

Foundation Trainees: Trainees reported that there is a lack of supervision out of hours and trainees regularly work beyond their competence. Foundation trainees advised they can be the only cover for multiple wards at night managing complex patients which can be challenging if the middle grade is in A&E. If trainees require assistance consultants are accessible via phone their response varies on each individual case, less urgent cases will be seen in a day and emergencies are seen within 30 minutes. The senior rota includes a Foundation trainee making them the most senior on-site trainee on that rota.

Core/Higher Trainees: Trainees advised that ward rounds are all Consultant led and theatre lists were few and far between. Trainees stated they had become de-skilled due to lack of theatre and clinics and felt their training had suffered as consequence. Consultants are all accessible and approachable.

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

Trainers: Trainers advised the department has the right trainees at the right levels and if the service is running well the balance of training is good. Trainees are exposed to emergencies and have a level of independence. Lists are based on high flow low complexity cases.

Foundation Trainees: Trainees agreed that core competencies are achievable as educational needs are met on the ward on a day-to-day basis. Trainees find it difficult to leave the ward for any additional learning due to workload.

Core/Higher Trainees: Trainees reported working between 80-90% as service provision and the require core competencies will not be met at the end of the year due to lack of theatre and clinic sessions. Leadership and clinical skills are not being met and trainees advised this post was detrimental to their career. Formal outpatient clinics are remote and over the phone which impacts the opportunity for trainees at attend. Trainees advised they undertake two weeks of nightshift every six weeks.

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

Core/Higher Trainees: Trainees advised there wasn't much scope to complete work placed based assessments as they had not been to a single clinic since starting in post and there were little opportunities to undertake anything other than a simple assessment.

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

N/A

2.9 Adequate Experience (other) (R1.22)

Trainers: Trainers reported that trainees are involved in active audit and quality improvement projects.

Foundation trainees: Trainees advised they have no additional time to undertake an audit due to the workload.

Core/Higher Trainees: Two trainees reported undertaking a quality improvement project with a medical student.

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: Trainers advised that every encounter with trainees can be used as feedback. Trainers provide active verbal feedback during the ward rounds and give a brief and debrief.

Foundation Trainees: Although there is no formal procedure to receive feedback, trainees reported they receive verbal feedback whilst in the high dependency unit, via ward rounds, and through mini CEXs.

Core/Higher Trainees: Trainees advised that consultants are very good at providing informal ad hoc feedback.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: Trainers reported that trainees can feedback informally at meetings with their Educational/Clinical supervisor which is a confidential space. Trainees can also contact management directly and escalate any concerns.

Foundation Trainees: Trainees advised there was no formal way to feedback to trainers and were unaware of any chief resident roles.

Core/Higher Trainees: Trainees advised that Consultants are aware of trainees concerns in relation to training. Due to lack of space at Dr Gray's patients are stabilised and transferred to ARI.

2.12 Culture & undermining (R3.3)

Trainers: Trainers were aware of an undermining concern from a junior trainee which had been escalated and flagged at a higher level. The trainee was well supported by all. Trainers try to promote a team culture and make trainees feel part of the team. Trainers advised the environment may not be completely free of any culture or undermining issues as there can be stressful situations, but they are working towards improving these by discussing issues and correcting incorrect behaviour.

Foundation Trainees: Trainees within the Surgery department reported an undermining incident which was escalated and dealt with accordingly. Although this was an upsetting experience the consultants were very supportive. Trainees reported consultants were incredibly supportive within Anaesthetics and the high dependency unit (HDU) and always available to contact if required.

Core/Higher Trainees: Trainees reported a supportive environment with friendly and approachable consultants. As the Training Programme Director is not on-site trainees are confident any undermining or bullying issues would be tackled and solved by the Clinical Director.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Trainers advised that trainees have a huge workload and can struggle especially with no breaks. Trainers regularly offer informal wellbeing chats and support on how to survive without immediate supervision. Trainers reported that overnight juniors can be in critical care on their own or look after the entire hospital and trainees regularly feel out of their depth.

Foundation Trainees: Trainees reported an overwhelming workload especially out of hours and at weekends. One trainee described crying every weekend shift due to the workload. Patients and ward staff can become irritated waiting to be discharged due to long wait times. Trainees can be left with little support trying to look after a number of patients which can be challenging if they deteriorate. Work can pile up very quickly which results in no breaks. Foundation doctors take referrals for HDU and are asked to assess critically ill patients in the ward. Prior to Covid there was advanced nurse practitioner (ANP) cover at night, but this has changed and there are currently no ANPs out of hours. Annual leave is fixed, and it can be difficult to swap shifts.

Core/Higher Trainees: Trainees stated the rota affects their education and training and physical and mental health. Trainees have undertaken 38 nightshifts in 6 months and all trainees have either requested a transfer, resigned, or thought of a different career following this placement. Trainees do not enjoy work and feel they do not treat patients. There are no beds, not enough nursing staff and patients get sent home returning as an emergency within a few weeks.

2.14 Handover (R1.14)

Trainers: Trainers advised that handover was dependent on individuals and the workload. The surgery handover is consultant led in the morning and peer to peer in the evening. On occasion it can be used as a learning opportunity. The high dependency unit handover is face to face with the foundation trainees and is consultant led in the morning.

Foundation Trainees: Trainees reported handover can vary depending on who leads, most of the time consultants discuss patients. Trainees are required to attend both General Surgery and Trauma & Orthopaedic Surgery handover which isn't possible as they take place at the same time. Handovers can be used as a learning opportunity during the day. A uniformed structure to handover would help as things can be missed. Consultants swap every few days and it is not always clear who would like what during handover.

Core/Higher Trainees: Trainees reported handover varies depending on which consultant is leading. Handover at night is ad hoc and there is no safe continuity of care with the Trauma and Orthopaedic department as there is no system to handover a sick patient. Trainees tried to set up a handover sheet but were met with resistance from nursing staff.

2.15 Educational Resources (R1.19)

Core/Higher Trainees: Trainees reported a lack of computers and no endoscopy simulation training.

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

Foundation Trainees: Trainees reported if they required any support regarding the job or health, they would contact their Clinical/Educational Supervisor or line manager.

Core/Higher Trainees: Trainees advised they would feel supported if they asked for help.

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

Foundation Trainees: Trainees were aware that the junior trainee forum had met a couple of times but were unaware of any improvements or changes that had been made.

Core/Higher Trainees: Trainees advised they had fed back their training concerns with their Educational Supervisor and Training Programme Director who stated they were in discussion with the Deanery regarding this. Trainees advised that consultants are keen to teach however there are no elective lists. Trainees believe they should not be sent to Dr Gray's until appropriate training is achievable.

2.18 Raising concerns (R1.1, 2.7)

Trainers: All trainers reported trainees are encouraged and supported to raise concerns. Trainees are made to feel part of the team and trainers use the crew resource management culture; if you aren't happy with something flag it up. Trainees are encouraged to discuss any concerns about training with their educational/clinical supervisor.

Foundation Trainees: Trainees would raise any patient safety concerns with nursing staff or their allocated supervisor.

Core/Higher Trainees: Trainees would raise any concerns with the training programme director or educational supervisor. Trainees advised they did not think sending trainees to train at Dr Gray's was appropriate and two trainees had asked to transfer to ARI. Trainees reported that trainers are keen to teach but there are no appropriate training opportunities.

2.19 Patient safety (R1.2)

Trainers: Trainers reported an understaffed, unsustainable environment. Patients are at risk due to lack of staff. Trainees need to find a way to survive due to the high volume of work. Any incidents raised via Datix are used as a constructive learning opportunity.

Foundation Trainees: Trainees reported no concerns from a medical point of view however there were patient safety concerns in relation to the volume of jobs and lack of staffing. Trainees advised they wanted the best care for patients, but it is not always possible due to such a high workload.

Core/Higher Trainees: Trainees reported patient safety concerns if a friend or relative was admitted and would prefer they were transferred to Inverness or Aberdeen. This is based on staff shortages and 2 nursing staff looking after 30-40 patients. Trainees reported a very stretched system with patients being seen in the assessment centre and sent home then returning as emergencies within 2-3 weeks. Nursing staff are rarely on the ward round which is a patient safety concern.

2.20 Adverse incidents and Duty of Candour (R1.3)

Trainers: Trainers advised there are regular Morbidity & Mortality meetings which are used as learning opportunities. Consultants present Datix's and debrief all staff.

Foundation trainees: Trainees advised that adverse incidents are reported via Datix. The incident is logged but there is not always feedback. Trainees are not informed of any steps being taken following the Datix or any team learning. Trainees reported more of a blame culture than supportive learning following an incident.

Core/Higher Trainees: Trainees advised they would be supported following an adverse incident. Ad hoc informal feedback is given following any Datix's that have been raised. Trainees advised they are not blamed for mistakes and discussions take place to make improvements. If something went wrong a senior colleague would get involved.

Average overall satisfaction scores:

Foundation trainees average score 5/10
Core/Higher trainees: average score 4/10

Additional questions:

Foundation trainees: Trainees advised due to workload it can be difficult to complete all jobs or get to patients as quickly as they would like.

Core/Higher Trainees: Trainees reported nightshift cover by either a ST, LAT or FY2 and stated that 2 FY2s seeing acute unwell medical patients and being the senior cover for the hospital is not acceptable. Trainees advised the issues raised with training in General Surgery at Dr Gray's have been the same since the visit in 2016 and although staffing issues may seem resolved with newly appointed Consultants one is no longer coming, and one has resigned. They questioned the purpose of Deanery visits if issues highlighted are not acted upon for this length of time, and asked why trainees are still being sent to Dr Gray's.

3. Summary

Is a revisit required?	Yes	No		Highly Likely	Highly unlikely

There are significant concerns regarding patient safety and the duty of care for trainees within the Surgical/Anaesthetic department at Dr Gray's hospital. Trainees reported working beyond competence due to staff shortages which is impacting on trainees physical and mental health. In view of the challenges facing Dr Gray's as a training environment the panel will seek further advice from the GMC to escalate the current Enhanced Monitoring to Enhanced Monitoring with conditions due to the seriousness of concerns and to ensure training can be met by the standards set by the GMC.

We have highlighted below both the positive aspects from the visit, and some areas for improvement and requirements.

What is working well:

- Supportive Consultant staff
- Each grade of staff can be if identified by the coloured lanyards
- Actively trying to address staffing issues

What is working less well:

- Lack of unit induction for all grades of trainees
- Lack of Educational Supervision, more than half of trainees reported not having met their Educational Supervisor
- No local teaching programme on site
- Excessive service provision particularly for Core and Higher trainees
- Trainees reported working beyond competence with an overwhelming and challenging workload particularly out of hours and weekends
- Handover inconsistent and unstructured causing patient safety concerns
- Lack of appropriate training opportunities, including clinics and elective surgery, resulting in major concerns among higher trainees that they will not achieve the required curricular competencies
- Lack of nursing staff

- Concerns over an unsafe training environment which is detrimental to trainees physical and mental well being

4. Areas of Good Practice

Ref	**Item**
4.1	N/A

5. Areas for Improvement

Ref	Item	Action
5.1	N/A	

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
7.1	Hospital and departmental induction must be provided which ensures trainees are aware of all of their roles and responsibilities and feel able to provide safe patient care.	3 monthly updates Jan 2022, April 2022, July 2022	All
7.2	A process must be put in place to ensure that any trainee who misses their induction session is identified and provided with an induction.	3 monthly updates Jan 2022, April 2022, July 2022	All
7.3	Educational Supervision structures must be formalised, and regular meetings held with trainees.	3 monthly updates Jan 2022, April 2022, July 2022	All
7.4	Tasks that do not support educational and professional development and that compromise access to formal learning opportunities for all cohorts of doctors should be reduced.	3 monthly updates Jan 2022, April 2022, July 2022	All
7.5	Doctors in training must not be expected to work beyond their competence.	Immediately	FY
7.6	Handover of care of patients must be introduced to support safe continuity of care and to ensure unwell patients are identified and prioritised.	3 monthly updates Jan 2022, April 2022, July 2022	All
7.7	Measures must be implemented to address the patient safety concerns described in this report.	3 monthly updates Jan 2022, April 2022, July 2022	
7.8	Trainees must be able to access learning opportunities to meet curricular objectives including, for example, outpatient clinics/theatre.	3 monthly updates Jan 2022, April 2022, July 2022	All
7.9	The department must develop and sustain a local teaching programme relevant to curriculum	3 monthly updates Jan 2022, April 2022, July 2022	All

	requirements of core/higher trainees including a system for protecting time for attendance.		
7.10	The scope of the ward cover and the associated workload at weekends and overnight must be reduced as currently they are not manageable and safe.	3 monthly updates Jan 2022, April 2022, July 2022	All
7.11	Medical staffing must be reviewed to ensure this is appropriate to safely manage the workload, with consideration of employing more non-training medical staff.	3 monthly updates Jan 2022, April 2022, July 2022	All
7.12	The Board must provide sufficient IT resources to enable doctors in training to fulfil their duties at work efficiently and to support their learning needs.	3 monthly updates Jan 2022, April 2022, July 2022	All