Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	16th March 2022	**Level(s)**	Foundation, Core, Specialty
Type of visit	Triggered (Virtual)	**Hospital**	Ninewells Hospital
Specialty(s)	General Surgery	**Board**	NHS Tayside

Visit Panel	
Dr Reem Alsoufi	Visit Chair – Associate Postgraduate Dean (Quality)
Dr Alison Lannigan	Training Programme Director
Dr Geraldine Brennan	Associate Postgraduate Dean (Quality) & Foundation Representative
Dr Emily Turner	Trainee Associate
Mrs Susan Fiddes	Lay Representative
Mrs Jennifer Duncan	Quality Improvement Manager
In Attendance	
Mrs Gaynor Macfarlane	Quality Improvement Manager

Specialty Group Information	
Specialty Group	Surgery
Lead Dean/Director	Professor Adam Hill
Quality Lead(s)	Dr Reem Alsoufi, Dr Kerry Haddow, Mr Phil Walmsley
Quality Improvement Manager(s)	Ms Vicky Hayter
Unit/Site Information	
Trainers in attendance	12
Trainees in attendance	37 (F1-17, F2-8, CT-2, ST-12)

Feedback session: Managers in attendance	Chief Executive	0	DME	1	ADME	1	Medical Director	1	Other	17

Date report approved by Lead Visitor	18/04/2022 Dr Reem Alsoufi 21/04/2022 Professor Adam Hill

1. Principal issues arising from pre-visit review:

Following review and triangulation of available data, including the GMC National Training Survey and NES Scottish Trainee Survey, a Deanery visit was arranged to the General Surgery Department at Ninewells Hospital. This visit was requested by the following Quality Review Panel(s): Higher Surgery QRP and Foundation QRP which took place in November 2021.

Issues highlighted include:

Triage/Top-Bottom 2%

Foundation:

General Surgery – Bottom 2%, STS Level Triage List, significant change in scores.

ST:

General Surgery – Bottom 2%, significant change in scores.

NTS 2021

Foundation:

F1 Surgery – Red Flag – Supportive Environment.

F2 Surgery – Red Flag – Clinical Supervision, Educational Supervision, Handover, Overall Satisfaction, Supportive Environment.

Core:

CST – Lime Flag – Reporting Systems

ST:

General Surgery – Pink Flags – Clinical Supervision, Clinical Supervision Out of Hours, Local Teaching, Rota Design, Supportive Environment, Workload.

General Surgery – Red Flags – Educational Governance, Handover, Induction, Overall Satisfaction, Regional Teaching.

STS 2021

Foundation:

General Surgery – All White.

Core:

CST – All White.

General Surgery – All Grey.

ST:

General Surgery – Pink Flag – Teaching.

General Surgery – Red Flag – Handover, Induction, Workload.

At the pre-visit teleconference the visit panel agreed that the focus of the visit should be around the areas highlighted in the survey data and pre-visit questionnaire.

In addition to the National Survey data the visit panel reviewed output from 8 Deanery Quality Management meetings following a notification of concern in September 2020.

Department Presentation:

The visit commenced with Ms Dorin Ziyaie and Ms Claire Carden delivering informative presentations on the Ninewells and Perth Royal Infirmary sites. These provided detailed information on the configuration of the units on both sites, the training journey, service redesign and the impact of COVID-19 on working arrangements. Supplementary material was provided to the panel detailing efforts by trainers and management at improving the training environment and meeting GMC standards. The visit panel commended Ms Ziyaie and Ms Carden for their leadership and comprehensive presentations.

2.1 Induction (R1.13):

Trainers: Trainers reported that all training grades receive a comprehensive induction which they believe prepares them for the role. Work has continued on the induction programme since 2018 with a standardised structure now in place and contribution from all key areas including escalation

pathways. Attendance records are kept, and sessions have been recorded for Perth Royal Infirmary, Ninewells Hospital green and amber zones. An induction booklet is also available which has been continually updated throughout the service restructures in the last 2 years. Trainers noted the importance of gathering trainee feedback to keep induction relevant and the importance of ensuring changes in the department are included and communicated. However, there is no formal programme induction for Specialty Trainees (STs) joining the East Surgical Programme, as the training programme director (TPD) informally e-mails all requesting a copy of their CV to discuss learning needs and how best to meet them.

Foundation Trainees: Trainees confirmed receiving departmental induction to general surgery. Those who missed induction were given a brief discussion. The 'green zone' covered multiple surgical specialties which were not part of the general surgery induction, Foundation Trainees were particularly unclear on the escalation policy for surgical specialties within the Green Zone (other than general surgery). Trainees felt it would have been useful to know how this area worked, their role, jobs expected of a foundation doctor and how to undertake these. They felt the induction for ward 7 acute surgical receiving unit (ASRU) was also unclear on roles and responsibilities. Pre-assessment and surgical high dependency unit (surgical HDU) inductions were noted as being of good quality.

Core and Specialty Trainees: Trainees who had been in post for a number of years reported never having received induction to the hospital or department. Lack of hospital induction was flagged in previous years by trainees to the medical education team and subsequently 10 online modules were provided however trainees stated they have no allocated time to undertake these modules. Core trainees (CT) described a slightly better experience with induction and noted some efforts were made to introduce them to general surgery. However, they did not feel adequately informed of their roles, responsibilities and how different teams interact within general surgery. Those who rotated to vascular and worked in general surgery at Perth Royal Infirmary praised the quality departmental induction they received at the time. Others described departmental induction in Ninewells as a quick chat and a tour with a more senior registrar, they felt that the most useful information they had received was from other trainees sharing their own experience with them informally. Difficulties were also noted in obtaining IT passwords which added stress to the experience of trainees joining Tayside from other Boards.

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

Trainers: Trainers reported that clinical fellows (CFs) help ensure trainees are released from the department to attend teaching. ST regional teaching takes place on the third Friday of the month which is recorded to allow them to catch up at their own convenience. Local teaching for ST trainees is scheduled for half a day 6 times a year, there is also a clinical effectiveness day, in addition to various journal clubs and morbidity and mortality (M&M) meetings which take place roughly once a month. For foundation trainees there is mandatory deanery teaching and local teaching which has recently started on a Monday at 2pm delivered by Mr Ekpete and an ST trainee via Microsoft Teams. Trainees are also invited to attend multidisciplinary team meetings (MDTs).

Foundation Trainees: Trainees stated that regional deanery teaching takes place on alternative Wednesdays. Difficulties in attending were noted if on ward 7 as this is a very busy ward, seniors are in theatre and there are no arrangements to hand bleeps over. On the rare occasion they can attend on Microsoft Teams there is insufficient space to do so therefore they are constantly interrupted when joining the teaching in a clinical area. They commented on being able to attend only 1-3 sessions in this post in real-time (out of 8) and having to catch up on missed sessions in their own time. Trainees in pre-assessment and surgical HDU commented on a better experience in being adequately released for teaching. They stated that the same issues are present for departmental teaching however which can be organised at a very short notice and is not recorded so there is no option to catch up at a later time. General surgery teaching takes place at 2pm on a Monday which was organised by the clinical fellows (CFs) and although all trainees are invited foundation trainees cannot attend as CFs will not provide ward cover for Monday teaching. Concerns regarding teaching have been raised with the department via the foundation rep for surgery who was led to believe that F2s were providing cover to allow F1s to attend however this is not the case as they work in different clinical areas and therefore this reciprocal cover is not feasible. Trainers were under the impression that CFs provided cover for FY doctors to attend teaching while FY doctors felt that this was rarely happening due to workload and rota gaps.

Core and Specialty Trainees: Trainees stated that regional teaching has started recently and takes places on the third Friday of the month. There is a concerted effort made to allow CT and ST trainees to attend however due to lack of adequate ward cover this is not always possible.

2.3 Study Leave (R3.12)

Trainers: Not asked, no concerns raised in pre-visit questionnaire.

Foundation Trainees: Not asked, no concerns raised in pre-visit questionnaire by F2 trainee.

Core and Specialty Trainees: Trainees reported that study leave it only approved if on elective days therefore there are limited opportunities to swap shifts with colleagues, particularly for CT trainees required to attend mandatory IST teaching.

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

Trainers: Not asked.

Foundation Trainees: All trainees confirmed having a designated educational supervisor who they have met at least once while in post however many are still awaiting this being officially recorded in their portfolio.

Core and Specialty Trainees: All trainees confirmed having a designated educational supervisor. They stated that it is the trainee's responsibility to find an educational supervisor for each 6-month post which can be difficult particularly for trainees new to the East region. The process of approaching different trainers can be time consuming and first meetings tend to take place late into post. This arrangement coupled with requirements for 3 Multiple Consultant Reports (MCRs) in each block are causing significant anxieties amongst core and specialty trainees.

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 robust arrangements for the provision of clinical supervision during the day and out of hours with clear lines of contact available on the rota. The panel asked who a new F1 would contact for support on ward 26 (Green Zone). Trainers stated first point of contact is the ward registrar. However, as this ward covers multiple specialties, they will also have their own specialty registrar that should be contacted for support. They can also contact the stepdown consultant or on-call registrar/consultant. This escalation policy is made clear during induction. Trainers reported that

consultant and registrar ward rounds take place every day where all patients are reviewed and that all emergency patients are seen by a consultant or senior registrar.

Foundation Trainees: Trainees confirmed being aware of who to contact for clinical supervision during the day and out of hours. When in ASRU they are provided with the contact numbers for the on-call registrar. The green zone covers 8 subspecialties trainees should contact patient specialties for support however this is not always clear. Trainees raised major concerns with the Green Zone, they described it as unsafe, chaotic with difficulties in communication and getting direction from different teams. Registrars conduct daily ward rounds as consultants are rarely present, these rounds do not always include FY doctors as they might be busy doing tasks or joining a different ward round. Most consultants are approachable if contacted although the main problems were felt to be contacting trauma and orthopaedics and urology, where trainees stated it was difficult to get these teams to see patients in the Green Zone.

Core and Specialty Trainees: Trainees confirmed knowing who to contact for clinical supervision during the day and out of hours. They have no concerns with escalation pathways however commented that it can be difficult at times to access appropriate support on stepdown wards. Trainees reported that they occasionally work beyond their level of competence. This is a particular concern in ‘hot clinics’ and the ‘green zone’ where STs are the most senior person on the ward and are conducting daily ward rounds with infrequent consultant presence or oversight of decision making. When on-call there are occasions when consultants are present. They also commented that not all emergency admissions are reviewed by a consultant. Acute on-call was felt to have more adequate consultant involvement than downstream wards or Green Zone, particularly colorectal consultants who are more hands on when it comes to ward patients compared to their upper GI colleagues.

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

Trainers: Trainers confirmed having recent training relating to the updated curriculum for the foundation training programme and general surgery training programme. They also attended inhouse meetings to keep up to date with Multiple Consultant Report (MCR) and coming changes to Intercollegiate Surgical Curriculum Programme (ISCP). Trainers reported that Placement Supervision Group (PSG) and Supervised Learning Events (SLEs) are difficult for foundation trainees to obtain

due to frequent moves between wards. A few confirmed having completed assessment request for foundation trainees. Theatre and clinic access for ST trainees has been forefront priority for the department who have maintained theatre list training opportunities despite the pandemic. They were pleased to note very good logbook numbers across the trainee group.

Foundation Trainees: Trainees reported spending 80% of their time carrying out duties that are of little benefit to their education and training. They have developed and improved their skills for managing sick patients because they perceive themselves to work in an environment with little support and feel they must step up and make decisions. They also learn from discussing cases with other teams particularly renal medicine, critical care, and medical registrars. Support is available in some wards by advanced nurse practitioners (ANPs) and physician associates (PAs) to reduce the burden of repetitive tasks although this is not consistent.

Core and Specialty Trainees: Trainees reported that opportunities to attend clinics have improved although these translating into assessments is variable. Workplace-based assessments can take a long time to verify and sign off even when they are submitted in real time. Trainees also raised concerns relating to endoscopy training despite there being a number of colonoscopy lists training opportunities are limited.

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

Trainers: Covered in section 2.6.

Foundation Trainees: Trainees reported difficulties in obtaining PSG assessment and have raised concerns with their foundation programme director. They also confirmed that the majority of assessments obtained in post have been completed by CFs and ST trainees, few trainees confirmed having assessments completed by general surgery consultants.

Core and Specialty Trainees: Difficulties were also noted in the department engaging with ISCP. Trainees are concerned regarding the feasibility of obtaining the required number of multiple consultant reports (MCR) by annual review of competence progression (ARCP) and are unclear on requirements. Some still require initial and mid-point meeting sign off from post 1. Concerns have

been raised with the TPD however trainees felt they were dismissed without clarity given. This has also been raised at a specialty training committee meeting (STC).

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

Trainers: Not asked, no concerns raised in pre-visit questionnaire.

Foundation Trainees: Not asked, no concerns raised in pre-visit questionnaire.

Core and Specialty 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.

Foundation Trainees: Not asked, no concerns raised in pre-visit questionnaire.

Core and Specialty Trainees: Not asked, no concerns raised in pre-visit questionnaire.

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: Trainers commented on providing a supportive environment where they encourage trainees to come and talk to them and not make decisions, they are uncomfortable with. ST trainees are now working on a new rota supported by advanced nurse practitioners (ANPs) and physician associates (PAs).

Foundation Trainees: Trainees stated that they are not provided with feedback on their clinical decisions during the day or out of hours. Trainees commented on being used a scribe on ward rounds but are not part of the decision making. This is however not the case in pre-assessment or surgical HDU where constructive and meaningful feedback is regularly provided.

Core and Specialty Trainees: Trainers reported they rarely receive feedback on clinical decisions during the day or out of hours when on the wards. Consultants work differently and while some

provide feedback in clinics and theatre sessions others are not forthcoming with constructive feedback. Supervision and feedback are felt to be lacking on ward rounds however, trainees described receiving meaningful feedback when in theatre.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: Not asked due to time constraints.

Foundation Trainees: Trainees reported having a good foundation trainee representative who attends meetings and takes forward any feedback or concerns to trainers and the management team on the quality of their training in post.

Core and Specialty Trainees: Trainees reported being able to provide feedback to trainers and the management team on the quality of their training at various meetings such as STCs, the General Medical Council (GMC) survey however often see no action resulting from this**.** Trainees described their engagement with feedback opportunities to be hindered by perception of lack of change or improvement and by a growing apprehension of being labelled as troublemakers, more details are discussed in section 2.12.

2.12 Culture & undermining (R3.3)

Trainers: Trainers advised of a new equality and diversity service lead for general surgery which is a new and evolving role. Bullying and undermining is covered at induction and educational supervisors make trainees aware that consultants are approachable should they have any concerns. They commented that ST trainees requiring a degree of protection as they provide supervision to juniors and can provide firm and direct feedback which can be misconstrued as bullying and undermining by STs towards their junior colleagues.

Foundation Trainees: Trainees stated that most senior colleagues are supportive however it is very much specialty dependant. Registrars do their best and most are approachable. Concerns were raised by 3 trainees regarding patronising comments on ward rounds and not being allowed to ask questions when on-call with one of the specialty consultants (not general surgery), details of which were passed on to the Director of Medical Education.

Core and Specialty Trainees: Trainees stated that the clinical team are supportive. They commented on instances of bullying and undermining with different members of staff and a passive aggressive culture in the department. They described micro-aggression in conversations with some trainers and corridor whispers about them to colleagues that have made them reluctant to raise concerns in fear of retaliation. They commented on being sought out after the department received negative feedback in the trainee surveys. Trainees were notably anxious about ARCP and feared the repercussions that could come from raising any concerns. They felt apprehensive and morals were low, they perceived there were no avenues they could pursue to gain appropriate support through the department, medical education team or the deanery itself. They commented on attending a meeting with the medical education team, Associate Postgraduate Dean, and department where trainees were accused of fraud, an apology was provided after the meeting, yet they felt let down by the system as a whole.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Not asked due to time constraints. Information was provided during the management session and in supplementary material.

Foundation Trainees: Trainees reported rota gaps which are supported by 4 CFs on the F2 rota and 3 CFs on the F1 rota. Workload is described as too busy and is felt to be affecting the health and wellbeing of trainees. Trainees are often moved to fill short notice gaps with no warning. Recent rota monitoring showed non-compliance with regulations.

Core and Specialty Trainees: Not asked during the visit due to time constraints. However, the following issues were raised through the pre-visit questionnaire:

There is a feeling that trainees are providing service without adequately balancing their needs for training. There are mandatory float weeks which are not viewed as educationally valuable by trainees; during which leave cannot be taken and they are not allocated to theatre lists or clinics.

Additionally, trainees used to work a stretch of 7-day on-call leading to about 90-95 hours of work in 7 days, although this has been changed recently in a new rota. Trainees reported on-call workload to

be incredibly intense including emergency theatre, conducting ward rounds and seeing all new referrals which was felt to affect their wellbeing and job satisfaction.

IST/ST described changes to their rota at short notice and a heated discussion around their rota monitoring outcomes where they were scrutinised, and some felt they were accused of fraud to intentionally fail their monitoring period. This added to the sense of breakdown in communication and lack of support.

2.14 Handover (R1.14)

Trainers: Trainers reported problems with handover partly due to the hospital interface and Hospital@Night (H@N) which was deemed to be unsafe. The department works 12-hour shifts, handover is now face to face and takes place in the morning and evening with senior STs, junior STs and foundation trainees in attendance**.**

Foundation Trainees: Trainees report that surgical HDU handover is good and works well. Ward 7 (ASRU) handovers take place at 8am and 8pm between registrars and the on-call team for general surgery patients only, no senior is regularly present from non-general surgery specialties such as vascular or urology. General Surgery Registrars tend to start their ward rounds after handing over their patients leaving foundation trainees to handover other patients on the ward and missing part of the morning ward round. Morning handover is particularly hectic and the F1 from night shift is expected to stay late to attend the ward round. Green zone handover can happen on the ward or in the H@N hub with no consultant involvement. Handovers are also taking place at the same time making it impossible for trainees to attend 2 places at the same time. Trainees do not consider handover to be a learning opportunity.

Core and Specialty Trainees: Trainees reported that handover for ward 7 was taking place at a whiteboard on the ward this now frequently takes place in the doctor’s office. Foundation doctors are not as involved in the morning handover as they might be completing or handing over tasks separately. However, they provide an up-to-date handover sheet to the registrars who recognise that this puts a lot of pressure on the foundation doctors to keep up to date with all patients. No consultants are present at this handover. No formal Green zone handover for registrars. There are often consultant ward rounds in the morning on the acute ward however consultants do not attend

handover on wards 8, 10, 11 or the boarding wards. There is no real structure to handover, and it is not considered a learning opportunity. Weekend ward rounds are led by consultants and registrars do not attend these ward rounds. They consider the best time to be admitted to the ward is at the weekend as patients are reliably seen by a consultant. Registrars dictate the Friday ward round as a handover to the weekend consultants. However, there is no weekend handover to Monday day shift.

While trainers were under the impression that there was an electronic handover documentation available on desktops and that registrars participated in updating it, the trainees were not aware of such document.

2.15 Educational Resources (R1.19)

Trainers: Not asked, no concerns raised in pre-visit questionnaire.

Foundation Trainees: Not asked, no concerns raised in pre-visit questionnaire.

Core and Specialty 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: Trainers reported on the appointment of the recent equality and diversity service lead which will be a key role in providing support to trainees. They believe that as the department moving back to parent units will be of great benefit to trainees as they will be working more closely as part of the team. Foundation programme directors are also very hands on and provide good support to those in difficulty.

Foundation Trainees: Trainees reported that they are not aware of any support available to them if they were struggling in post or with their health.

Core and Specialty Trainees: Trainees stated that some trainers are very approachable and there for advice and support if they were struggling in post however, they are unsure any action would be taken. Trainees commented on pastoral support from Mr Smith, which was greatly appreciated, unfortunately he has now retired.

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: Trainers reported that Specialty Training Committees (STC) meet 3 times per year, that these meetings are well represented by trainers and include trainee representatives. Some trainers also take on a lead role and have responsibility for attending management and quality meeting to represent the consultant group and also provide them with feedback.

Foundation Trainees: Not asked.

Core and Specialty Trainees: Trainees commented on being well supported by a few trainers in particular Ms Ziyaie who is they viewed as hardworking, supportive and deals with concerns in a respectful manner. Multiple examples were provided by the trainee group on instances of feeling ignored and belittled when raising concerns. They also voiced concerns about escalating training issues through their TPD.

2.18 Raising concerns (R1.1, 2.7)

Trainers: Trainers reported on clear escalation pathways and approachable consultants. Trainees are aware of and encouraged to use the escalation policy when required.

Foundation Trainees: Trainees reported that they had raised concerns with their F2 representative and the foundation lead who is sometimes helpful. Ongoing concerns have been raised within ward 7 and patients being admitted directly from the Emergency Department to the ward with no direct handover to the FY doctors, particularly non-general surgery specialties.

Core and Specialty Trainees: Covered in previous sections (2.11 and 2.12).

2.19 Patient safety (R1.2)

Trainers: Trainers reported no concerns regarding the safety of boarded patients. There are clear lines of escalation as to who look after these patients. They confirm that TRAKCARE is used to produce a patient list for review daily at 8.30am, this is e-mailed to all consultants and registrars to ensure all patients are reviewed on a daily basis.

Foundation Trainees: Trainees reported concerns regarding patients in ward 10 who following testing positive with covid-19 being moved to “Covid Ward” with loss of follow up or daily surgical review.

Core and Specialty Trainees: Trainees stated that they would not be comfortable if a friend of family member were admitted to the department, this is down to lack of consultant oversight. They would be comfortable with the operative and the immediate post-operative care however have concerns about downstream wards and follow up.

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

Trainers: The panel highlighted feedback received from all trainee group in the pre-visit questionnaire stating that trainees were aware of the datix reporting system however were unaware of any meeting or learning as a result of a reported incident. Trainers stated that M&M meetings are closed meetings and not recorded. This is an area they felt could be improved upon. There is also a new standard operating procedure for deaths that has been implemented in the last few weeks and it tasks FY doctors of reporting deaths in the surgical division via Datix.

Foundation Trainees: Trainees are aware of the datix reporting system for adverse incidents however they have not been involved with this themselves. Trainees in surgical HDU reported on cases being discussed and provided with feedback.

Core and Specialty Trainees: Trainees stated that the different sub specialities have different processes for sharing learning from adverse incidents, for example Upper GI take cases to the clinical effectiveness day. General surgery has no generic M&M meetings, and colorectal have a separate M&M meeting with trainee representation. Trainees were not aware of the lessons learnt from the 8 green zone deaths and were advised a few of these were not to be discussed at M&M meetings. They do not consider the reporting of morbidity to be done particularly well in the department. An example was provided to the panel of patients coming to harm due to no consultants being present at word rounds. A questionnaire was distributed, and the findings collated in a document which was tabled at an STC meeting however no response was provided.

2.21 Other

Overall Satisfaction Scores:

Foundation – 6.6/10.

Core and Specialty – 5/10.

3. Summary

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

The panel commended the engagement of the site and medical education team in supporting the visit and efforts made to improve induction and escalation policies. The panel appreciate this is a continuum of deanery meetings and visits since 2017 and acknowledge the efforts made to improve both patient care and the training environment despite ongoing challenges faced due to Covid-19.

The panel identified significant concerns in areas of team culture, wellbeing and patient safety. The key areas for improvement noted at the visit relate to induction, supervision, teaching, workload, rota, handover, and adverse incidents. The serious concerns raised within the report will be highlighted with the Lead Deans for Surgery and Foundation where the panel recommendation for escalation to enhanced monitoring will be considered. An action plan review meeting will also be arranged 6 months post visit where the department will be given the opportunity to show progress against the requirements listed below.

Positive aspects of the visit:

1. Majority of trainers are approachable, special mentioning of Ms Dorin Ziyaie as Clinical Lead for being very approachable and hardworking
2. Trainers (particularly Mr Ekpete) and one of the STs (Sameera Sharma) worked very hard at producing induction materials for FY doctors, this material is available in electronic format and uploaded to Microsoft Teams.
3. IST/STs reported that PRI Q&A-based induction was useful, and praised the comprehensive induction by the Vascular Surgery team
4. IST/STs welcomed Mr Smith’s offer for pastoral support when they joined (since retired without replacement)

5. Escalation policies (General Surgery) for FY doctors were covered in the induction
6. Regional teaching for IST/ST is mainly delivered by consultants and was reported to be of high quality
7. Most FY doctors had met with their ES, although meeting documentation varied
8. IST/ST seen as supportive by their junior colleagues
9. IST/STs reported satisfaction with the quantity and quality of theatre training
10. IST/STs reported increased access to clinic learning opportunities since rota changes made in Feb 2022. Revised rotas allow more consistency with longer blocks of elective and emergency general surgery
11. IST/STs reported good in-person verbal feedback on their performance when attending theatre lists
12. IST/STs reported discussion of cases in some clinics and subsequent CBDs and CEXs from these discussions
13. FY doctors reported that the Surgical High Dependency Area were good at learning and communicating lessons from adverse events

Serious Concerns: immediate action required:

1. **Hands-off approach to ward rounds and 'hot clinics' by consultants in General Surgery:**

- Consultant supervision of ward rounds is infrequent and there is considerable variation in practice amongst the consultants in providing direct patient reviews when asked for advice, particularly for the Green Zone and downstream wards. Colo-rectal consultants would attend more ward rounds in ward 7 than UGI/HPB
- Ward rounds during weekdays are led by STs/ISTs, including junior ISTs who are new to Tayside and who might not know what they do not know
- Acute admissions to general surgery are not always assessed by a consultant and patients may be discharged with no direct consultant review, particularly if admitted directly to a downstream ward or COVID ward
- Patients undergoing complex surgical procedures ending up in downstream wards for 2-3 weeks with infrequent or no consultant review after their initial phase of recovery

2. **Direct admissions from the Emergency Department to downstream wards without communication with the FY doctors** in these wards (Vascular and Urology cases). This left FY1 doctors unaware of admissions or plans decided by the specialty STs

Major concerns related to trainee wellbeing:

1. **Departmental Culture**: Senior Trainees had breakdown in trust when raising concerns related to patient safety or training needs; this was felt to be caused by frequent micro-aggressions by some trainers, culture of “you need to toughen up” and frequent breaches of confidentiality. Trainees described micro-aggression in conversations with some trainers and corridor whispers about them or their colleagues that made them feel reluctant to raise concerns in fear of retaliation.

Trainees who tried to raise concerns at a higher level than the local department repeatedly felt that they were not listened to and therefore lost faith in “the system”. Further details will be discussed directly with the DME and the PG Dean for Surgery Prof Adam Hill.

Foundation Trainees described multiple patronising events by one of the Specialty Consultants (not General Surgery), details will be discussed separately with the DME.

The Deanery panel has significant concerns for the mental and emotional wellbeing of the trainees. An immediate action to support trainees in General Surgery is required, any inappropriate comments made to the trainees about their contribution to the Deanery visit will be taken seriously.

Less positive aspects of the visit:

1. **Induction for FY Doctors has improved yet requires further work:**
   Trainers explained multiple investments in improving induction for the FY group. However, some aspects of induction remain an issue particularly lack of face-to-face tours of the multiple clinical areas covered by FYs and lack of awareness of escalation policies for specialties in Green Zone (non-general surgery specialties). None of the training grades had induction to the Green Zone.

2. **Induction for IST/ST is lacking:**
   - No formal IST/ST Programme induction for G Surgery in the East beyond informal emails from TPD.

- No formal Hospital induction was offered to IST/STs new to Tayside beyond Learnpro online modules, several had delays in obtaining passwords and lacked familiarity with the setup in Ninewells.
- IST/ST trainees were vague about their roles when covering the different surgical areas at the start of their rotations. They felt that the induction material available is FY-focused and did not explain their roles and responsibilities adequately.
- No induction to the Green Zone.

3. Formal Regional/Deanery teaching is not protected:

- FY doctors were able to attend only 1-3 sessions of Deanery Teaching live out of 8. This poor attendance was due to high workload, no available clinical fellows to cover them and lack of office space to join Microsoft Teams without interruptions from ward staff. Despite these issues being raised several times by trainee representatives there were no improvements.
- IST/ST Regional teaching takes place monthly for 3 hours. However, it is not protected and not all IST/ST can attend due to lack of cover for their clinical duties on a Friday afternoon.

4. Departmental Teaching is not well established in General Surgery:

- There is no departmental teaching delivered to the level of FY doctors in G Surgery. A new initiative for Wednesday afternoon teaching started 3 weeks prior to the visit and most FYs could not attend due to workload.
- IST/STs are encouraged to attend M&M, MDTs and Clinical Effectiveness meetings as “departmental teaching”. Attendance at these meetings is variable due to workload and clinical commitments.

5. Educational Supervision arrangements for IST/STs are vague and trainee-dependent

IST/STs are expected to choose their own ES and to approach them individually without any form of guidance. Trainees new to the East Region might not know whom to approach resulting in anxieties, delay of first meeting and vagueness around support available to them at the start of their rotation.

As trainees are assigned two blocks every year, they are expected to identify ES for each block and then engage with 3 MCRs for each block creating further anxieties and perception

of lack of engagement from the trainers. When these concerns were discussed with the TPD, trainees felt their concerns were dismissed without clarity given.

6. **Engagement of trainers with Work-place-based assessments is slow and communication is lacking**

   Considerable anxiety amongst IST/STs about uncertainties in timeline for assessments and what is required for the MCRs, compounded by apparent confusion amongst the educational supervisors about what is expected in the new curriculum despite reporting they had attended educational sessions to familiarise themselves with the new curriculum.

7. **There is a significant discrepancy between what the consultants in general surgery perceive to be happening in the wards and what their trainees are perceiving to be the case:**

- FY doctors reported being unclear which consultants were responsible for specific patients in the green zone and were unsure who to escalate clinical concerns to despite consultant showing us escalation plans that were supposed to be available in every ward.
- FY doctors reported calling the on-call IST/ST when requiring support in the Green Zone rather than the named team registrar/consultant due to uncertainty – in contrast to the impression from the consultant group.
- FY trainees felt that help and senior support with sick patients often came from other specialties such as anaesthetics or medicine rather than the general surgical team.
- IST/ST trainees felt that often they could not contact consultants responsible for step-down wards.
- Within the Green Zone, both groups of trainees reported that the vast majority of ward rounds were conducted by IST/STs in contrast to what the consultants perceived to be consultant-led reviews.

The discrepancy between the two narratives is concerning as it reflects significant breakdown in communication between trainers and trainees. The picture emerging is of a complex structure for senior supervision and escalation that is inconsistently followed leading to variation in practice and uncertainties amongst trainees.

8. Handover remains fragmented with discrepancies between trainers and trainees' perceptions:

Handover taking place in silos rather than a cohesive team meeting:

- Trainees perceived handover to be largely led by IST/STs with infrequent presence of consultants.
- FY presence in Ward 7/ASRU handover can be disrupted by IST/ST starting the ward rounds while their FY colleagues are trying to handover non-general surgery patients. FY1s felt pressured as general surgery team leave after their patients are discussed, leaving them to conduct a junior unsupervised handover of surgical specialty patients without senior presence from other surgical specialties.

Weekend Handover:

- No formal handover before or after weekends: Handover is dependent on IST/ST dictating a note for review by weekend consultants, rather than any formal weekend handover from IST/ST to consultants directly.

Green Zone Handover:

- Trainees were not aware of any formal handover taking place in the Green Zone and practices varied widely depending on the team involved.
- Green Zone FY will be attending the H@N hub handover and if they had sick patients from the night shift being hand over, they might miss the start of G Surgery or other specialties ward rounds taking place in the Green Zone while H@N handover is still going on.

Handover of boarded patients:

Trainees are not aware of any formal processes to handover patients being boarded out-with surgical wards e.g COVID ward.

Documentation of handover:

While the trainers were under the impression that handover was documented on desktops in a folder with contributions made by FYs and IST/STs, the trainees referred to a list of patients with short summaries and "jobs" made by the FYs. IST/STs were not contributing to the "handover folder".

9. Heavy workload and Non-compliant Rotas

FY Trainees described heavy workload that is skewed towards repeated tasks of very little educational benefit to their level of training. They frequently miss their breaks and teaching sessions and stay late to finish tasks. FY rota is non-compliant following a period of monitoring.

IST/ST described changes to their rota at short notice and a heated discussion around their rota monitoring outcomes where they were scrutinised, and some felt they were accused of fraud to intentionally fail their monitoring period. This added to the sense of breakdown in communication and lack of support.

10. There is no robust system to engage trainees in learning from adverse events in General Surgery, particularly Green Zone.

FY doctors were not aware they were invited to attend M&M meetings and stated that the timings coincide with their clinical duties. M&M meetings take place separately for different teams i.e colorectal M&M, UGI M&M, etc. There is no general surgery-wide M&M meetings for lessons learned across the department. However, FY2 in surgical HDU reported useful feedback on adverse incidents and learning being shared in surgical HDU.

Majority of IST/ST trainees who attended the visit were not aware of the deaths in the green zone and some of them were under the impression that some of these cases “were not to be discussed” in the M&M. The panel learned from pre-visit material that 8 deaths were reported in the Green Zone since April 2020 and were referred for SAER analysis.

Given the concerns raised by the trainees around the Green Zone it is unclear why no lessons were shared with the trainees related to the 8 deaths.

4. Areas of Good Practice

Ref	Item	Action
4.1	Special mentioning of Ms Dorin Ziyaie, Clinical Lead, Mr Ekpete, Foundation Lead for being very approachable and hardworking and Sameera Sharma, ST for improvements made to induction material for foundation trainees.	n/a
4.2	IST/STs reported increased access to clinic learning opportunities since rota changes made in Feb 2022. Revised rotas allow more consistency with longer blocks of elective and emergency general surgery	n/a
4.3	FY doctors reported that the Surgical High Dependency Area were good at learning and communicating lessons from adverse events	n/a
4.4	Pastoral support provided by Mr Smith.	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	IST/STs are expected to choose their own ES and to approach them individually without any form of guidance. Trainees new to the East Region might not know whom to approach resulting in anxieties, delay of first meeting and vagueness around support available to them at the start of their rotation.	Collaboration with other TPDs in Scotland to ensure educational supervision and MCR practices in Tayside are similar to other regions Involving senior trainees in designing an induction programme for new

	As trainees are assigned two blocks every year, they are expected to identify ES for each block and then engage with 3 MCRs for each block creating further anxieties and perception of lack of engagement from the trainers. When these concerns were discussed with the TPD, trainees felt their concerns were dismissed without clarity given.	specialty trainees joining the programme

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	Measures must be implemented to address the (ongoing) patient safety concerns described in this report.	Immediate	All
6.2	All staff must behave with respect towards each other and conduct themselves in a manner befitting Good Medical Practice guidelines. The department must have a zero-tolerance policy towards undermining behaviour. Specific example of undermining behaviour noted during the visit will be shared out with this report.	Immediate	All
6.3	Departmental induction must be provided which ensures trainees of all grades are aware of all of their roles and responsibilities and feel able to provide safe patient care in all areas including 'green zone' in and out of hours. This must also include a mechanism for any trainee who misses their induction. Handbooks or online equivalent may be useful in aiding this process but are not sufficient in isolation.	August 2022	All
6.4	All trainees must have timely access to IT passwords and system training through their induction programme.	August 2022	All

6.5	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.	August 2022	All
6.6	A regular programme of formal teaching should be introduced appropriate to the curriculum requirements for Foundation trainees (departmental teaching)	August 2022	F1 and F2
6.7	Educational supervisors must understand curriculum and portfolio requirements for their trainee group. Mechanisms for assigning ES in a timely manner should be in place.	Immediate	IST and ST
6.8	Trainees must be provided with clearly identified seniors who are providing them with support during out of hours cover for all clinical areas. Those providing this supervision must be supportive of trainees who seek their help and must never leave trainees dealing with issues beyond their competence or 'comfort zone'.	December 2022	All
6.9	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 with written or electronic documentation.	December 2022	All
6.10	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.	December 2022	All
6.11	Rota/ timetabling management must be addressed to eliminate frequent, short notice, movement of trainees away from their base ward.	December 2022	All
6.12	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	December 2022	All

	the consequent learning that comes from an effective system.		
6.13	Programme induction must be provided to ensure specialty trainees aware of the training opportunities within the programme and how they collectively meet curriculum needs. Programme Induction should provide information on potential educational supervisors and their areas of interests and guidance on formal assessments and ARCP requirements. An induction booklet or online equivalent should be sent to specialty trainees before commencing in post.	December 2022	All