# Scotland Deanery
# Quality Management Visit Report

NHS Education for Scotland

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| **Date of visit** | 1st December 2022 | **Level(s)** | FY1, FY2, GPST, IMT, ST |
| **Type of visit** | Enhanced Monitoring Re-visit | **Hospital** | Dr Gray's Hospital, Elgin |
| **Specialty(s)** | General Internal Medicine | **Board** | Grampian |

| **Visit Panel** | |
|---|---|
| Professor Alastair McLellan | Visit Chair – Postgraduate Dean |
| Dr Clive Goddard | Associate Postgraduate Dean for Medicine – South East |
| Dr Shona McLellan | Foundation Programme Director |
| Dr Barry Gibson-Smith | GP Programme Director |
| Dr Gemma McGrory | Training Programme Director – IMT |
| Mr Brian Winter | Lay representative |
| Dr Katherine Quiohilag | Trainee representative |
| Ms Kate Bowden | GMC representative |
| Ms Gillian Carter | Quality Improvement Manager |
| **In Attendance** | |
| Ms Patriche McGuire | Quality Improvement Administrator |
| Mr Richard Gibbons | Lay representative (shadowing) |
| Dr Holly Metcalfe | Associate Postgraduate Dean for Quality (shadowing) |
| Mrs Lauren Hart | Quality Improvement Administrator (shadowing) |

| **Specialty Group Information** | |
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| Specialty Group | Medicine |
| Lead Dean/Director | Professor Alastair McLellan |
| Quality Lead(s) | Dr Reem AlSoufi, Dr Greg Jones, Dr Alan McKenzie |
| Quality Improvement Manager(s) | Ms Gillian Carter |

| **Unit/Site Information** | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Non-medical staff in attendance | 5 | | | | | | | | | |
| Trainers in attendance | 5 | | | | | | | | | |
| Trainees in attendance | FY1 x 3 | | FY2 x 1 | | GPST x 2 | | IMT x 1 | | ST x 1 | |
| Feedback session: Managers in attendance | Chief Executive | | DME | | ADME | √ | Medical Director | | Other | |

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| Date report approved by Lead Visitor | 12th December 2022 |

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

In September 2020 the Deanery Quality team undertook a visit to Dr Gray's Hospital, Elgin, for General Internal Medicine, General Surgery, Anaesthetics and Emergency Medicine. At this visit the panel found significant concerns about the training environment. The challenges facing Dr Gray's as a training environment were such that it was escalated to the GMC's Enhanced Monitoring process for Anaesthetics, General Surgery and General Internal Medicine.

An Enhanced Monitoring re-visit was conducted on 18th November 2021. The visit panel found the training being provided to trainees in General Internal Medicine had improved since the last visit, but concerns remained around the fragility of the training environment due to several long-term substantive consultant vacancies which were proving very difficult to recruit to. The requirements resulting from this visit were:

- There must be sufficient substantive consultant trainers to support the supervision and training of the doctors in training in General Medicine.
- All staff must behave with respect towards each other and conduct themselves in a manner befitting Good Medical Practice guidelines.
- 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'.
- Alternatives to doctors in training must be explored and employed to address the chronic gaps in the junior rota that are impacting on training.
- Trainees must be able to access learning opportunities to meet curricular objectives including, for example, outpatient clinics.
- The department must develop and sustain a local teaching programme relevant to curriculum requirements of all trainees, including consultant-led sessions. A system for ensuring protected time for attendance should also be implemented.
- All consultants, who are trainers, must have time within their job plans for their roles to meet GMC Recognition of Trainers requirements.
- The Board must provide sufficient IT resources to enable doctors in training to fulfil their duties at work efficiently and to support their learning needs.

At the 2022 Quality Review Panel (QRP) there were found to be 3 red flags in National Training Survey (NTS) all trainee data for clinical supervision, clinical supervision out of hours and induction as well as a pink flag for teamwork. In Foundation data there was a red flag for induction and a pink flag for clinical supervision out of hours, and in IMT data there was a pink flag for

handover. A negative free-text comment was made by an FY2 regarding lack of teaching. Similarly the Scottish Training Survey (STS) IMT data showed a red flag for teaching and a pink flag for handover. These results represented a slight deterioration since 2021.

This re-visit is being undertaken to review progress against previous visit requirements, identify good practice and to identify any current trainee concerns**.** A summary of the discussions has been compiled under the headings in section 2 below. This report is compiled with direct reference to the GMC's Promoting Excellence - Standards for Medical Education and Training. Each section heading below includes numeric reference to specific requirements listed within the standards.

The panel would like to thank Dr Louise Millar, ADME, Foundation Programme Director and acting Clinical Lead, who delivered a very detailed and informative presentation to the panel providing an update regarding progress against the previous visit's requirements.

### 2.1 Induction (R1.13)

**Trainers:** Trainers described hospital induction as being a corporate induction by NHS Grampian including lectures and time to complete mandatory training. There are specific lectures for FY2s and the nationally agreed period of shadowing is provided for FY1s. Departmental induction comprises an introductory video, presentation, departmental handbook, tour of the hospital and issuing of passcodes. This induction is offered to all trainees starting at Dr Gray's within medicine, including those who start out of sync. Trainers would like to improve induction by offering a departmental induction to those rotating into medicine from elsewhere in the hospital and will trial this at the upcoming December changeover.

**Trainees:** Trainees all received induction which they found useful. This included a tour of the hospital and receipt of an up-to-date induction document. The involvement of the physician associate in induction was described as positive. All trainees had their required IT access promptly and by the end of their first week at the latest.

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

**Trainers:** Regional teaching is bleep free for Foundation trainees and they are encouraged to give the on-call bleep to Advanced Nurse Practitioners (ANPs). Teaching is recorded, but the department encourages trainees to attend live rather than watching in their own time. Face-to-face

Foundation teaching is due to re-start the week following this visit so bleeps will be left with the postgraduate administrator during teaching. Trainers thought IMT and ST trainees had attended all of their available regional teaching and encouraged them to swap night shifts to attend if needed. Departmental teaching is not bleep free as someone is required to cover the ward. Topics are chosen to be non-repetitive and they try to choose topics which fit into all curricula, however trainers recognised this was easier for Foundation and IMT curricula and harder for ST.

**Trainees:** Trainees reported attending a total of 2-3 hours of teaching per week which they described as well-organised. This includes the Tuesday departmental meeting (run by the physician associate), that incorporates the departmental morbidity and mortality (M&M) meeting, approximately alternate Wednesday 'multi-professional' meeting and cohort-specific teaching sessions. Trainees are also supported to attend their regional/national teaching programmes. Some trainees noted that they struggled to attend local teaching due to their shift patterns, however recordings of local teaching sessions are made available for those who cannot attend live. Trainees appreciated having the opportunity to lead teaching sessions, however senior trainees felt the quality of the Tuesday teaching sessions would be improved with greater involvement of consultants.

### 2.3 Study Leave (R3.12) – Not covered

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

**Trainers:** Trainers felt they were well supported by the broader team and had enough time to see their trainees. They were encouraged to do Continuing Professional Development (CPD) to support their trainer roles and were able to contact Dr Millar regarding any issues. All trainers have 1 hour per week in their job plan for supervision except Dr Millar. This was due to being the only substantive consultant in General Internal Medicine and was not expected to change until other substantive posts were filled. Nonetheless, Dr Millar operates an open-door policy and meets her own trainees regularly.

**Trainees:** Trainees reported regular contact with their educational supervisors and were satisfied with the support they received.

### 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 that all trainees and locum consultants are advised about supervision structures at their inductions. During the day trainees are advised to contact the consultant for the patient they are seeing, and out of hours they should contact the on-call consultant. Trainers were not aware of any recent occasions where trainees have had to cope with problems beyond their competence or experience and have encouraged locums to support trainees with unwell patients. No issues had been reported regarding accessibility of locum consultants during the day or out of hours.

**Trainees:** Trainees knew who to contact during the day and out of hours and felt consultants were approachable and accessible. Trainees felt confident that consultants would come and see patients if they asked them to. There are no ANPs or physician associates available overnight and trainees felt more staff overnight would be beneficial. Trainees could feel overwhelmed overnight, particularly middle grade trainees offering support to FY1s, however there was recognition that support was available and feelings of being overwhelmed stemmed from trainees' own judgement regarding when to escalate. Trainees felt that sometimes patients were not reviewed by consultants frequently enough, however this was being addressed following discussion at a recent M&M meeting.

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

**Trainers:** Trainers felt confident regarding the curriculum requirements for trainees under their supervision as a result of local meetings and the opportunity to bring queries to Dr Millar. Dr Millar would then contact the relevant Associate Postgraduate Dean if further information were needed. Trainees are offered the opportunity to attend clinics and preference is given to STs and IMTs due to their curriculum requirements, although GPSTs often attend clinics too. The department is currently in the process of recruiting a rota co-ordinator who it is hoped can schedule clinics into the rota. Currently trainees are required to police clinic attendance themselves. Trainers felt the hardest competencies to provide were clinics and procedures. Training in procedures is offered by the physician associate and trainees attend bootcamps to support this.

**Trainees:** Trainees felt they were able to see a good medical case-mix and there are opportunities to gain experience in practical procedures under supervision, in particular from the physician associate, but also from seniors. Clinic opportunities were limited and senior trainees were given priority in clinic attendance so this could be a challenge for more junior trainees; senior trainees

were accessing reasonable numbers of clinics. IMTs could access some, but not enough clinics. Although GPSTs don't have a specific target around numbers of clinics, their access to clinics was minimal. Trainees worked a high percentage of on-calls which could be an obstacle in attending clinics or teaching. Trainees felt that around 20-30% of their work was non-educational and they found on-call shifts more educationally beneficial. Rotation around different wards was reported to be very frequent for Foundation trainees and they noted that the frequency of moves compromised continuity of patient care and learning as well as being disruptive to relationship-building with supervisors and nurses.

**2.7 Adequate Experience (assessment) (R1.18, 5.9, 5.10, 5.11)** – Not covered

**2.8 Adequate Experience (multi-professional learning) (R1.17)** – Not covered

**2.9 Adequate Experience (quality improvement) (R1.22) –** Not covered

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

**Trainers:** Trainees are given feedback informally when they ask questions and are given direct feedback after a night shift when a consultant meets with them to discuss the cases they have seen overnight. Trainees are also given feedback on the teaching sessions at which they present, either in real time or following review of a recording, and consultants try to offer bedside teaching. As Foundation Programme Director for the Foundation doctors at the hospital, Dr Millar meets with them specifically to discuss their progress. Reflective practice sessions form part of the Foundation teaching programme which is useful for discussion of difficult cases.

**Trainees:** Senior trainees felt they received helpful and constructive 'on the job' verbal feedback on 90-95% of the acute medical cases they managed; they were also able to access formal Workplace-based Assessments (WPBAs) such as Acute Care Assessment Tools (ACATs). However, Foundation trainees and GPSTs reported lack of feedback to them on their input to the management of their acute cases. Foundation trainees also reported absence of feedback on their input to inpatients who had become unwell in the wards overnight. They reported that if they sought feedback on particular cases this was provided.

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

**Trainers:** Trainers reported that they do not have consultant resource to support the gathering of regular departmental feedback so they are reliant on NTS and STS feedback. There is a trainees' forum but there are plans for this to become a regular, scheduled regular event and trainers would like to see this be more management-led so trainees can speak freely without consultants present.

**Trainees:** Trainees described being able to give feedback to their supervisors and Foundation/Training Programme Director, however, there was variable awareness, including some with no awareness, of a trainees' forum.

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

**Trainers:** Trainees are encouraged to contact their supervisor, another consultant, or Dr Millar if they experience bullying or undermining. An incident was reported where Foundation doctors reported undermining by a more senior trainee. This was managed within the department by Dr Millar.

**Trainees:** Trainees felt the culture in the department was supportive and felt they could raise concerns with consultants. Trainees noted that the undermining incident reported by Foundation doctors regarding a senior trainee had been escalated and managed appropriately.

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

**Trainers:** Trainers reported that rotas have been through rota monitoring successfully. Rotas are full and long-term locums are used to cover trainee absence so shifts have not been left uncovered and trainees have not been asked to cover additional shifts.

**Trainees:** Trainees felt that more staff would be beneficial for the department as they are vulnerable in cases of unexpected absence. Ideally they would like clinics to be included in their rota planning to protect access to these. It was reported that the rota is currently missing an FY1 doctor.

### 2.14 Handover (R1.14)

**Trainers:** Trainers described morning handover as covering all patients who have arrived within the last 24 hours. Representatives from every team attend. FY1s are encouraged to handover early so they can leave. Trainers try to make handover educational, but noted it could depend on who was present.

**Trainees:** Trainees described the new admissions' handover that takes place twice daily as working well while downstream handover was more ad hoc. FY1s must usually stay late for the 5pm handover as handover takes place at the time they are scheduled to finish. There is no electronic record of handover with notes being kept on a whiteboard; the whiteboard is 'wiped clean' every morning. Trainees commented that the surgical handover system (based on a 'handover sheet') appears to work well.

### 2.15 Educational Resources (R1.19)

**Trainers:** Not covered.

**Trainees:** Trainees advised that there is a library and doctors' mess on site and the mess has 3 computers as well as a sofa, microwave and fridge. Trainees staying in hospital accommodation noted that their accommodation did not have internet access.

### 2.16 Support (R2.16, 2.17, 3.2, 3.4, 3.5, 3.10, 3.11, 3.13, 3.16, 5.12) - Not covered

### 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 covered.

**Trainees:** Trainees stated they would speak to consultants, managers or nurse managers about any concerns regarding their training and felt these individuals were all approachable.

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

**Trainers:** Trainers felt that trainees were aware they could contact their supervisor or another consultant for support. Dr Millar has an open door policy and this is provided by other colleagues when she is not available. Patient safety concerns are always discussed at M&M meetings.

**Trainees:** Trainees were aware of the Datix system to raise concerns, although some regarded this with a degree of cynicism. Amongst those with experience of using Datix, experiences were mixed regarding whether they received feedback on these or not. Trainees felt their consultants and other colleagues such as nursing and pharmacy would be supportive if they raised concerns.

### 2.19 Patient safety (R1.2)

**Trainers:** Trainers reported that boarded patients should receive the same care as others. There is a nominated consultant for patients boarded to a surgical ward who does a ward round twice per week. The department tries to balance the skill mix across all areas including boarding and sometimes changes this as demand requires.

**Trainees:** Whilst trainees thought highly of their colleagues, they had some patient safety concerns related to understaffing including lack of nurses. Trainees had been aware that occasionally patients were not being reviewed for as long as 7-9 days; however since a recent M&M meeting, at which this had been raised as an issue, this situation has improved. Trainees thought on average patients would be reviewed by a consultant 2-3 times per week.

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

**Trainers:** Trainees are encouraged to attend and present cases at M&M meetings for learning, both at departmental level and hospital level.

**Trainees:** Trainees felt that M&M meetings fostered learning regarding incidents and noted these were recorded. These were not usually attended by locum consultants, but substantive consultants made an effort to attend or watch recordings.

## 3. Summary:

| Is a revisit required? | Yes | No | Highly Likely | Highly unlikely |
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Overall the visit team noted that this was a very positive visit, but the department remained fragile due to its reliance on the leadership of a single substantive consultant in General Internal Medicine.

Trainees were asked to rate their overall satisfaction with this post out of 10 and the average score given was 7.

**Positive Aspects of the Visit:**

- The visit panel noted a positive training culture and with transformation in the training opportunities.
- Departmental induction was working well (and we noted plans to incorporate additional video content to enhance the content).
- Trainees were clear about escalation pathways and felt consultants were very accessible and supportive.
- Access to relevant structured, scheduled teaching sessions that involve trainees in their delivery – although these would benefit from greater consultant input.
- Trainees were supported to access regional/national training opportunities.
- Use of the physician associate model to support the delivery of training. The postholder's excellent contribution to supporting training was commended by many trainees.
- Senior trainees received extensive on-the-job feedback in relation to their management of acute medical cases.
- The openness to receive feedback and to respond to concerns.

**Less Positive Aspects of the Visit:**

- The lack of trainers supporting training in General Medicine presents a risk. Although the risk is being mitigated currently there is vulnerability in a dependence upon one key individual.
- More junior trainees reported not receiving feedback on their management of acute cases. Also FY1s did not receive feedback on their management plans for patients who had become unwell overnight in the wards.

- Trainees' base wards changed too frequently leading to discontinuity that compromised training, reflecting staffing levels.
- Clinic access has improved significantly but more access is required for IMTs and some access is required for GPSTs. We noted the ambition for the new rota co-ordinator to have a role in scheduling and managing trainees' attendance at clinics.
- Evening handover takes place at 5pm which is when the FY1s' daytime shifts end. This handover should occur within their scheduled hours of work.
- There is absence of a written record of handover – a suggested improvement would be to incorporate such a record.

**Progress against 2021 visit requirements:**

| Ref | Issue | Trainee cohorts in scope | Requirement met? |
|---|---|---|---|
| 6.1 | There must be sufficient substantive consultant trainers to support the supervision and training of the doctors in training in General Medicine. | Service leads | Not yet met |
| 6.2 | All staff must behave with respect towards each other and conduct themselves in a manner befitting Good Medical Practice guidelines. | FY/GPST/IMT/ST | Met |
| 6.3 | 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'. | FY/GPST/IMT/ST | Met |
| 6.4 | Alternatives to doctors in training must be explored and employed to address the chronic gaps in the junior rota that are impacting on training. | FY/GPST/IMT/ST | Met |

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|---|---|---|---|
| 6.5 | Trainees must be able to access learning opportunities to meet curricular objectives including, for example, outpatient clinics. | FY/GPST/IMT/ST | Partially met |
| 6.6 | The department must develop and sustain a local teaching programme relevant to curriculum requirements of all trainees, including consultant-led sessions. A system for ensuring protected time for attendance should also be implemented. | FY/GPST/IMT/ST | Partially met |
| 6.7 | All consultants, who are trainers, must have time within their job plans for their roles to meet GMC Recognition of Trainers requirements. | Service leads | Partially met |
| 6.8 | The Board must provide sufficient IT resources to enable doctors in training to fulfil their duties at work efficiently and to support their learning needs. | FY/GPST/IMT/ST | Met |

The Deanery and GMC will review the content of this report and following this the GMC will write to the Health Board regarding the status of Enhanced Monitoring.

## 4. Areas of Good Practice

| Ref | Item | Action |
|---|---|---|
| 4.1 | Use of the physician associate model to support the delivery of training. | |

## 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 | Trainees should all be made aware of the opportunities to provide feedback as a group on the quality of training through the trainee forum. The proposal to schedule these regularly is to be encouraged. | |
| 5.2 | Trainees should receive meaningful feedback on all Datix reports they submit. | |
| 5.3 | It is recommended that an electronic record of handovers is kept. | |
| 5.4 | The evening (informal) handover should be completed before the end (at 5pm) of the daytime Foundation shift. | |
| 5.5 | The Tuesday departmental teaching sessions should have more input from consultants to enhance their educational benefit. | |

## 6. Requirements - Issues to be Addressed

| Ref | Issue | By when | Trainee cohorts in scope |
|---|---|---|---|
| 6.1 | There must be sufficient substantive consultant trainers to support the supervision and training of the doctors in training in General Medicine. | 1st September 2023 | Service leads |
| 6.2 | Appropriate outpatient clinic training opportunities must be provided for IMTs and for GP trainees (noting that some progress has been made). | 1st September 2023 | GPST/IMT |
| 6.3 | Feedback to Foundation and GP trainees on their management of acute receiving cases (and on Foundation trainees' management of unwell inpatients overnight) must be provided to inform | 1st September 2023 | FY, GP |

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|---|---|---|---|
| | their learning and training (aiming for this in at least 40% of cases). | | |
| 6.4 | The discontinuity of ward placements for Foundation trainees must be addressed as a matter of urgency as it is compromising quality of training, feedback, workload and the safety of the care that doctors in training can provide. The duration of ward attachments of Foundation doctor must be increased to be for at least 4 weeks. | 1st September 2023 | FY |