Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	1st March 2022	**Level(s)**	Foundation, Core, Specialty
Type of visit	Revisit	**Hospital**	Inverclyde Royal Hospital & Royal Alexandra Hospital
Specialty(s)	Trauma & Orthopaedics	**Board**	NHS Greater Glasgow & Clyde

Visit Panel	
Dr Geraldine Brennan	Visit Chair – Associate Postgraduate Dean (Quality)
Dr Jane Rimer	Training Programme Director
Dr Sanju Vijayan	Trainee Associate
Mr Gordon Laurie	Lay Representative
Mrs Jennifer Duncan	Quality Improvement Manager
In Attendance	
Mrs Gaynor Macfarlane	Quality Improvement Manager

Specialty Group Information	
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	10 (F1-4, F2-2, ST-4)

Feedback session: Managers in attendance	Chief Executive	0	DME	1	ADME	1	Medical Director	0	Other	18

Date report approved by Lead Visitor	01/04/2022 Dr Geraldine Brennan 06/04/2022 Professor Clare McKenzie

1. Principal issues arising from pre-visit review:

Following a Deanery visit in January 2020 a number of concerns were raised regarding Foundation training in Trauma and Orthopaedics at Inverclyde Royal Hospital and Royal Alexandra Hospital. Along with a number of requirements made in the final reports the visit panel also stated their intention to return to the unit.

Survey Data

IRH, NTS Data (2021)

Foundation NTS data combines both General Surgery and T&O.

F1 Surgery – Pink Flag – Educational Supervision, Induction.

F1 Surgery – Red Flags – Educational Governance, Rota Design, Supportive Environment.

IRH, STS Data (2021)

T&O – Foundation – All Grey Flags.

T&O – Foundation – Aggregated Red Flags – Clinical Supervision, Handover.

RAH, NTS Data (2021)

Foundation NTS data combines both General Surgery and T&O.

F1 Surgery – Pink Flag – Facilities, Induction, Supportive Environment.

F1 Surgery – Red Flags – Adequate Experience.

F2 Surgery – All Grey Flags.

F2 Surgery – Aggregated Red Flags – Clinical Supervision, Clinical Supervision Out of Hours, Overall Satisfaction, Rota Design, Study Leave, Supportive Environment.

RAH, STS Data (2021)

T&O – Foundation – Red Flag – Team Culture.

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.

Department Presentation:

The visit commenced with Ms Zoe Higgs and Ms Alison Winter delivering an informative presentation to the panel. This provided detailed information on the trauma service redesign, curriculum changes, an update on the previous visit action plan, and the impact of COVID-19 on working arrangements.

2.1 Induction (R1.13):

Trainers: Trainers reported that all training grades receive comprehensive induction to both sites. Foundation induction includes general surgery and bespoke sessions are provided to F2s rotating from their base of RAH to IRH. Difficulties were noted at IRH in capturing all F2s as one group and therefore a checklist is used to ensure all receive induction. Difficulties were also noted at RAH for the few foundation trainees who cover nights in medicine. Induction for ST trainees was provided face to face at RAH with IRH joining via Microsoft Teams and departmental tours provided in both sites. Electronic induction information is also provided to all trainees which is felt to prepare them for their roles within the departments. Both sites seek regular trainee feedback to allow continued improvement of induction sessions and handbook content.

Foundation Trainees: Trainees reported being provided with a trainee guide created by a previous trainee at RAH and a tour. Unfortunately, due to the changes that have occurred since the service merged, this is not a true reflection of the roles and responsibilities of an F1 or F2 on a day-to-day basis. Trainees reported having no consultant contact on the wards for the first few days of being in post, jobs were allocated by nurses and trainees reviewed any unwell patients. They were later advised by a registrar that they should review every patient every day. A short induction was provided for F1s rotating into IRH from RAH which was not felt to be sufficient. F1s based in IRH commented on a good full induction which included orthopaedics and general surgery.

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

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

Trainers: Trainers reported that West of Scotland training programme provides a rolling programme of teaching for ST trainees. Trainees are requested to ensure the department is kept up to date on

teaching dates which are fully supported, and all trainees can relinquish duties to attend. Trainers reported no issues in Foundation trainees attending regional teaching at IRH however at RAH there have been difficulties in trainees attending live sessions. These are however recorded to allow trainees to catch up in their own time. Departmental teaching at RAH is tailormade to each training block with trainees asked for input on topics via a survey. At IRH sessions take place twice a week and provide ST trainees with the opportunity to present. Foundation sessions focus on basic surgical skills however attendance has been poor and requires review.

Foundation Trainees: F1 trainees described an enthusiastic teaching lead who created a good programme of departmental teaching at RAH. Trainees had only been able to attend 1 session within the last 6 weeks which is in part due to it taking place over lunch time. Trainees also commented that staff shortages and ward pressures also contribute as at any one time there are only 2 F2s and 2 F1s covering 3 wards. F1 trainees raised no concerns in attending departmental teaching at IRH which takes place over Zoom and includes a few practical sessions. Trainees commented that fortnightly Friday teaching is due to be introduced soon. Mandatory foundation teaching can also be difficult to attend for those based in RAH due to ward pressures, no concerns were raised in attending this when based at IRH. Trainees stated that teaching is not bleep free and although it is recorded, they must catch up with sessions in their own time.

ST Trainees: Trainees reported no formal teaching taking place in RAH. Trainees believe they learn case by case and at daily trauma meetings where they are asked questions about each case. Trainees based in IRH reported on teaching taking place at 8.30 am on a Monday and Friday. Monday sessions are registrar led and Friday sessions are case-based discussions. IRH trainees have no issues attending unless they are on-call. There is no option for those trainees based in RAH to attend sessions at IRH via Microsoft Teams. Regional teaching is provided once a month via Microsoft Teams and is protected; they felt this worked well and request study leave to attend.

2.3 Study Leave (R3.12)

Trainers: Trainers reported that last minute request for study leave are challenging for the department to manage however help is provided to try and accommodate late requests. The process states that trainees should provide a minimum of 6 weeks-notice.

Foundation Trainees: Not asked, no concerns raised in pre-visit questionnaire, not relevant for F1.

ST Trainees: Trainees reported no difficulties 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 that Ms Winter provides supervision in IRH for both F1 trainees. For ST trainees the training programme director (TPD) allocates educational supervisors based on the clinical needs of each trainee. The West region encourages trainees to have multiple clinical supervisors. Trainers stated that all job plans have sufficient time for consultants to fulfil supervision roles. They commented that several job plans are under review due to significant change as a result of the unit merger.

Foundation Trainees: Trainees confirmed having designated educational supervisors, however the experience at each site was different. Some have only met their supervisor once and some interact with supervisors regularly. Most have agreed learning plans for the post in place.

ST Trainees: Trainees in RAH reported meeting their educational supervisor on the first day which included completion of learning objectives for the post. Trainees in IRH are yet to have their initial supervisor meeting and have been in post almost 4 weeks.

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 described robust arrangements for the provision of clinical supervision during the day and out of hours across both sites. There are also clear escalation policies which form part of the induction handbook. Trainers commented that foundation trainees may have felt they have had to work beyond their competence in this block due to rota gaps, increased workload and staffing issues. This has not been an issue in the previous block. Trainers are aware of the situation and agree this needs to be addressed, however they feel these trainees are capable, well supported and would have no concerns in escalating any problems. Trainers also commented that rota gaps have been filled with locum appointments, however as these are international medical graduates (IMGs), they require a period of shadowing and therefore are limited in the help they can provide. Trainers also believe that the spread of trainees across general surgery and trauma and orthopaedics requires review as

both departments manage the same volume of patients however trauma and orthopaedics do so with half of the trainee complement compared to general surgery.

Foundation Trainees: Trainees confirmed being aware of who to contact for clinical supervision during the day and out of hours. F1s stated they would escalate to F2s and then the medical registrar as it is often quicker than trying to contact the surgical registrar or consultant. F2s confirmed they would contact the registrar of the consultant assigned to that patient. Registrars have recently changed over, and it can be difficult to contact them as individual contact numbers have not been updated in the department handbook; therefore, they often use a WhatsApp Group to communicate.

Most felt they work beyond their level of competence regularly due to difficulties in accessing support. Trainees provided the panel with a few working examples of this; one related to a trainee being asked to deliver sensitive and complex information to patients and their families. Trainees often stay late to complete tasks to ensure patient safety is not compromised. Trainees reported that consultants and registrars are rarely on the ward.

They commented that trainers are approachable however only attend ward rounds once a week. When they do so, ward rounds tend to be quick, and each consultant uses a different style. Often there is no documentation of the ward round although some dictate notes. An example was shared where a Foundation trainee was asked to make a note of a ward round when the trainee had not been present with the senior staff member and had not directly seen the patient with them. To support patient reviews the foundation trainees devised a handover and split the ward in half. Due to rota gaps, it was not feasible to see every patient daily, but the handover helped ensure patients were reviewed 2-3 times a week and when rota gaps were covered all patients could be reviewed. Issues regarding ward rounds have been raised just prior to the Deanery Visit with Mr Brett within a pre-deanery welfare meeting.

ST Trainees: Trainees confirmed being aware of who to contact for clinical supervision during the day and out of hours. They do not feel they have to work beyond their level of competence and find senior colleagues approachable.

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

Trainers: Trainers reported no issues in all training grades attending a satisfactory amount of specific learning experiences at IRH. F1 and F2 trainees have good opportunities to undertake quality improvement projects and F2 trainees have enjoyed attending clinics. ST trainees shadow a consultant and therefore have a lot of 1-1 time, however due to Covid-19 elective operative experience has been significantly impacted. Trainers are conscious of this and are assisting where possible to help trainees reach targets. They believe there is a good balance between training and administrative tasks and encourage and support trainees to undertake research and audit.

Foundation Trainees: Trainees reported having no difficulties in achieving learning outcomes for the posts. The best time to do this is when they are on-call as they build relationships with registrars and most are comfortable to sign off assessments. Those based in RAH felt that non-educational tasks are part of their day-to-day duties. F1s work along with F2s and manage half a ward a day which includes making management plans and actioning these. They referred to a ‘black book’ used by nursing staff, in which anything written must be actioned by foundation trainees. Trainees reported that this was intended for non-urgent tasks however it was being increasingly used inappropriately to relay more urgent tasks. This issue was raised with Ms Higgs, Mr Brett and Dr Donaldson and an agreement has been made that this should stop. Those based in IRH commented on a “hospital culture” around some processes, where trainees must use processes which they believe are out of date, inefficient and unsafe, rather than taking more suitable action. An example of this is how they are expected to make referrals.

ST Trainees: Trainees reported having some concerns in achieving minimum operative numbers but commended the efforts made in allocating trainees to additional clinics. Trainees based in IRH stated they had excellent access to clinics however have no access to theatre lists at present.

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

Trainers: Trainers stated that there is no shortage of opportunities for trainees to obtain portfolio assessments. At IRH the interesting cases session on a Friday provides good opportunities to obtain CBDs. Trauma at RAH also provides a lot of opportunities for work-place based assessments. They

commented that the situation has been slightly more challenging for F1s as there have not been a lot of orthopaedic patients on the ward due to boarders.

Foundation Trainees: Trainees reported having good clinical fellows who are happy to complete assessments. Only one trainee in RAH has had an assessment completed by a consultant and no foundation trainees have had assessments completed by T&O consultants in IRH.

ST Trainees: Trainees reported that on-call consultants are happy to help complete assessments. Difficulties were noted in achieving numbers for elective cases

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

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

Foundation/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.

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

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: Trainers reported that 5pm handover and trauma meetings are good opportunities to provide foundation trainees with feedback. As ST trainees shadow consultants and undertake a team-based apprenticeship, feedback is provided continuously.

Foundation Trainees: Trainees reported that they do not always know when ward rounds are taking place, they tend to just happen whenever it is convenient for whoever is leading the round. Trainees do not receive feedback on either site on the clinical decisions they make during the day or out of hours. They report that they often find out about what is happening through notes left in patient records. F2s commented on receiving feedback at the daily trauma ward round however as these are

fast paced, there is little time for them to learn about specific orthopaedic problems and the feedback provided is often not constructive.

ST Trainees: Trainees reported no concerns in attending ward rounds with consultants. They stated that feedback is received frequently during the day and out of hours and is constructive and meaningful.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: Trainers commented that regular meetings are held with trainees at RAH where they are asked to provide feedback on their working experience in the department and take forward any issues for discussion and improvement. Ms Higgs also provides a slot every Tuesday lunchtime should any junior trainees require support or wish to discuss concerns. At IRH, teaching sessions are considered a good mechanism for interaction and taking issues forward for development. There are also formal feedback meetings with managers and rota co-ordinators to proactively find out how trainees are getting on. Trainees can also approach any consultant or raise issues with the chief resident responsible for all surgical specialties who will take issues forward at hospital meetings. There is also a process of feedback within the Intercollegiate Surgical Curriculum Programme (ISCP).

Foundation Trainees: Trainees at RAH reported having one arranged meeting with Ms Higgs and a rota co-ordinator where they were able to feedback on the quality of training in post and raise any concerns. Ms Higgs also offers a session on a Tuesday lunch time should anyone wish to raise concerns. Trainees commented on feeling beaten down, tired about their workload issues and are now just trying to make it through to the end of the block. They do not believe that any concerns they have raised are listened to. Trainees at IRH commented that they could discuss any issues with Ms Winter who they are confident would act upon these.

ST Trainees: Trainees reported they were unaware of what opportunities were available to them to feedback to trainers and the management team on the quality of their training.

2.12 Culture & undermining (R3.3)

Trainers: Trainers stated that they are a supportive group of consultants. Trauma meetings are constructive, educational, and business like due to the volume of patients to be discussed. Trainees are given the opportunity to present at these meetings and are provided with supportive and constructive feedback. Morbidity and Mortality (M&M) meetings have changed recently due to the restructure; these now have a high emphasis on education and are intended to be non-judgemental. There is also a specific section in the trainee handbook regarding bullying and channels to raise issues through their educational supervisor or another senior in the department.

Foundation Trainees: Trainees reported that most of the clinical team are approachable however some commented on witnessing and experiencing behaviours that undermined their confidence, performance and self-esteem. Examples of such behaviour were provided to the panel.

ST Trainees: Trainees reported no concerns regarding bullying and undermining. They stated that it can be slightly more difficult to build relationships with senior colleagues in IRH as there are now more people in the team to get to know. Overall, the support available is very good and consultants are easily approachable.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Trainers reported that the rota accommodates learning opportunities. There are gaps in the foundation rota which are being filled with locum appointments, however as these are IMGs, they require a period of shadowing. Due to these gaps, they are aware that there are aspects of the post that are compromising trainee wellbeing.

Foundation Trainees: Trainees at RAH reported 4 gaps in their 10-person rota. Gaps are on occasion filled by locums or by bringing in the on-call foundation trainees to cover during the day. There have been recent appointments of clinical fellows to help cover gaps, however these are IMGs and have not been provided with sufficient induction to the NHS. They also do not have all relevant logins and have no experience in using most of the clinical systems. Although they are part of the rota, which gives the impression they are contributing to the level of their peers, they are there in a shadowing capacity and as such require additional support and assistance which is being provided by

the foundation trainees. The foundation trainees commented that there are several aspects of the rota that compromise their wellbeing; in particular pressures from gaps are worse during 8.30am – 4.30pm and they often must stay late to complete tasks. They commented on feeling mentally exhausted having to teach people to do their job and they feel the stress of being the most responsible person on the ward. IRH have an ongoing F1 gap which has been filled by a surgical F1; they have also had weekends with no F2 cover, this has however recently been filled. They commented that long days are an area of concern as they also cover the surgical on-call rota.

ST Trainees: Trainees confirmed there are no rota gaps for them at either site. They do not believe the rota is designed for the purpose of training; however, they are given enough theatre and clinic time. They are aware of rota organisers however it can be difficult to make any changes especially as the RAH rota is complex. They do not believe any aspect of the rota compromises trainee wellbeing.

2.14 Handover (R1.14)

Trainers: Trainers commented that the morning trauma meeting provides safe continuity of care for new admissions and downstream wards and also provides a good platform for learning. They stated that the introduction of TRAKCARE will help address issues relating to hospital at night (H@N) handover to the day team.

Foundation Trainees: Trainees commented that handover in both sites could be improved as there is no agreed structure. The day shift is 8am-4pm and there is a morning trauma meeting to set up jobs for those going to theatre. By 4.30pm, most junior doctors leave the wards and the on-call team take over. There is also an information handover at 8.30pm with the night F2. No written handover records are kept. The weekend handovers are felt to be unsafe as the trainees are unsure about the structure for them. The ‘black book’ and the ongoing work to stop this was referenced again here. Foundation trainees also commented that there is no handover for patients who come from the trauma admissions unit to the ward. Trainees from IRH stated that there is an agreed time to handover in the evening. F1s have also created a handover sheet to ensure colleagues have all the relevant information required. Handover arrangements do not provide safe continuity of care and often trainees must stay late.

ST Trainees: Trainees commented that handover is structured and takes place at the same times every day and the introduction of Microsoft Teams makes it easily accessible to all. They commented on easily accessible information being available on the “Bluespier” trauma programme which ensures safe handover arrangements of new admissions and patients in downstream wards. The downside to the system is if it hasn’t been updated then it is possible a new admission could be missed. They consider the trauma meeting to provide good learning opportunities.

2.15 Educational Resources (R1.19)

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

Foundation/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 due to time constraints.

Foundation Trainees: Trainees stated that as a collective group the foundation trainees have bonded well and provided ongoing support to each other. In the last 10 days there has been good welfare support offered out with the department at RAH by Dr Donaldson and Mr Brett in preparation for the deanery visit. They stated that their foundation programme director (FPD) also checks in with them once a month.

ST Trainees: Trainees stated that support is available from educational supervisors or TPD should they be struggling with any aspect of the job or their health. They are aware of the systems to use and who to contact and would not hesitate to escalate if they felt this necessary.

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.

Foundation Trainees: Trainees commented on the pre-deanery visit meeting during which they were able to raise concerns with the DME team. They commented that the RAH team have set up a “saw

school” which has been well received. Trainees from IRH commented on a similar meeting and had no major concerns to raise. There is a plaster session planned for them.

ST Trainees: Trainees reported that they can raise concerns regarding the quality of training with clinical and educational supervisors and the West of Scotland trainee rep.

2.18 Raising concerns (R1.1, 2.7)

Trainers: Trainers described a patient safety issue raised regarding a locum which was escalated using the agreed pathway, which is considered to have worked well in practice. Trainees are aware of and encouraged to use the escalation policy when and if required.

Foundation Trainees: Trainees at RAH commented on being able to raise concerns with Ms Higgs. They understood the F1 role to be heavily supervised as they are new and learning however in reality, they are managing half a ward which entails reviewing patients, making decisions, starting treatments and changing prescriptions with minimal day to day oversight. There are noted difficulties with the rota which have not helped their experience. The process to rectify issues raised is slow and could lead to patient safety issues. Trainees often go home worrying that something has been missed. Trainees from IRH commented on a particularly bad experience involving a locum, this was raised and acted upon swiftly.

ST Trainees: Trainees stated that they would raise any patient safety concerns with their clinical supervisor or escalate through the system.

2.19 Patient safety (R1.2)

Trainers: Trainers reported no concerns regarding the safety of boarded patients in the hospitals. They described a hospital wide escalation policy based on NEWS scores with stickers placed in patient records with a clear outline on what trainees are required to do. There are regular ward huddles which are described as valuable and helpful add on to ward round for ensuring patient safety. Huddles include ECON, ANP, trainees and consultants.

Foundation Trainees: Trainees reported that they would not be comfortable if a friend or family member was to be admitted to the ward. They stated that the technical aspects would be done well and that all staff do their absolute best for patients, but given the workload they have, they would have concerns about all aspects of care beyond any immediately necessary issues would be missed.

ST Trainees: Trainees stated they would be comfortable if a friend of family member were admitted to the ward. They stated that safety huddles are held on the ward by nursing staff and the trauma liaison team liaise with the emergency medicine department.

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

Trainers: Trainers reported that there is a sector wide governance structure in place that reviews adverse events which are reviewed pan-specialty. The M&M meetings also objectively review cases, extract learning points and provide feedback. Trainers stated that should something go wrong with a patient's care, a trainee would not be expected to deal with this alone; a consultant would take the lead, discuss the case, provide a debrief and ask the trainee to complete a reflection and the case would be put forward to the next M&M meeting.

Foundation Trainees: Trainees commented on being aware of the datix system for reporting adverse incidents.

ST Trainees: Trainees commented on being aware of the datix system for reporting adverse incidents and quarterly M&M meetings being held.

2.21 Other

Overall Satisfaction Scores:
F1 – 3.75/10.
F2 – 2/10.
ST – 8/10.

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 note the considerable effort to improve induction. The panel noted a good training environment for specialty trainees however this is again in contrast to the poor experience reported on by the foundation trainees. The key areas for improvement noted at the visit relate to induction, supervision, teaching, feedback, support, rota and handover. An action plan review meeting will 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:

- Strong engagement from GG&C Medical Education team, Trainers, and site management teams in supporting the visit
- Good relationships and support between F1 and F2 trainees across both sites.
- ST trainees feel well supported and enjoy their time within the training programme. They report high levels of overall satisfaction within the post.
- ST trainees reported no difficulties in attending teaching.
- ST trainees commented on a robust, clear, and well supported escalation policy.
- The daily Trauma Meeting was highlighted as a learning opportunity for all trainees.
- Improvements to induction made since the last visit are recognised, but continued development of induction is encouraged.
- Enthusiastic and motivated Foundation trainer group on both sites, who appear keen to implement change.
- Foundation trainees commended Ms Higgs for the Tuesday afternoon pastoral support meetings she holds in RAH and the support received from Ms Winter in IRH.
- All consultants appear to have suitable time within their job plans for their role in training. This should allow adequate time for supporting junior trainees in achieving WPBAs.
- All trainees confirmed having designated educational and clinical supervisors; the majority have had an initial meeting and have set learning objectives for the post.
- ST trainees reported access to additional clinics which has been well received.

- Trainees reported a robust system for the handover of trauma patients from admission.

Serious Concerns: immediate action required:

- Wellbeing of Foundation trainees. The panel was struck by the extent of anxiety, stress, exhaustion and isolation expressed by Foundation trainees around their roles in caring for ward patients.
- Foundation trainees reported that ward rounds are often adhoc and occur unannounced; on occasions they happen quickly, without relaying outcomes to Foundation doctors or formal records being made in the patient's notes. This represents a clinical governance and safety risk.
- WhatsApp is being used as a handover mechanism. Although patient names are not disclosed, patient initials and bed numbers are the main means of identification; this represents a risk to patient safety.
- An incident of bullying behaviour was reported which left trainees feeling under-valued. The alleged details appear to indicate existence of a blame culture within the department Details of this incident have been shared with Dr Donaldson and Dr Harrow by email following the visit.
- Perceptions around the roles of the Foundation trainees within the department, which are damaging to a cohesive culture. The panel heard a reference made by ST trainees which described Foundation trainees in derogatory manner.

Less positive aspects of the visit:

- There is a lack of consultant engagement in completing mandatory assessment requirements for Foundation trainees. This activity is more often undertaken by a fixed term Clinical Fellow.
- Ways to deliver departmental teaching and facilitate attendance for Foundation trainees should be investigated. Only 1 trainee had reported attendance at this event.
- None of the Foundation trainees interviewed had attended mandatory teaching since starting this post.
- There should be no expectation for trainees to catch up on recorded mandatory teaching in their own time.
- The panel were pleased to note improvements in induction including the development of a unit Handbook; however, roles, responsibilities and "how things are done" for Foundation trainees needs to be updated to reflect the changed patient pathways since the unit merger

- A more consistent approach to induction for those Foundation trainees rotating to IRH for on-call is required.
- A clear contact list of consultants and the related ST trainee should be made readily available to Foundation trainees at both sites. This should be updated at times of changeover and redistributed.
- Handovers are not used as a learning opportunity, aside from the daily Trauma Meeting
- The process for weekend handover is not clear to junior trainees, who raise concerns about consequences for patient safety with the current arrangements.
- There are limited opportunities for Foundation trainees to receive feedback on patient management because of very little contact with their consultants and ST trainees.
- Foundation trainees welcome the appointment of clinical fellows who have been employed to support gaps on the rota; however, these doctors are undertaking a period of shadowing and some are also awaiting logins to clinical systems. This has caused additional stress and workload to Foundation trainees who are providing mentorship to the new appointees in addition to doing their own work.
- Foundation trainees reported being asked to deliver sensitive and complex information to patients and their families unsupported
- Foundation trainees gave low overall satisfaction scores to this post and would not recommend it to their peers

Requirements from previous visit (T&O, RAH - 21/01/2020)

Progress against previous requirements recorded as ‘addressed’, ‘significant’, ‘some progress’, ‘little or no progress’.

Ref	Issue	Progress noted – October 2020	Progress – March 2022
7.1	All Consultants who are trainers must have time within their job plans for their roles to meet GMC Recognition of Trainers requirements.	All consultants who are trainers in the department have time in their job plans for both educational and clinical supervision.	Addressed
7.2	Trainees must have an allocated educational supervisor throughout their post.	Following review by the Clinical Director all trainees have an educational supervisor allocated for the entirety of their post.	Addressed
7.3	Educational supervisors must understand curriculum and portfolio requirements for their trainee group. Initial meetings and development of learning agreements must occur within a month in post.	All trainers have attended a recent focused Recognition of Trainers Workshop delivered to their department by the Directorate of Medical Education. This included understanding curriculum and portfolio requirements and the role of WPBA including educational induction and the need for learning agreements. Within this group of trainers they also have 2 representatives of the specialty training committee who help communicated educational and curricula changes from the STC to the wider consultant group.	Addressed

7.4	FY1 trainees in surgical specialties must have opportunities to assess acutely unwell patients during ward rounds and to receive constructive feedback on their contributions to add learning to their experience.	Foundation Doctors in Trauma and Orthopaedics in the RAH are ward based with a structure of F2, Clinical Fellow, ST and Consultant above them. Any acutely unwell patients are assessed as a team and escalated as required. The team is also supported by Advanced Nurse Practioners and Elderly Care Orthopaedic Nurses. Any acutely unwell patients from out of hours are identified at the morning Trauma meeting and their case is discussed with the entire team.	No progress – Carried forward (see 6.7)
7.5	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.	A new lead Foundation Trainer has been appointed by the clinical team and she is currently working on the induction material for the trainees. Included within this will be a plan to ensure bleep free teaching – the plan is that pagers will be handed up to the trainee level above them. The on-call page is now being carried by the clinical fellow or registrar on call.	No progress – Carried forward (see 6.4)
7.6	Lack of access to clinics for F2 trainees must be addressed to improve the training opportunities for these cohorts.	A weekly clinic rota is put up on the wall in the trauma room to allow all doctors to timetable themselves to clinics. Going forward the team also plan to email this out on a weekly basis to re-enforce the availability of this teaching opportunity. A generic timetable will also be added to the	Addressed Although it is desirable for F2 trainees to experience clinics it is not a requirement of the Foundation curriculum

		induction material - *Copy of Rota in evidence folder	
7.7	All handovers within Trauma & Orthopaedics must be more structured and more robust with written or electronic documentation.	All handovers in T&O are now structured and placed in the "Bluespeir" electronic handover system. This is supported by handover whiteboards on the trauma room wall. Dictated consultant ward round note also contain handover information which are uploaded to clinical portal.	No progress – Carried forward
7.8	The morning and/or evening handover must be scheduled within the rostered hours of work of the trainees.	The new educational lead is currently working with the rota manager to agree rota changes to allow the new hours of work to match the new trauma meeting times. This will require compensatory rest which will be factored in - *Copy of Rota in evidence folder	No progress – Carried forward
7.9	All references to "SHOs" must cease.	The trainers recently undertook specific and individualised ROT session with the ADME in Clyde the reasoning behind the term SHO disappearing from our vocab was discussed the trainers agreed that the term would be discontinued in all future documentation going forward. Medical Education are working with Facilities and wider board to eradicate this term from being printed on badges – although this	Addressed

		may be a specific issue with Locum staff.	
7.10	The level of competence of trainees must be evident to those that they come in contact with. Raise awareness and promotion of colour coded badges.	As described, the Clyde Sector of NHSGGC has an embedded colour coded ID badge project which supports the identification of an individual trainees level of training and guides the staff to their level of competence. In addition, all new F1 doctors are issued with red scrubs which has helped identify them easily on the ward. The Medical Education team in Clyde have produced 2 infographic pop up posters to help raise the awareness and promote the colour coded badges. However due to current infection control restrictions the use of these has been curtailed	Not asked at visit
7.11	There must be a process that ensures trainees understand, and are able to articulate, arrangements regarding Educational Governance at both site and board level.	The Directorate of Medical Education reports to the Board staff governance twice a year. We utilise the organisational online induction distributed to all trainees to highlight this process to them. share.dynamicbusiness.co.uk/2020/NHS_GGC/Ggc-Trainee-V5-Subs_HB.mp4 We have recently reinforced this with the distribution of an educational governance spotlight email. This included a word document explaining	Addressed

		the structures and who's who – Copy of document in evidence folder	
7.12	Trainees must receive adequate induction to all sites they cover out-of-hours to allow them to begin out-of-hours working safely and confidently.	With support from their respective CDs, all educational leads who support HAN doctors in training are developing a group induction to ensure they understand all specialities they may be covering. A new F1 handbook has also been produced to support induction to out-of-hours working across the site.	Some progress – Carried forward see 6.2
7.13	A process must be put in place to ensure that any trainee who misses their induction session is identified and provided with an induction.	The new educational lead along with two other trainers (one from IRH) are working on a new electronic document to support induction. They ultimately hope to be able to put this in to an electronic app to support the doctors during the planned trauma redesign in Clyde.	Some progress – Carried forward
7.14	Educators must be trained and calibrated in the assessments they are required to conduct.	All T&O trainers across Clyde attended a focused Recognition of Trainers Workshop in November that supported them in the use of commonly used WPBA.	Addressed

Requirements from previous visit (T&O, IRH - 28/01/2020)

Ref	Issue	Progress noted – October 2020	Progress – March 2022
7.1	All Consultants who are trainers must have time within their job plans for their roles to meet GMC Recognition of Trainers requirements.	All consultants who are trainers in the department have time in their job plans for both educational and clinical supervision.	Addressed
7.2	Trainees must have an allocated educational supervisor throughout their post.	Following review by the Clinical Director all trainees have an educational supervisor allocated for the entirety of their post.	Addressed
7.3	Educational supervisors must understand curriculum and portfolio requirements for their trainee group. Initial meetings and development of learning agreements must occur within a month in post.	All trainers have attended a recent focused Recognition of Trainers Workshop delivered to their department by the Directorate of Medical Education. This included understanding curriculum and portfolio requirements and the role of WPBA including educational induction and the need for learning agreements. Within this group of trainers they also have 2 representatives of the specialty training committee who help communicated educational and curricula changes from the STC to the wider consultant group.	Addressed
7.4	FY1 trainees in surgical specialties must have opportunities to assess acutely unwell patients during ward	Foundation Doctors in Trauma and Orthopaedics in the RAH are ward based with a structure of F2, Clinical Fellow, ST and Consultant above	Addressed

	rounds and to receive constructive feedback on their contributions to add learning to their experience.	them. Any acutely unwell patients are assessed as a team and escalated as required. The team is also supported by Advanced Nurse Practioners and Elderly Care Orthopaedic Nurses. Any acutely unwell patients from out of hours are identified at the morning Trauma meeting and their case is discussed with the entire team.	
7.5	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.	A new lead Foundation Trainer has been appointed by the clinical team and she is currently working on the induction material for the trainees. Included within this will be a plan to ensure bleep free teaching – the plan is that pagers will be handed up to the trainee level above them. The on-call page is now being carried by the clinical fellow or registrar on call.	Addressed
7.6	Lack of access to clinics for F2 trainees must be addressed to improve the training opportunities for these cohorts.	A weekly clinic rota is put up on the wall in the trauma room to allow all doctors to timetable themselves to clinics. Going forward the team also plan to email this out on a weekly basis to re-enforce the availability of this teaching opportunity. A generic timetable will also be added to the induction material - *Copy of Rota in evidence folder	Addressed
7.7	All handovers within Trauma & Orthopaedics must be more	All handovers in T&O are now structured and placed in the	No progress

	structured and more robust with written or electronic documentation.	“Bluespeir” electronic handover system. This is supported by handover whiteboards on the trauma room wall. Dictated consultant ward round note also contain handover information which are uploaded to clinical portal.	

4. Areas of Good Practice

Ref	Item	Action
4.1	ST trainees commented on a robust, clear, and well supported escalation policy.	
4.2	The daily Trauma Meeting was highlighted as a learning opportunity for all trainees.	
4.3	Foundation trainees commended Ms Higgs for the Tuesday afternoon pastoral support meetings she holds in RAH and the support received from Ms Winter in IRH.	
4.4	Trainees reported a robust system for the handover of trauma patients from admission.	

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	The panel were pleased to note improvements in induction including the development of a unit Handbook; however, roles, responsibilities and “how things are done” for Foundation trainees needs to be updated to reflect the changed patient pathways since the unit merger	
5.2	Foundation trainees welcome the appointment of clinical fellows who have been employed to support gaps on the rota; however, these doctors are undertaking a period of shadowing and some are	

	also awaiting logins to clinical systems. This has caused additional stress to Foundation trainees who are providing mentorship to the new appointees in addition to doing their own work.	
5.3	Foundation trainees referred to a 'black book' used by nursing staff, in which anything written must be actioned by foundation trainees. Trainees reported that this was intended for non-urgent tasks however it was being increasingly used inappropriately to relay more urgent tasks. This issue was raised with Ms Higgs, Dr Brett and Dr Donaldson and an agreement has been made that this should stop.	

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	The unit handbook must be kept up to date to reflect changes to departmental processes.	5th December 2022	All
6.2	Trainees must receive adequate induction to all sites they cover out-of-hours to allow them to begin out-of-hours working safely and confidently.	3rd August 2022	Foundation
6.3	Initial meetings and development of learning agreements must occur within a month of starting in post.	7th September 2022	All
6.4	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. Trainees should not be expected to complete this teaching in their own time.	5th December 2022	Foundation

6.5	The learning environment for Foundation trainees must be supportive and inclusive.	5th December 2022	Foundation
6.6	There must be senior support, including from consultants/recognised trainers to enable doctors in training to complete sufficient WPBAs/SLEs to satisfy the needs of their curriculum	5th December 2022	Foundation
6.7	There must be regular Consultant ward rounds which review trainee decisions and care plans and offer constructive feedback & teaching.	5th December 2022	Foundation
6.8	Foundation trainees must not be expected to work beyond their competence by delivering sensitive and complex information to patients and their families unsupported.	5th December 2022	Foundation
6.9	All staff must behave with respect towards each other and conduct themselves in a manner befitting Good Medical Practice guidelines. Specific example of undermining behaviour noted during the visit will be shared out with this report.	Immediate	Foundation
6.10	Handovers involving Foundation trainees must include senior input to ensure patient safety and learning opportunities.	5th December 2022	Foundation
6.11	Handover processes must be improved to ensure there is a safe, secure and 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 during the day and out of hours.	5th December 2022	Foundation
6.12	Measures must be implemented to address the patient safety concerns associated with ad-hoc ward rounds and the clinical governance issues raised by inadequate record keeping.	Immediate	Foundation
6.13	Ref: Page 20, Item 7.7 Carried forward – T&O RAH 21/01/2020	5th December 2022	All

	All handovers within Trauma & Orthopaedics must be more structured and more robust with written or electronic documentation.		
6.14	Ref: Page 20, Item 7.8 Carried forward – T&O RAH 21/01/2020 The morning and/or evening handover must be scheduled within the rostered hours of work of the trainees.	5th December 2022	All
6.15	Ref: Page 22, Item 7.13 Carried forward – T&O RAH 21/01/2020 A process must be put in place to ensure that any trainee who misses their induction session is identified and provided with an induction.	5th December 2022	All
6.16	Ref: Page 22, Item 7.7 Carried forward – T&O IRH 28/01/2020 All handovers within Trauma & Orthopaedics must be more structured and more robust with written or electronic documentation.	5th December 2022	All