# Scotland Deanery
# Quality Management Visit Report

NHS Education for Scotland

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| **Date of visit** | 25th May 2021 | **Level(s)** | F1, F2, IMT, GP and Specialty |
| **Type of visit** | Revisit | **Hospital** | Glasgow Royal Infirmary |
| **Specialty(s)** | General Internal Medicine | **Board** | NHS Greater Glasgow & Clyde |

| **Visit panel** | |
|---|---|
| Dr Marie Mathers | Visit Chair – Associate Postgraduate Dean (Quality) |
| Dr Kerri Baker | Training Programme Director |
| Dr Fiona Cameron | Associate Postgraduate Dean (Foundation) |
| Dr Oisin Keenan | Trainee Associate |
| Mr Hugh Paton | Lay Representative |
| Mr Brian Winter | Lay Representative (Shadowing) |
| Mrs Jennifer Duncan | Quality Improvement Manager |
| **In attendance** | |
| Mrs Gaynor Macfarlane | Quality Improvement Administrator |

| **Specialty Group Information** | |
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| Specialty Group | Foundation |
| Lead Dean/Director | Professor Clare McKenzie |
| Quality Lead(s) | Dr Geraldine Brennan & Dr Marie Mathers |
| Quality Improvement Manager(s) | Mrs Jennifer Duncan |
| **Unit/Site Information** | |
| Trainers in attendance | 14 |
| Trainees in attendance | F1 - 12. F2 – 6. IMT – 2. GP – 3. ST - 17. |

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| Feedback session: Managers in attendance | Chief Executive | 0 | DME | 0 | ADME | 1 | Medical Director | 1 | Other | 5 |

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| Date report approved by Lead Visitor | 03/08/2021 Dr Marie Mathers<br>03/08/2021 Professor Clare McKenzie |

## 1. Principal issues arising from pre-visit review:

Following a Deanery visit in May 2019 a number of concerns were raised regarding Foundation training in General Medicine at Glasgow Royal Infirmary. Along with a number of requirements made in the final report the visit panel also stated their intention to return to the unit within 12 months. Due to Covid-19 the visit scheduled for 2020 was cancelled however it was agreed at the Foundation Quality Review Panel in August 2020 that there were still significant concerns in Foundation data and that a revisit was required.

Below is data from the GMC National Training Survey 2019 (NTS) and the Scottish Training Survey 2020 (STS).

**NTS Data 2019**

F1 – Red Flags – Clinical Supervision Out of Hours, Educational Governance, Induction.
F2 – Red Flags – Handover, Rota Design.

Core – All White Flags.

GP – Pink Flag – Educational Supervision.
GP – Red Flags – Handover, Rota Design.

**STS Data**

Foundation - White Flags – Educational Environment, Teaching.
Foundation - Pink Flags – Team Culture.
Foundation - Red Flag – Clinical Supervision.
Foundation – Triple Red Flags – Handover, Induction, Workload.

Core – All White Flags.
GP – White Flags – Clinical Supervision, Educational Environment, Handover, Induction, Teaching, Team Culture.
GP – Red Flag – Workload.
ST – All White Flags.

At the pre-visit teleconference the visit panel agreed that the focus of the visit should be around the areas highlighted in the previous visit report recommendations.

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.

**Note – F2 trainees were interviewed on 18th June 2021 by a reduced panel using the same question set as 25th May 2021. Panel Members – Dr Marie Mathers, Dr Fiona Cameron, Mrs Jennifer Duncan, Mr Hugh Paton and Mrs Gaynor Macfarlane.

**Department Presentation:**

The visit commenced with Dr David McCarey delivering an informative presentation to the panel which provided an update regarding the progress against the previous visit requirements.

**2.1 Induction (R1.13)**:

**Trainers:** Trainers reported that medical specialties have taken a lead on providing individual departmental inductions. Face to face induction is supported by new written and online materials. These sessions are however not repeated should a trainee be unable to attend. Trainers give trainees the opportunity to come forward and ask for information on induction. They also commented on the challenges of delivering inductions every 4 month.

**F1 Trainees:** All trainees confirmed receiving adequate induction to the hospital and out of hours. Departmental inductions were varied between departments with some being brief however were considered enough to allow them to undertake jobs safely. Induction was provided for those who missed it due to nights.

**F2 Trainees**: Trainees reported being invited to attend hospital induction however if unable to attend due to nights no additional sessions were arranged. No formal general medicine induction was received, and medical speciality departmental inductions varied with most reporting they had to find

things out from previous trainees. Those who were new to the hospital had to rely heavily on guidance from F1 trainees who knew the wards well. Trainees commented that they were provided with a detailed handbook which they found useful however it did not provide details on on-call, medical receiving, referral guidance for each of the medical specialties or trainee roles and responsibilities within cardiology which would be welcomed. For those new to the hospital carrying the arrest bleep guidance on the logistics or getting to other areas of the hospital would also have been useful. Staff are however very friendly and always happy and willing to help.

**GP/IMT Trainees:** Trainees confirmed receiving hospital induction and a brief department induction. They did not consider departmental induction enough to equip them to work in the department especially if new to the region and stated sessions are not repeated should anyone start out of sync. Information on shifts, contacts, on-call, duties, hospital systems, escalation policies and a tour of the hospital would be welcomed. There was no induction to downstream on-call overnight or weekends and there is no cross cover which results in trainees having to pick things up as they go.

**ST Trainees:** Trainees reported having no hospital induction. Departmental inductions were reasonable however did not cover out of hours (OOH) or on-call. An induction handbook was provided however this requires updating as handover times and locations were wrong.

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

**Trainers:** Trainers reported that F1 trainees are provided with 1 hour of departmental teaching per week via Microsoft Teams. They also have access to pan regional F1 teaching again delivered via Microsoft Teams with sessions saved to a repository to allow access at any time. F2 trainees follow a half day teaching programme which is delivered across the region. Trainers commented on a lack of available IT equipment which results in multiple trainees having to share one device. The hospital is aware of this. There is lack of suitable space to follow social distancing guidelines which is also a concern. Trainers also commented that trainees are not being released from wards as much as they should be to attend virtual sessions and often, they stay on wards and use their mobile phones.

**F1 Trainees:** Trainees reported being invited to attend 1 hour of health board organised teaching weekly via Microsoft Teams. The department of medical education (DME) also provide 3 hours of teaching. Trainees confirm being able to attend less than 50% of regional core teaching. They stated

that IT in the department is inadequate and often they must use their own devices to log in. Space is also an issue and trainees are interrupted frequently to attend to ward duties. Teaching is not considered protected and they find it extremely difficult to attend due to workload. This is a particular concern in acute receiving where trainees are very rarely able to attend teaching. This is due to teaching taking place over lunchtime which leaves very little time between ward rounds to get high priority tasks completed.

**F2 Trainees:** Trainees reported that departmental teaching is very good and works well via Microsoft teams. West of Scotland foundation teaching was cancelled due to Covid however has recently been reinstated. Workload and on-call are the main reasons given for non-attendance at teaching. Trainees confirmed being able to attend 40% of delivered teaching and that when sessions are missed, they catch-up in their own time.

**GP/IMT Trainees:** Trainees reported difficulties in being released to attend teaching sessions due to workload or on-call. Most trainees commented on attending only 10% of teaching whilst at work and accessing 90% of online recordings at home in their own time. There have also been some logistical problems with linking to GP teaching with broken links and information being sent out late.

**ST Trainees:** Trainees reported that national general internal medicine teaching was paused due to Covid but has recently been reinstated virtually. Departmental teaching is provided once a week however is different within each department for example Cardiology only runs once a month. Trainees can also attend weekly grand rounds. Trainees commented that it is easier for them to be pulled out of virtual teaching and if they cannot attend must catch up in their own time. Trainees commented on being able to attend 70% of regional teaching.

### 2.3 Study Leave (R3.12)

**Trainers:** Trainers reported that there are times that requests for study leave from junior trainees are turned down this can be due to ensuring safe numbers on the wards. Comments were received on trainers prioritising approval of annual leave before study leave. Some also request junior trainees complete study leave applications to attend teaching sessions which is often declined. They expressed concerns with regards to allowing all F2s leaving the ward to attend teaching as this then leaves wards short staffed and unsafe. Trainers reported that internal medicine training (IMT) trainees

attend national training days and have no concerns with accessing study leave. Sessions are recorded to allow trainees to catch up at another time.

**F1 Trainees:** Not applicable.

**F2 Trainees:** Trainees reported no concerns in requesting study leave. They commented on applying for study leave to catch-up on missed teaching.

**GP/IMT Trainees:** Trainees reported finding it very difficult to access study leave which is mainly due to rotas and on-call.

**ST Trainees:** Trainees reported no concerns in accessing study leave.

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

**Trainers:** Trainers reported they are well supported in their supervisory roles. They provided an example of sessions being run to ensure trainers were aware of the changing curriculums from core medical training (CMT) to internal medicine training (IMT). Trainers confirmed having time within their job plans for supervisory roles however some consider this is not enough. They commented that part of the annual appraisal process is to ensure enough time is given and if flagged as an issue relevant support is provided.

**F1/F2/IMT/GP/ST Trainees:** Not asked. No concerns raised in pre-visit questionnaire.

### 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 stated they were extremely impressed with how well out of hours (OOH) functions and the exceptional support ST trainees provide. They commented on a clear hierarchical structure with ST trainees supporting F1, F2, CMT, IMT and GP trainees. Each specialty team have on-call commitments with clear lines of contact established. During Covid departments had to be flexible and agile due to increased wards. They commended on the excellent work by the chief residents during this time in ensuring trainees knew who was providing support and what handovers were taking place

and when. Trainers also reported they were unaware of any instances where trainees have felt they have had to cope with problems that are beyond their competence.

**F1 Trainees:** Trainees reported no concerns in knowing who to contact during the day and out of hours for support. On occasion it can be difficult to find the “SHO” if they are in clinics however there are others who can be contacted. They are not asked to work beyond their level of competence and find the team and consultants supportive and easily accessible.

**F2 Trainees:** Trainees stated they are aware of who to contact for support during the day and out of hours and all staff are approachable. Trainees commented that they work on a hybrid rota with CT1/2 trainees. Part of the rota involves cardiology on-call where trainees are expected to work to CT level and as part of this rota hold the referral page for 3 weeks which can be challenging. Also, there is no cardiology registrar onsite overnight however they are contactable by phone. Although help and support are always available when needed the F2 can be the most senior trainee and it was considered that working along with a more senior trainee would be more beneficial.

**GP/IMT Trainees:** Trainees reported being aware of who to contact for support during the day and out of hours. They commented that during the day consultants are approachable and supportive. Comments were made with regards to cardiology on-call where no face to face or written induction was provided. When they are on-call in the coronary care unit trainees find it stressful and unsafe as there is no cardiology registrar onsite overnight and often support must be provided by the medical registrar. Trainees also commented on being reluctant to contact the cardiology consultants for support out of hours and would seek support from the registrar as they are the first point of contact for junior trainees.

**ST Trainees:** Trainees reported being aware of who to contact for support during the day and out of hours. They have not been expected to work beyond their competence and find consultants approachable, helpful and supportive.

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

**Trainers:** Trainers advised that all departments provide clinic timetables and encourage trainees to take advantage of all opportunities. Junior trainees are rostered for out-patient clinics and ST trainees

are allocated to specific clinics over a 3-month period. Due to Covid clinics have been significantly reduced and some moved to the virtual environment. There are also restrictions on what clinics or telephone consultations trainees can attend based on their experience in specific specialty. Trainers reported that bronchoscopy and endoscopy are of concern for trainees achieving minimum numbers. Though there are ample opportunities for pleural procedures in the hospital there is an issue with supervision as there is only one supervisor currently undertaking these which can cause bottle necks and is very heavy on consultant time.

**F1 Trainees:** Trainees reported no concerns in achieving curriculum competence. They stated that 70% of their time is spent carrying out duties that are of little benefit to their education, training and personal development. Trainees reported that phlebotomy services are capped which results in them taking a high volume of bloods. They also undertake all cannulation and catheterisation as these are not tasks undertaken by the nursing team.

**F2 Trainees:** Most trainees reported a very similar experience to that described by the F1 trainees however in addition to a high volume of non-educational tasks they also have additional responsibilities that come with being an F2.

**GP/IMT Trainees:** Trainees reported difficulties in being scheduled into out-patient clinics when covering various wards. It can also be difficult to get procedures signed off by some consultants however registrars are very supportive and happy to help. Trainees commented on spending at least 75% of their time undertaking non-educational tasks.

**ST Trainees:** Trainees reported no difficulties in achieving learning outcomes in general internal medicine and commented on good opportunities to obtain competence. Some concerns were raised with regards to the effects Covid has had in accessing pleural procedures in acute medicine, pericardiocentesis, paediatric clinics in rheumatology and endoscopy lists. Trainees also commented on spending little time in high dependency unit (HDU) other than OOH which limits opportunities for procedures and critical care experience. Trainees reported that they are scheduled for 2 weeks of outpatient clinics when not on-call or nightshift these clinics are a mixture of face to face and virtual. Trainees commented on spending under 25% of their time carrying out tasks of little or no benefit to their training and these are generally whilst on-call. Comments were also made that there is an

imbalance between general internal medicine and specialty commitments which can have a negative impact on specialty training.

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

**Trainers:** Trainers reported that as with any busy admissions hospital specialty activity can be heavily impacted by acute medicine provision. Getting the right balance to allow trainees to gain minimum assessment requirements can be difficult.

**F1 Trainees:** Trainees reported no concerns in obtaining workplace-based assessments (WPBA). It can sometimes take a while for some consultants to sign off an assessment however most “SHO’s” and seniors are very helpful.

**F2/GP/IMT Trainees:** Trainees reported no concerns in obtaining workplace-based assessments (WPBA). Consultants are generally keen to help.

**ST Trainees:** Trainees reported that is has been difficult to obtain acute care assessment tools (ACATs) and Mini-CeX due to minimal face to face opportunities. No concerns were raised with regards to achieving minimum assessment requirements in general internal medicine or gastroenterology.

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

**Trainers:** Not asked. No concerns raised in pre-visit questionnaire.

**F1/F2/GP/IMT/ST Trainees:** Not asked. No concerns raised in pre-visit questionnaire.

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

**Trainers:** Not asked. No concerns raised in pre-visit questionnaire.

**F1/F2/GP/IMT/ST Trainees:** Not asked. No concerns raised in pre-visit questionnaire.

## 2.10 Feedback to trainees (R1.15, 3.13)

**Trainers:** Trainers reported providing trainees they work with, with valuable feedback and suggested improvements in real-time. They consider feedback provided in the specialist assessment and treatment area (SATA) and downstream wards as satisfactory however they are aware that in the acute medical receiving unit this may be a problem and will continue to make improvements in this area. Consultants are approachable, supportive and have a clear open-door policy.

**F1 Trainees:** Trainees reported receiving frequent informal feedback however there is no formal feedback mechanism and no feedback is received out of hours. They find the best way to receive feedback is to return to check patient notes for comments. Most of the time F1s report that they work very independently.

**F2/GP/IMT Trainees:** Trainees commented that receiving feedback is variable and very much consultant dependant. Most do not receive regular feedback unless on the ward for a full day. They commented that when on call they tend to admit and clerk patients and rarely see them again. They need to keep note of a patient to check notes later.

**ST Trainees:** Trainees reported that receiving feedback OOH is rare however is adequate during the day. Often trainees have to be proactive in seeking out feedback as this is rarely provided by consultants.

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

**Trainers:** Trainers commented on junior doctors' forums, informal meetings and preparation meetings for deanery visits which allow trainees the opportunity to feedback any concerns regarding their training or experiences. Trainees also have very close relationships with educational supervisors and chief residents who are very supportive and provide trainees with opportunities to feedback.

**F1 Trainees:** Trainees reported providing minimal feedback to trainers on their experience in the department. Some commented on providing feedback via the national training survey (NTS) and Scottish training survey (STS). Some are aware of the junior doctors' forum and comments were made that F1s had not had a good experience with the chief residents in this training year.

**F2 Trainees:** Trainees commented that they had not been invited to provide feedback to trainers on the quality of their training other than in the GMC national training survey.

**GP/IMT Trainees:** Trainees commented that they were not aware of any mechanisms to provide feedback to trainers or the quality of their training. When asked if they were aware of the chief residents and their role the trainees commented they were unaware of the chief residents.

**ST Trainees:** Trainees reported that they can feedback to trainers on the quality of their training via the GMC and NES surveys and deanery visits. They also stated that it is harder to provide feedback with regards to just general internal medicine.

### 2.12 Culture & undermining (R3.3)

**Trainers:** Trainers reported they were unaware of any trainees having received comments that could be considered less than supportive or undermining.

**F1 Trainees:** A varied response was received from trainees when asked if they had witnessed or experienced behaviours of bullying and undermining. Some stated that they had not witnessed or been subject to such behaviours in general medicine however some stated that they have frequently witnessed and experienced these behaviours from non-medical staff and nursing staff. F1s are often told to provide cross cover or pick up shifts with little or no discussion or consideration for their wellbeing. It was commented that the chief residents have no role with F1 trainees, and they would only approach with rota concerns. F1s tend to discuss any concerns with each other however are aware they could approach “SHO’s” or their educational supervisors.

**F2 Trainees:** Trainees commented on an ongoing issue with the nursing team being uncomfortable with F1 trainees seeing patients on the ward. If the trainees themselves had any concerns with regards to bullying or undermining, they would raise with educational supervisors or consultants.

**GP/IMT Trainees:** Trainees reported that if they had concerns with regards to bullying or undermining, they would contact their educational supervisors. They commented that although they have not been subject to any behaviours of bullying or undermining, they do exist but are not considered systemic.

**ST Trainees:** Most trainees reported never having witnessed or experienced behaviours of undermining or bullying. Comments were made regarding escalating a patient concern to a consultant which resulted in the trainee being berated and a datix inappropriately raised against them. It is not believed that this is a systemic problem. Trainees confirmed they would raise concerns with regards to undermining and bullying with their educational supervisor, training programme director or clinical lead.

### 2.13 Workload/Rota (1.7, 1.12, 2.19)

**Trainers:** Trainers reported that there are rota gaps which are currently being filled by a pool of 30 clinical fellows. Rota gaps that occur within a 48-hour period are supported by the staff bank. Trainers stated that there are always improvements that can be made to rotas. Listening to trainees and ensuring they feel part of the system and that their wellbeing is considered is key. Trainers consider the ST rota as a good example of how this is achieved. From September 2020 they moved to 3 doctors on-call overnight this was recently changed to 2 with the third doctor retained on zero hours and available at short notice. They commented that this should be integrated across all rotas. Comments were made that foundation, IMT and GP trainees feel demoralised as they are often expected to cover known long-term gaps at extremely short notice. Trainers accept that last minute communication is an issue and going forward from August 2021 hope that the addition of 4 new F1 trainees will help alleviate pressures. It was also commented that gaps in the rota management team have also contributed to the strain on rotas and communications. They confirmed these posts have now been filled and hope this will also help in the long term. Trainers commented that they are not aware of any aspects of the post that compromise trainee wellbeing and consider trainees to be well protected in getting rest days and have no complaints of trainees working out with rostered hours.

**F1 Trainees:** Trainees reported that there are many long-standing permanent gaps in their rota. They do not consider these to have been managed at all and report OOH gaps every week. Trainees report being often pulled from rest days, annual leave or other wards to cover these gaps. They often receive communications stating that if no one comes forward to cover a gap that a name will be picked out of a hat. It was perceived that when rotas are monitored these gaps disappear or are ignored. Trainees stated that the rota does not accommodate learning opportunities and they have no opportunity to engage with rota organisers or suggest improvements to the rota.

**F2/GP/IMT Trainees:** Trainees reported many long-term gaps within rotas. These are not managed well; communication is extremely poor, and trainees are contacted at the last minute to cover weekends with an e-mail stating that if no one volunteers then a name will be pulled from a hat. They stated the rota had been monitored however results were insufficient. Trainees commented on service provision is prioritised over their training and learning needs of trainees. A huge proportion of the rota is on-call, receiving and clerking which compromises training. Trainees have fed back concerns via their trainee rep however are unsure what impact if any this has had. F2 trainees commented that it can be difficult to attend clinics as priority is given to middle grade trainees.

**ST Trainees:** Trainees reported having a full rota until 4 STs were taken off the rota to act up which resulted in running with a compressed rota at very short notice. Covid has also generated a lot of sickness absence and people are pulled to cover at short notice. Trainees consider the rota gaps to be very poorly managed and they are made to feel guilty if they do not undertake any extra shifts OOH. Communication for gap cover is via e-mail or Whatsapp. There is also pressure on clinical fellows to fill rota gaps during the day. Trainees are aware of gaps within the rota management team which are also contributing the short notice of trying to fill gaps. Trainees have fed back concerns with regards to rota gaps.

### 2.14 Handover (R1.14)

**Trainers:** Trainers reported that they are not involved in handover arrangements. SATA and high dependency unit (HDU) in general are consultant led. Morning handover in HDU is also consultant led however they do not do nights. Backshift for downstream wards has leadership from the ST trainee on for SATA. Nightshifts are challenging due to the nature of the site and difficulties in covering multiple areas however the chief residents are working on ways to improve this. Front door handover has also been difficult due to social distancing requirements.

**F1 Trainees:** Trainees reported handover has improved however there are areas that still require work. Handovers are not part of the rota however do take place at regular times during the day. There is no written handover kept, and trainees do not consider handovers to be a good learning opportunity as there is no senior person in attendance. Handover is to the on-call F1 who must then track down the other F1s to pass over tasks which can often be difficult as they cover multiple wards. ST handover can be very fast to allow them to finish.

**F2 Trainees:** Trainees described a good electronic situation-background-assessment-recommendation (SBAR) handover with patients added to TRAKCARE. There can be delays due to the emergency medicine department not always updating the system. 5pm handover is considered good and gives an overview of outstanding jobs. Handover still requires a lot of improvements especially for those patients who move in the evening as they may not be reviewed until the next day. Also, handover from the emergency department to acute receiving and acute receiving to downstream wards needs further improvement. Trainees do not consider handover a learning opportunity.

**GP/IMT Trainees:** Trainees reported that the handover system has hugely improved however still requires a lot of work. They are aware this is being actively addressed. Trainees commented that the "SHO" at downstream handover is generally the highest grade in attendance however if an ST is in attendance handover can be a learning opportunity. This does not happen often due to staffing issues.

**ST Trainees:** Trainees reported that downstream handover is inadequate, and work is underway to try and improve this. There are also 4 handovers that take place at the same time and only 2 STs on who can attend. Handovers have also changed multiple times due to Covid however it would be useful for trainees to be asked to provide feedback on handovers before changes are implemented. Handover is not considered a learning opportunity.

### 2.15 Educational Resources (R1.19)

**Trainers:** Not asked. No concerns raised in pre-visit questionnaire.

**F1/F2/IMT/GP/ST Trainees:** Not asked. No concerns raised in pre-visit questionnaire.

### 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. No concerns raised in pre-visit questionnaire.

**F1/F2/IMT/GP/ST Trainees:** Not asked. No concerns raised in pre-visit questionnaire.

### 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 due to time constraints.

**F1/IMT/GP Trainees:** Trainees reported they are unaware of any local trainee forums or meeting where they can raise concerns with regards to the quality of the training they receive.

**F2 Trainees:** Trainees commented on the West of Scotland foundation forum as a very useful resource for taking forward any training concerns.

**ST Trainees:** Trainees reported being aware of the junior doctors' forum and that concerns with regards to the quality of training can be raised with the chief residents. Trainees also commented on a medical education forum that meet monthly via Microsoft teams.

### 2.18 Raising concerns (R1.1, 2.7)

**Trainers:** Not asked due to time constraints.

**F1 Trainees:** Trainees reported they are aware of escalation pathways and who to contact if they had any patient safety concerns.

**GP/IMT Trainees:** Trainees reported that concerns with regards to patient safety are generally addressed during handover. They would also contact their educational supervisor or the consultant in charge of the patient if they had any concerns.

**F2 Trainees:** Trainees reported that they would raise any patient safety concerns with the on-call medical registrars who are very helpful and supportive. Trainees commented that if a friend or relative were to be admitted over a holiday weekend they would have concerns. Patients moving to a downstream ward can go a few days without consultant review. For example, a patient admitted on a Thursday with a holiday weekend starting on the Friday may not be reviewed at a consultant ward round until the Tuesday or Wednesday. The highest grade these patients may see is an F2. There is also no phlebotomy service over this period.

**ST Trainees:** Trainees reported that they would raise concerns with regards to patient safety with consultants, educational supervisor and charge nurses. Datix can also be raised and feedback is provided on the outcome.

### 2.19 Patient safety (R1.2)

**Trainers:** Trainers acknowledged the site has challenges relating to patient safety. During Covid the site worked hard to optimise ways of working to mitigate risk. Personal protective equipment is adequate and used appropriately by all. Trainers commented on daily calls via Microsoft teams to discuss and co-ordinate the safe flow of patients including medical boarders on site. These were enacted through lead nurses and the infection control team with significant senior level input.

**F1/F2 Trainees:** Trainees reported that as F1s they have no responsibility for the tracking of medical boarders, this task is undertaken by middle and senior grade trainees. Trainees commented that they are responsible for the day-to-day care on the wards of medical boarders. Should a medical boarder become seriously unwell ST trainees would provide support and then escalate to the relevant department.

**GP/IMT Trainees:** Trainees reported that they unsure of the procedures for medical boarders and rarely know what is happening with these patients. They believe that consultants are aware but there is no clear system for their management.

**ST Trainees:** Trainees reported being aware of a daily consultant meeting to discuss boarders. Generally, boarders are arranged by managers they are admitted under a specific consultant and that specialty team get a list daily from the co-ordinator. Should they not attend a ward round then the F1 would bleep the HDU ST however this very rarely happens.

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

**Trainers:** Trainers reported that all medical specialties have morbidity and mortality meetings (M&M meetings) which discuss adverse incidents. They are aware of how large an operation cross system learning is across the site and recognise the challenges in delivering this. They are part way through mobilising M&M meetings online based on the TRAKCARE system and are committed over the next

year to rolling this out to all medical specialty M&M meetings. This will allow the recording of shared learning events which can be wider circulated.

**F1 Trainees:** Trainees are aware of the datix system for reporting adverse incidents however have not been involved in any cases and are unaware of formal feedback routes should they be involved in an incident.

**F2/GP/IMT Trainees:** Trainees reported being aware of the datix system for reporting adverse incidents. They commented that some but not all departments have M&M meetings. Generally, if involved in an incident feedback would be given by their clinical supervisor. Comments were also made that a middle grade trainee had a bad experience after raising a datix and was not fully supported.

**ST Trainees:** Trainees reported using the datix system to report an adverse incident. These are discussed at M&M meetings and are very well supported within the department.

### 2.21 Other

Overall Satisfaction Scores:
F1 (6) – 7.4/10.
F2 – n/a.
IMT/GP (1) - 6/10.
ST (15) – 7.3/10.

## 3. Summary

| Is a revisit required? | Yes | No | Highly Likely | Highly unlikely |
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The visit panel recognised the efforts made to make improvements against the previous visit report action plan during the pandemic. Progress was noted against some of the requirements however there remain areas that require further improvement. The key areas of concern raised at the visit relate to induction, teaching, study leave, adequate experience, workload/rota, handover and culture/undermining. The panel were pleased to note involvement of the chief residents in improvements to rota management and handover. It is evident the department and DME team are motivated, willing and committed to providing a better training environment. The visit panel are highly likely to revisit within the next year to ensure progress is achieved in a reasonable timescale.

**Positive aspects of the visit:**

- Approachable, enthusiastic and supportive supervisors.
- Good quality educational and clinical supervision.
- Move to virtual platform for teaching has been well received.
- Highly motivated and supportive DME team.
- Adequate departmental induction.
- Well supported clear lines of escalation.
- Good training opportunities for ST1 trainees in wards and clinics.
- Good range of clinical experience.
- Involvement of chief residents in improvement discussions for rota management and handover.

**Less positive aspects of the visit:**

- Concerns raised by all trainee grades with regards to rotas and management of rota gaps.
- Poor communications with regards to covering of rota gaps. Use of wording pulling a name out of a hat should no volunteers come forward considered by trainees to cause guilt and pressure.
- Trainees report that phlebotomy service is capped, and that cannulation and catheterisation is done by them as nursing teams on wards are unable to do this.

- Recognise the work put into handover however all training grades express concerns with regards to morning, evening and weekend handovers.
- Raise awareness across all training grades to roles of chief resident, junior doctors' forum, datix and mortality and morbidity meetings.
- Concerns with regards to F1, IMT and GP trainees being released to attend regional teaching.
- Concerns raised with regards to lack of equipment and private safe space for all training grades to attend local and regional teaching sessions.
- Trainees reported an ongoing lack of feedback on decision making, particularly when on-call and overnight.
- Lack of consistency with roll out of department induction. Several trainees reported having inadequate or no departmental induction, including out of hours.
- Induction handbook/material require updating as there are several factual inaccuracies.
- Concerns raised with consultant inappropriately raising a datix against a junior trainee when contacted for support.
- Concerns regarding aspects of patient safety including patient movement and admissions over holiday weekends.

**DME Action Plan: Triggered Visit 14th May 2019 (Carry forward to new action plan not met/partially met)**

| Ref | Issue | Update February 2020Action(s) | Requirement: Met, partially met, not met |
|---|---|---|---|
| 8.1 | All Consultants who are trainers must have time within their job plans for their roles to meet GMC Recognition of Trainers requirements. | Review of all job plans required. Work underway and discussions ongoing. | Met. |
| 8.2 | 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. | Induction completed for all medical specialties at changeover in August. Expanded shadowing and Induction process was in place pre the August start date – an increase from 4 to 5 days for the new FY1 intake.<br>FY2 induction held and further dates arranged in August to accommodate those doctors who could not attend at the beginning of the month. | Partially met. |
| 8.3 | Involve trainees in the ongoing design of their rota. | FY1 rota redesigned ahead of the August changeover. Involvement from FY1 trainees (pre-August) and Chief Resident. | Not met. |
| 8.4 | Rota/ timetabling management must be addressed to eliminate frequent, short notice, movement of trainees away from their base ward. | FY1 rota has been re-modelled on a 46 doctor rather than 48 doctor basis. This reduces planned gaps and therefore reduces the movement of trainees away from base wards. Unplanned gaps/ sickness etc will need to be | Partially met. |

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| | | managed safely on an adhoc basis. | |
| 8.5 | Alternatives to doctors in training must be explored and employed to address the chronic gaps in the junior rota that are impacting on training. | Workforce planning for ANP roles underway however funding stream and role definition are ongoing pieces of work. | Not met. |
| 8.6 | Barriers preventing trainees attending their dedicated teaching days must be addressed. | The redesign of the rota has improved the ability of trainees to attend the Thursday teaching educational programme. | Not met. |
| 8.7 | The site must ensure an effective system of safe selection and managing boarded patients and ensuring appropriate clinical ownership and oversight of patient care. | Boarding policy in place regarding selection of patients to board. Reinforced with nursing and bed management teams. Boarding patients reported daily and circulated to medical teams. | Met. |
| 8.8 | Handover processes must be improved to ensure there is a safe, robust handover of patient care with adequate documentation of patient issues, senior leadership and involvement of all trainee groups who would be managing each case. | Handover process formalised. Dedicated area identified in receiving unit and downstream medical wards to support handover. Handover times standardised between receiving and downstream wards and there is senior medical leadership of the handover process. | Not met. |

## 4. Areas of Good Practice

| Ref | Item | Action |
|---|---|---|
| 4.1 | Move to virtual platform for teaching has been well received. | n/a |
| 4..2 | Well supported clear lines of escalation. | n/a |
| 4.3 | Involvement of chief residents in improvement discussions for rota management and handover. | n/a |

## 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 | 2.17, 2.20 | Raise awareness across all training grades to roles of chief resident, junior doctors' forum, datix and mortality and morbidity meetings |
| 5.2 | 2.15 | Concerns raised with regards to lack of equipment and private safe space for all training grades to attend local and regional teaching sessions. |

## 6. Requirements - Issues to be Addressed

| Ref | Issue | By when | Trainee cohorts in scope |
|---|---|---|---|
| 6.1 | 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. This should also cover out of hours for all areas covered. Induction handbooks should be updated and sent to all training grades prior to commencing in post. | 28/02/2022 | ALL |
| 6.2 | Involve trainees in the ongoing design of their rota. | 28/02/2022 | F1/F2/GP/IMT |
| 6.3 | Rota/ timetabling management must be addressed to eliminate frequent, short notice, movement of trainees away from their base ward. | 28/02/2022 | F1/F2/GP/IMT |
| 6.4 | Alternatives to doctors in training must be explored and employed to address the chronic gaps in the junior rota that are impacting on training. | 28/02/2022 | F1/F2/GP/IMT |
| 6.5 | Handover processes must be improved to ensure there is a safe, robust handover of patient care with adequate documentation of patient issues, senior leadership and involvement of all trainee groups who would be managing each case. | 28/02/2022 | ALL |
| 6.6 | There must be active planning of attendance of doctors in training at teaching events to ensure that workload does not prevent attendance. This includes bleep-free teaching attendance. | 28/02/2022 | F1/F2/GP/IMT |
| 6.7 | There must be access to study leave for all eligible trainees and this must not be dependent on trainees arranging their own service cover. | 28/02/2022 | GP/IMT |
| 6.8 | Tasks that do not support educational and professional development and that compromise access to formal | 28/02/2022 | F1/F2/GP/IMT |

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|---|---|---|---|
| | learning opportunities for all cohorts of doctors should be reduced. | | |
| 6.9 | Appropriate outpatient clinic training opportunities must be provided for IMT and GP trainees. | 28/02/2022 | GP/IMT |
| 6.10 | All references to “SHOs” and “SHO Rotas” must cease. | 28/02/2022 | F1 |
| 6.11 | A process for providing feedback to Foundation, IMT and GPSTs on their input to the management of acute cases must be established. Higher trainees must similarly receive feedback on their out of hours work (that is 'back of hospital' rather than acute medical receiving). | 28/02/2022 | ALL |
| 6.12 | A formal mechanism for all trainees to be able to feedback to the department must be established. | 28/02/2022 | ALL |