Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	8th June 2022	**Level(s)**	FY, IMT & ST
Type of visit	Triggered	**Hospital**	Aberdeen Royal Infirmary
Specialty(s)	Cardiology	**Board**	NHS Grampian

Visit panel	
Dr Geraldine Brennan	Visit Chair – Associate Postgraduate Dean Quality
Dr Ruth Isherwood	Training Programme Director
Dr Surinder Panpher	Foundation Programme Director
Mrs Natalie Bain	Quality Improvement Manager
Dr Sarah Milliken	Trainee Associate
Ms Vivienne Hart	Lay Representative
In attendance	
Mrs Gaynor Macfarlane	Quality Improvement Administrator

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	6	
Trainees in attendance	4 FY1, 2 FY2, 2 IMT & 5 ST	

Feedback session: Managers in attendance	Chief Executive		DME	X	ADME		Medical Director		Other	

Date report approved by Lead Visitor	12th July 2022

1. Principal issues arising from pre-visit review:

The Foundation Quality team at Deanery has triggered a visit in view of survey data relating to the Cardiology department at Aberdeen Royal Infirmary, NHS Grampian. The visit team plan to investigate the aggregated red flags at FY2 level in the 2021 GMC National Training Survey for facilities, induction, overall satisfaction, and rota design, as well as pink flags for feedback. The 2021 Scottish Training Survey results showed a red flag for clinical supervision at Foundation level along with a further red flag for teaching at Foundation level.

The visit team will also use the opportunity to gain a broader picture of how training is carried out within the department and to identify any points of good practice for sharing more widely.

At the pre-visit teleconference the panel decided that the areas of focus for the visit were rota design, induction, and clinical supervision.

A summary of the discussions has been compiled under the headings in section 2 below. This report is compiled with direct reference to the GMC's Promoting Excellence - Standards for Medical Education and Training. Each section heading below includes numeric reference to specific requirements listed within the standards.

2.1 Induction (R1.13):

Trainers: The trainers reported that feedback has been sought in recent years about induction. This has been taken on board and changes were implemented. The trainers note than an induction handbook is distributed via email prior to the trainees beginning in post, if the department is aware of who is beginning in post. The trainees also get a guided tour of the department with the trainers and nurses. The trainers note that those trainees who are not in the department on the first day will be provided with a catch-up session. The trainers emphasised that the pandemic has influenced how induction was delivered, however they are looking to obtain feedback once more for any improvements.

FY1 Trainees: All trainees reported receiving an online induction to site due to COVID. All trainees received their IT passwords with no issues highlighted. The trainees reported that they received a walk around the department during induction. A trainee noted that they were not on shift during

induction and there was no follow-up from this. The trainee stated that they would have benefitted from having more information from induction. The trainees were given a PDF handbook prior to beginning in post and the roles and responsibilities for the department were clear. The trainees were directed to a board in the department where policies were located and were guided towards the information provided on the intranet for clinical protocols.

FY2/IMT Trainees: Trainees reported that they all received a hospital induction and the department induction was incorporated into the handover in the morning. The trainees received an email with induction material ahead of beginning in post. A trainee noted that they did not attend induction due to changeover in shifts, therefore didn't feel that they received a suitable induction and reported that this was not followed up on. There was HAN induction that covered areas of relevance. There was a walk around the department with the senior nurse and the consultant. There wasn't really an induction on CCU and the trainees felt they would have benefitted tremendously if there was a detailed induction here. There was an issue with the FY2/IMT induction document as it did not contain up to date information relating to curricular changes. The trainees were directed to policy and protocol information in folders in the department but these were found to be bulky and difficult to read. It was suggested that a quick reference guide would be useful to have. The department has asked for feedback on the induction provided, but trainees have yet to respond.

ST Trainees: The trainees reporting receiving induction to site and department when beginning in post. The trainees felt that induction was well co-ordinated and roles and responsibilities were clearly outlined.

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

Trainers: The trainers reported that there are different levels of teaching available to trainees. The department holds MDT meetings every day at 8.30am to which all trainees are invited to attend. There is departmental teaching on Friday afternoons that has a consultant or registrar present. There is also junior led teaching on a Wednesday afternoon. Monthly Morbidity & Mortality (M&M) meetings are held and all trainees are welcome to attend. The trainers note that the Wednesday lunchtime teaching is specific to FYs and it is well attended; this is supported by the Advanced Nurse Practitioners (ANPs) and Physician Associates (PAs) who allow the trainees to attend. The trainers stated that the consultants are happy to support the trainees to attend teaching but as their rota is

managed by a separate team, there are times when the rota does not support the trainees attending some teaching events. It was emphasised that the rota does not have sufficient staff to absorb swaps and there can be limited response from the rota management team resulting in no support for the trainees. It was highlighted by the trainers that there have been no issues raised by the IMT/FY trainees about attending teaching; the trainee's portfolios have been reflecting that they are managing to attend. The trainers report that the ST trainees are on the Cardiology rota, therefore there is more flexibility with their rota for them to attend their mandatory teaching.

FY1 Trainees: The trainees reported that there is usually an hour of teaching each Wednesday and Friday. There have been times when there has been a shortage of consultant or registrars to provide the teaching as was the case for the first few weeks in post. However, when the teaching is available, it is excellent. It was suggested that these teaching sessions could be improved if they were recorded so that they are available to any trainees that may be on leave. Trainees felt it would have been useful to have more teaching at the beginning of their block. The trainees reported that they are unable to attend their formal Deanery teaching (Thursday) regularly; trainees reported attending 1-3 of these sessions over the first 2 months of post. The main barriers are service demands and not having enough staff to hand ward tasks to; if they attend teaching then this can impact on their ability to leave on time at the end of the day. None of the teaching available is bleep free. There are ANPs in the department but they are reluctant to carry a phone for the trainees to allow "bleep free" attendance. The trainees have also been advised to eat during their teaching time as their lunch break is scheduled whilst at teaching. Trainees were aware they could ask their seniors for help with holding phones but feel guilty about doing so. The trainees report that they can watch the recorded Deanery sessions in their own time when they have not been able to attend in person on the day.

FY2/IMT Trainees: Trainees report that they aim to attend 1 hour per week of teaching that is held on a Wednesday. There is also a monthly M&M meeting and an educational meeting on a Friday for an hour. Trainees comment that is not always easy to attend teaching due to clinical commitments and workload so they have attended a very limited amount of teaching. They reported that teaching is not bleep-free but commented that their phones were being held by someone else to allow them to attend this Deanery Quality meeting. The trainees note that the teaching they manage to attend is fantastic, but most have only been able to attend one teaching session since starting in post.

ST Trainees: The trainees report that there are several channels available to access teaching, with plenty of informal teaching opportunities with the consultants. There is an official North of Scotland teaching programme that runs monthly and cardiology specific teaching is delivered through the Scottish Cardiac Society that follows their curriculum. There is weekly departmental teaching and they also have morning MDT meetings to discuss PCI cases. There has also been a journal club, but with COVID and service pressures, this has not been as well organised lately. The trainees stated that most teaching is virtual and easy to access and attend. Trainees are supported to attend local meetings and most have achieved around 80% of the formal teaching that is required.

2.3 Study Leave (R3.12)

Trainers: The trainers report that inflexibility of trainee rotas combined with a limited number of trainees and high workload associated with ward patients and boarders impacts on their ability to approve study leave. The trainers report that the department is honest with the trainees about not always being able to facilitate their requests, due to the service demands. The department is aware that this may be different to other areas of the hospital where these requests may be more easily accommodated.

F1 Trainees: Not relevant

FY2/IMT Trainees: The FY2 trainees reported that they were told they would be unable to organise a taster session during their Cardiology rotation. The IMT trainees have found it difficult to have study leave approved.

ST Trainees: Trainees report no concerns in requesting or taking study leave.

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

Trainers: The trainers reported a variable amount of time allocated in their job plans for formal supervision duties and some were uncertain about their exact personal allocation. A trainer reported submitting a Freedom of Information request to detail the extent of Programmed Activities (PAs) within the Cardiology consultants job plans. This was intended to demonstrate to the board that the department carries a significant clinical burden which impacts on their availability to provide

supervision to doctors in training. Some trainers reported that the department is adequately set up to provide teaching and training. Trainees are encouraged to seek exposure to procedures and clinical opportunities available, however service pressure can compromise a trainer's ability to teach trainees appropriately.

All Trainees: All trainees reported meeting with their educational supervisor and agreeing a personal learning plan in this post.

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: The trainers reported that there are very clear escalation pathways for trainees to follow. The department is split into two teams. Team A is the receiving team that contains a dedicated consultant and registrar with a PA and middle grade trainees. Team B works with an FY1, junior grade trainee (FY2/IMT) and a dedicated registrar on the ward. There is a clear escalation policy detailed to trainees at induction; the trainees are aware of who is their on-call consultant and registrar and this information is also available around the department. The trainers adopted this team-based approach following a previous Deanery visit and believe this approach has had a positive effect on workload as the trainees follow patients from admission to discharge. The trainers noted however that this system would be greatly improved if they had a further middle grade trainee as sometimes there is a gap on Team B. The trainers report that they have not heard of any trainees needing to work beyond their competency, the trainers have a visible presence on the ward and encourage the trainees to report any issues they may have.

FY1 Trainees: The trainees report knowing who to contact both during the day and OOH for clinical supervision, but also report coping with problems beyond their experience and competence, particularly when reviewing patients in the boarding wards as the registrar is not always available for advice. The trainees highlight that at times there may only be an FY1 available to cover the boarding wards, although they can run any queries past a senior colleague when available. FY1 trainees stated that the boarding wards would benefit from having more senior input as it is not always clear which registrar is covering the wards. The trainees feel that this situation can leave them feeling quite exposed. The trainees highlighted that the senior colleagues are approachable.

FY2/IMT Trainees: Trainees report that there is a registrar on-call 24-7 for Cardiology specifically, however they do not answer calls regarding patients who are stable or ready for discharge. There is usually a registrar nominated to cover the ward but it is not always easy out find out who that person is, although lately there has been an ST3 available on the ward which has been very helpful. There is no designated phone for the registrar providing cover and this can result in delays accessing advice for managing patients. It was noted that the trainees can also find it difficult to locate a consultant. Trainees report that they don't routinely take on jobs out with their competence but occasionally this happens. In these situations, the nursing staff on the Cardiology ward or CCU are usually very helpful and supportive. The trainees note that whilst working OOH, there have been occasions where the trainees have found it uncomfortable to call the on-call consultants. It was highlighted that on the Cardiology ward and boarding wards, the junior middle grade trainees can sometimes be the most senior colleague available for FY1s and this leaves them feeling exposed. Trainees commented that most trainers are approachable when they can be reached but some are hard to access and they sometimes need to hunt them down; this is a particular issue when managing boarding patients. The trainees also noted that there are some trainers that they would hesitate to approach for advice, as they believe these seniors would think they should have been able to cope. They also commented that occasionally when trainees have had to take more initiative, they have received feedback retrospectively that has been negative.

ST Trainees: The trainees reported that they are aware of who is providing clinical supervision for them. It is easy to see who to contact both during the day and OOH. The trainees do not work beyond their competence and the senior colleagues are approachable and accessible.

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

Trainers: The trainers report that they encourage trainees to attend clinics and the cath lab to gain exposure in these areas. The only barrier to being able to attend clinics occurs during their on-call week. With the team-based approach, the trainees have ward rounds and review patients they have admitted in the previous week. IMT trainees have specific specialty days to attend and encouraged to attend echo lists and shadow the registrars when they are doing referrals in the hospital.

FY1 Trainees: The trainees report that their placement is long enough to build relationships with the trainers. The trainees report that the amount of time spent carrying out duties that are of little benefit to their education depends on which ward they are allocated to. The boarding wards are busy and there is pressure from the nursing staff to free up bed space, however this has recently improved with having more junior trainees allocated to the ward. The trainees believe that there are good learning opportunities available and good exposure to procedures.

FY2/IMT Trainees: Trainees report that their placements are long enough to allow trainers to get to know them and judge their performance, however some trainers interact more and know the trainees better than others. CCU shifts provide very good learning opportunities and there is a very experienced PA based on CCU to support them, however a lot of trainee's time is spent covering boarding patients (>50%). Many trainees find this activity to be less beneficial to them as there is not as much opportunity to have feedback provided and so this feels more like service provision than training. The trainees explained that the situation has improved since extra ward staff have been deployed on the boarding wards which has helped to reduce their workload significantly. This has included addition of a phlebotomist and others to help with the ward tasks. The trainees comment that this has allowed them more time to access learning opportunities.

ST Trainees: The trainees report that many of them have been in post for several years, therefore know the consultant and nursing teams very well. The trainees state they spend around 15% of their time doing tasks that are of little benefit to their education. However, this is dependent on workload and COVID pressures. There is pressure felt when there are gaps in the rota, but consultants will contribute when there are gaps. The trainees highlight that they have plenty of learning opportunities whilst on-call.

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

Trainers: Not formally asked

FY1 Trainees: The trainees all report that they have plenty of opportunity to have assessments completed and signed off.

FY2/IMT Trainees: Trainees report that ACATs in the IMT curriculum are difficult to achieve as it is impossible to arrange a discussion at morning handover to do so. They report that other requirements are relatively easy to access but noted that some trainers don't respond to requests to complete tickets for WPBAs.

ST Trainees: Trainees report that the availability of certain competencies depends on luck and opportunities arising at the correct stage of training. The trainees emphasised that there are plenty of opportunities available in the department for more routine competencies. It was noted that it can be difficult to obtain certain competencies for IMT Dual accreditation, however it was stated that a trainee representative at the TPD meeting confirmed that a change in the portfolio would be implemented by August 2022 which would help this.

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

Trainers: Not asked

Trainees: Not asked

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

Trainers: Not asked

Trainees: Not asked

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: The trainers reported that whilst a trainee is on Team A, they attend ward rounds and can receive feedback during this time. The trainers noted that feedback provided can be more challenging if trainees have made poor decisions and no feedback is possible if the trainees have left before ward rounds happen after an on-call shift. The trainers state that trainees are given feedback during their mid-block meeting but note that feedback is variable and perhaps could be done better. Trainees are also offered an opportunity to have a review done by a Consultant of ECG interpretation during their block, but there is limited uptake for this.

FY1 Trainees: The trainees report receiving feedback during time working on Cardiology ward as there is a debrief following ward rounds. The trainees noted that there is little feedback given whilst allocated to the boarding wards.

FY2/IMT Trainees: The trainees report that feedback can be variable depending on the workload and how busy the registrars or consultants are that day. The trainees state that there is no feedback given when on boarding wards, but there is feedback given when on CCU. All trainees agreed that the feedback was positive when it is given.

ST Trainees: The trainees reported receiving feedback which is constructive and meaningful.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: Not formally asked

FY1 Trainees: The trainees reported giving feedback to their supervisor prior to end of block sign off, as well as feeding back through the Scottish Trainee and National Training surveys.

FY2/IMT Trainees: The trainees reported that there have been no opportunities to provide feedback, and the Deanery visit is their first opportunity. The trainees were not aware of any local trainee forums to feedback.

ST Trainees: The trainees report that they have a good relationship with the team and therefore feel comfortable raising any concerns about the training being delivered. The trainees state they would also raise any concerns with their TPD individually or at the formal group meeting with the TPD.

2.12 Culture & undermining (R3.3)

Trainers: The trainers report that steps were taken previously to implement a team-based working and the trainers believe it has had a positive effect on the trainees. The trainers note that they ask for feedback from colleagues and update the trainees with this information and thank them for their contributions. The trainers hope that the trainees feel valued during their time in the department. The

trainers state they are happy to be approached by juniors and they have an open-door policy. It is emphasised at induction that any issues should be highlighted and escalated appropriately and those behaviours will not be tolerated.

FY1 Trainees: The trainees report that the department is supportive and the trainers have created a supportive environment. The trainees state that their supervisors and the nursing team are all very approachable and they have not witnessed or experienced any undermining behaviour.

FY2/IMT Trainees: The trainees reported that they had witnessed undermining/bullying behaviour from a member of the consultant team during a ward round. The consultant had reacted poorly to information provided which had made the team feel uncomfortable. The trainees noted that they would raise any concerns via their educational supervisor as they are very approachable and supportive, however they had not done so on this occasion. Further details of this incident have been shared confidentially, however full details of these could not be shared with the Board as the trainee involved did not wish to lose anonymity.

ST Trainees: The trainees report that the department is very supportive with plenty of opportunity for training. The trainees have not experienced or witnessed any undermining behaviours but felt they would be able to raise any concerns with their educational supervisor or TPD.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: The trainers report that due to the rota being managed by a separate team, the trainees sometimes can't get swaps, but this is out with the control of the trainers.

FY1 Trainees: The trainees report that they have a reasonable rota that that has enough rest days. They can contact the rota team who appear happy to help should any issues arise. A trainee noted that there was an occasion when there was a gap in the rota and there was no locum to fill the gap and this left the rota short.

FY2/IMT Trainees: The trainees report that the rota can be disorganised, inflexible and does not accommodate plans for annual leave or swaps. They stated that the rota team are often not responsive when requests are made to them and provide limited support to help cover any gaps that

arise. The number of shifts allocated following nights is also challenging for recovery and trainees reported that this can adversely affect their work/life balance.

ST Trainees: The trainees report that there is currently a gap at ST level but understand that it has been difficult to recruit to. The department has secured a research fellow and this has helped the rota significantly. The trainees state that they organise their own rota, therefore they have plenty of flexibility with it and react well to help one another if required. The trainees understand that the rota is busy but it is relatively fair.

2.14 Handover (R1.14)

Trainers: The trainers report that at F2 induction they encourage the trainees to have a structure to their working day as all the wards are busy. The trainees are encouraged to use both paper-based and electronic notes depending on ward location. The CCU department has a live handover and Ward 109 (Cardiology ward) has a morning huddle with the nursing staff and there is an evening handover to the Hospital at Night (H@N) team.

FY1 Trainees: The trainees report that they are happy with the structure of handover. However, there can be challenges when handing over patients from the boarding wards as there may be patients that they are unaware of who are under Cardiology care. Handover is not used as a learning opportunity as senior colleagues do not attend to facilitate this. There is a weekend handover for Cardiology ward patients, but not for boarding patients. This can cause issues as trainees are not aware of the tasks required for the boarders. There is a written handover available although this is geared more towards nursing staff. The trainees highlight that the nurse in charge provides them with a detailed handover in the morning.

FY2/IMT Trainees: The trainees report that there is an agreed structure for handover, although the handover for boarding patients can be challenging, as the trainees are often unaware of them and so do not always know what may be required for these patients. The trainees note that the handover in CCU is excellent.

ST Trainees: The trainees report handing over mostly verbally but will email if on-call or busy with duties. Handover can be used as a learning opportunity when there are interesting cases to discuss. The trainees believe the handover arrangements are safe for the continuity of care.

2.15 Educational Resources (R1.19)

Trainers: Not formally asked

Trainees: Not formally asked

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

Trainers: The trainers report that the trainees have the generic support from NHS Grampian, such as from the occupational health department. The trainers also note that the educational and clinical supervisors are available to support trainees with any issues that may arise. The trainers can direct the trainees to support networks and try to deal with any issues respectfully. A trainer highlighted that they try to ensure that trainees leave work on time and would pay attention to those who are from out of town especially at the start of posts, who may not have an established support network close by.

Trainees: Not formally asked

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 formally asked.

Trainees: Not formally asked.

2.18 Raising concerns (R1.1, 2.7)

Trainers: The trainers reported that trainees are encouraged to talk directly to their educational supervisor to raise any concerns. The trainees are welcomed to raise any concerns through the Datix system. If there are specific patient safety concerns, the trainees are urged to contact the responsible consultant, to ensure there are no delays in providing care to the patient. The trainers

emphasise that there is significant consultant presence for trainees to approach if they have any immediate concerns.

FY1 Trainees: The trainees report that they can raise any concerns with the registrar or middle grade doctors who are happy to give support and advice.

FY2/IMT Trainees: The trainees report that they would raise any concerns with their ES and they would be followed up. The trainees state that their clinical supervisors are also helpful and would not hesitate to approach them with any concerns.

ST Trainees: Trainees report that they can raise concerns with the responsible consultant and they are addressed. There is also the formal Datix system.

2.19 Patient safety (R1.2)

Trainers: Not formally asked

FY1 Trainees: The trainees report that they would have concerns if a friend or family member was admitted to the boarding wards under Cardiology care. This is because the nursing teams on boarding wards are not always as experienced with cardiology issues. Patients in boarding wards can occasionally miss out on regular senior reviews; a trainee quoted an example of a patient waiting 10 days for a senior review, although acknowledged this was an exception. Generally, the patients in boarding wards are deemed to be lower risk, for example awaiting a care package or a procedure, but lately more high-risk patients are appearing. The trainees confirmed that the consultants attended the boarding wards to do a ward round.

FY2/IMT Trainees: The trainees agree that the service is excellent within the Cardiology unit and the quality of care is good there. The process of boarding patients out is less than ideal and can result in difficulties with the management of patients who can sometimes be moved several times. The time taken to arrange diagnostic work can often be delayed which causes anxiety and frustration for the patients and families.

ST Trainees: Most trainees report that they would have no concerns with admission of a friend or family member to the unit, but the pressure felt across the board in all the units in Scotland is immense between bed space and service provision. The trainees noted that there are many boarded patients, due to the “push policy” from the emergency medicine department and often higher risk patients must be boarded out with the main ward to accommodate patients who from a specialty perspective would be considered as low risk. This focus on bed management more than specialty-based decisions has resulted in a change in demography of boarding patients and has had an impact on training and patient safety. The trainees highlighted that heart failure patients are often boarded out which can cause delays in their management which can result in near misses and potential patient safety issues. An example was also shared of a high-risk patient being boarded out who subsequently had a cardiac arrest and died.

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

Trainers: The trainers reported that most of the time any communication to patients about an incident would come from a senior level but recognise that it is helpful for trainees to get exposure to this. The trainers actively encourage the trainees to complete reflection forms to learn from their experiences and there has been a significant uptake of these forms within the trainee’s portfolios. The trainers note that there is an ongoing programme of audits by the specialty pharmacist which review prescribing habits for the junior trainees to improve patient safety. The trainers concluded by stating that making a mistake is part of medicine, but mistakes can be used a learning opportunity and are not necessarily always a negative.

FY1 Trainees: The trainees report that they have not been involved in any adverse incidents but are aware of who to go to should these occur. The trainees commented that they felt that the department would be very supportive around incidents. The trainees have attended the monthly M&M meetings and have found these a useful educational opportunity.

FY2/IMT Trainees: Not formally asked.

ST Trainees: Trainees report that they would receive support from the trainers for an adverse incident. There is a debriefing after events and M&M meetings to attend and learn from. The trainees highlight that everyone is available to discuss and find out the root cause of any incident. There is no

blame culture and there is a willingness to improve. It was emphasised that there are good channels to give feedback following any incidents also GMC duty of candour dictates what the trainees should do and they are supported by the department.

2.21 Other

Trainers: n/a

FY1 Trainees: Overall satisfaction is 7.75 out of 10, with a range of 7-8

FY2/IMT Trainees: Overall satisfaction is 6 out of 10, with a range of 5-7

ST Trainees: Overall satisfaction score is 8 out of 10.

3. Summary

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

Positive aspects of the visit.

• Majority of trainers are very supportive and keen to support the education of doctors in training

• Hospital induction is universally good, along with induction to Ward 109.

• Excellent training opportunities within the unit; ST trainees are happy with these and can attend the required 80% of their regional teaching.

• Informal feedback given to ST trainees is useful

• Addition of the phlebotomy service in the boarding wards has been welcomed by Foundation trainees who also recognised the excellent support from nursing staff and pharmacists in Cardiology

• Universally all doctors in training were complimentary of the service and care provided by the consultant team to the patients.

Less positive aspects of the visit

• Consultants and several trainee cohorts commented on the negative impact of a “push policy” from the front door, with negative consequences for high-risk cardiology patients who are boarded out in favour of newer potentially low risk patients being admitted; the visit team heard some examples of patient harm from this activity.

• The visit team heard an account of undermining in the department, the details of which have been shared separately with the DME and Cardiology Service Manager following the meeting.

• Handover arrangements are not clear to all groups for all patients. Handover is fragile around weekends with no clarity around the patients required to be looked after or what needs to be addressed particularly in the boarding wards.

• The visit team sensed a huge amount of frustration from the consultant body, who appeared to be disempowered by the inflexibility of rota arrangements for the doctors in training.

• FY2 and IMT trainees commented that their rota was inflexible, specifically around annual leave and swaps and interaction with the rota team to resolve this was often difficult.

• Not all consultants seemed to be aware of the amount of time in their job plans for them to provide training. A variable “tariff” was quoted for this activity.

• Junior trainees would welcome a more comprehensive induction to allow them to begin working in CCU.

• Although there was a very comprehensive document that outlined the unit policies, trainees commented that this was very large and difficult to digest; a quick reference guide was thought to be a potential solution to support this.

• Trainees who were not present for departmental induction were not given a formal induction to the unit. The induction material given in advance to the trainees was not fully up to date in some areas, including for information regarding boarding patients.

• Foundation doctors are not able to attend their mandatory teaching due to workload on the ward. The trainees reported that there was nobody nominated to take their phones to allow this to be “bleep free”; the ward ANPs specifically said they would not take it.

• Foundation trainees were not supported to take “Taster weeks” during this block

• Clinical supervision can be problematic as the escalation policy is sometimes unclear, with no dedicated telephone number for the Registrar team who provide this cover. Trainees recognised good support from nurses and pharmacists within the Cardiology wards but felt unsupported around the management of boarders, where they were doing unsupervised ward rounds. Junior trainees (Foundation and IMT) did not always feel able to approach all consultants.

• Feedback provided to juniors trainees (Foundation and IMT) is limited.

- Overall, the experiences reported by senior trainees within the unit were more favourable when compared with those reported by more junior colleagues
- Use of SHO terminology was evident in one trainee session

4. Areas of Good Practice

Ref	Item	Action
4.1	Availability of excellent learning opportunities for all trainee cohorts	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	Consider providing an abbreviated version of the unit clinical protocols to facilitate easy use by trainees	
5.2	Extend the induction provided for CCU to ensure that FY2/IMT trainees feel equipped to perform on call duties at the start of their post	
5.3	The induction handbook would benefit from being updated to reflect the up-to-date curricula along with other information relating to the department.	
5.4	All references to “SHOs” and “SHO Rotas” must cease.	

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	All staff must behave with respect towards each other and conduct themselves in a manner befitting Good Medical Practice guidelines.	Immediate	All
6.2	Handover processes must be improved to ensure there is a safe, robust handover of patient care with adequate documentation of patient issues, senior leadership and involvement of all trainee groups who would be managing each case. Handover should also be used as a learning opportunity.	8th March 2023	All
6.3	There must be a systematic handover, including during weekends, of issues that arise in boarded patients	8th March 2023	All
6.4	There must be robust arrangements in place to ensure the tracking of all boarded patients. In addition, for boarded patients, there needs to be clarity around which Consultant and clinical care team are responsible, how often patients are reviewed and what the escalation policy is.	8th March 2023	All
6.5	Departmental induction must be provided which ensures trainees are aware of all of their roles and responsibilities and feel able to provide safe patient care. Handbooks or online equivalent may be useful in aiding this process but are not sufficient in isolation. A process must be put in place to ensure that any trainee who misses their induction session is identified and provided with an induction.	8th March 2023	All

6.6	There must be active planning of attendance of doctors in training at teaching events to ensure that workload does not prevent attendance. This includes provision of bleep-free teaching attendance. Trainees should access mandatory teaching sessions during their working hours and must not be expected to catch up on recorded teaching sessions during their non-working time	8th March 2023	FY/IMT
6.7	The rota pattern must be reviewed with the trainees who are on the rota to identify ways to address their concerns.	8th March 2023	FY/IMT
6.8	All Consultants who are trainers must have time within their job plans for their roles to meet GMC Recognition of Trainers requirements.	8th March 2023	FY/IMT
6.9	All trainees must be able to access Study Leave with a system put in place to allow for cover when trainees are away. This should include access to Taster sessions for Foundation trainees who are in posts 3 and 4 of their training cycle.	8th March 2023	All
6.10	Those providing clinical supervision must be supportive of trainees who seek their help and must never leave trainees dealing with issues beyond their competence or 'comfort zone'.	8th March 2023	All
6.11	Trainers must engage in developing a culture of routinely supporting opportunities to provide informal feedback, particularly for FY and IMT trainees. Ward rounds in downstream wards must provide feedback to trainees on their management of medical inpatients.	8th March 2023	All