Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	24th November 2022	**Level(s)**	FY1, FY2, GPST, ACCS, ST
Type of visit	Triggered visit	**Hospital**	Royal Infirmary of Edinburgh
Specialty(s)	General Internal Medicine	**Board**	NHS Lothian

Visit Panel	
Dr Greg Jones	Visit Chair – Associate Postgraduate Dean for Quality
Dr Alan McKenzie	Associate Postgraduate Dean for Quality
Dr Andrew Docherty	Foundation Programme Director
Dr Amanda Connelly	GP Programme Director
Ms Helen Adamson	Lay representative
Ms Gillian Carter	Quality Improvement Manager
In Attendance	
Ms Patriche McGuire	Quality Improvement Administrator

Specialty Group Information	
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)	Alex McCulloch, Gillian Carter

Unit/Site Information										
Trainers in attendance	6									
Trainees in attendance	FY1 x 6		FY2 x 1		GPST x 1		ACCS x1		ST x 5	
Feedback session: Managers in attendance	Chief Executive		DME		ADME	✓	Medical Director		Other	

Date report approved by Lead Visitor	16th December 2022

1. Principal issues arising from pre-visit review:

Following review and triangulation of available data, this visit was requested by the Medicine Quality Review Panel in 2021 around the following concerns; Acute Internal Medicine featured on the GMC National Training Survey (NTS) triage list 2021 for red flags and an amber flag for change in scores; there were red flags at all trainee level for adequate experience, educational governance, educational supervision, feedback, induction, overall satisfaction, reporting systems and study leave.

A visit date was agreed with the site for May 2022, however unfortunately we were unable to source a panel for the visit so the original date was cancelled and re-scheduled for 24th November 2022.

It should be noted that although the Royal Infirmary of Edinburgh (RIE) featured on the GMC triage list for Acute Internal Medicine in 2021, it does not feature on the 2022 triage list for any of the group 1 medicine specialties. 2022 NTS data showed a slight improvement from 2021 but multiple red and pink flags remained across all grades.

The visit aims to further investigate issues previously highlighted by the 2021 triage list, as well as current data, and to advise on steps towards addressing and resolving them where required.

The panel would like to thank Dr Johanne Simpson, Clinical Director, who delivered a detailed and informative presentation to the panel providing information about the structure and staffing of the site and explaining recent changes and ongoing challenges.

2.1 Induction (R1.13):

Trainers: Trainers reported that the induction programme had recently been over-hauled including updates to the handbook. The focus of induction is understanding the team and knowing who to contact for support during the day and out of hours. Induction packs are sent to all trainees prior to starting. Supervisors ask at their initial trainee meetings whether trainees have had an effective induction and responses so far this year have been positive. Trainees who miss induction would still receive the induction pack and on their first day would be shown around and given some introductory information. Trainers felt induction could be improved by ensuring Trak training and access to computer systems which can sometimes be delayed by Human Resources (HR).

FY: Trainees felt that the FY1 shadowing and induction period was appropriate for new doctors, however they felt that hospital induction was inadequate for other grades. Trainees felt that they learnt how to do their day-to-day work from senior colleagues including explanations of where they could find hospital guidelines and protocols. Those who missed induction were described as receiving an induction pack by e-mail, but no orientation when they arrived. Trainees did understand who to contact for support when starting work. Trainees felt departmental induction could be improved by providing information about what happens where within the wards.

GPST/ACCS: Trainees received both hospital and departmental induction and felt it prepared them well to start work. Their departmental induction included a physical tour of the department which was helpful. Trainees not scheduled to work on the induction dates were encouraged to attend and given a day off in lieu. Trainees understood roles within the department and who to contact for support. An improvement to induction would be more time spent on Hospital Electronic Prescribing and Medicines Administration (HEPMA) prescribing and earlier access to this.

ST: Trainees all received hospital induction and felt that it was well organised with clear sign-posting to further information and support. It was easy for them to get their ID badges and the induction booklet for registrars was felt to be good. Trainees felt that their departmental induction equipped them to work there. Hospital at Night induction for FY2+ was felt to be brief and aimed at those with prior experience of working in NHS Lothian. Similarly, those only working in General Internal Medicine overnight felt that they needed a specific induction for this as they were not told who to contact for support overnight.

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

Trainers: Trainers reported that trainees are given time off to attend regional teaching, but sometimes miss this if they are on-call. FY1s are encouraged to leave the ward for teaching and FY2 teaching is embedded in the rota.

FY: Foundation trainees felt that teaching was of good quality and appreciated that it was recorded, but felt accessibility of live teaching was poor. FY1 teaching is at the same time as General Internal Medicine ward rounds, while FY2 teaching is a 4-hour session once per month which is difficult to attend due to lack of shift cover. Both FY1 and FY2 teaching is intended to be bleep free, however in practice FY2 teaching is not as there is no cover available on the ward. Some trainees reported attending only 0 or 1 live teaching sessions so far in this post.

GPST/ACCS: Trainees felt both local and regional teaching was accessible and usually easy to attend unless seeing an acute patient or not at work. GPST/ACCS trainees often opted to stay on the wards during teaching to allow more junior trainees to attend, particularly when working in the Acute Medical Unit (AMU) where it was busier.

ST: Trainees identified that local teaching was available 2 days per week, however registrars found it difficult to attend as they were often on the interface unit where they could not leave. ST trainees often opted to stay on the wards during teaching to allow more junior trainees to attend. Protected time was given to attend Mastery Skills simulation sessions. Trainees estimated they attended 50-60% of available teaching but could probably attend 100% when working on wards. Trainees had no issues attending regional teaching which was bleep free. Leave was usually granted to watch recordings of any missed teaching.

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 are supported to fulfil their roles with formal training and update meetings. Foundation trainers have been offered training by the local Foundation lead. The Deanery and clinical director have offered support with trainees in difficulty and HR matters. All trainers had time in their job plan for their educational role.

Trainees: Not covered.

2.5 Clinical supervision (day to day) (R1.7, 1.8, 1.9, 1.10, 1.11, 1.12, 2.14, 4.1, 4.6)

Trainers: Trainers stated that trainees usually work supported by a senior doctor and a consultant is in the department from 9am-9pm. Supervision was provided by a consultant during the day and a registrar at night with a consultant on-call from home. Consultants felt they were visible on shift including in interface. Trainers noted that clinical advice is also available to trainees from tertiary units.

FY: Trainees noted that they were supported by a registrar during the day and often also a consultant. Support overnight was felt to be variable and Foundation trainees felt that middle grade doctors did not always have the experience to support them, for example clinical fellows without prior NHS experience. Trainees described the evening handover period as problematic as

all senior staff were unavailable for 1.5 hours. Trainees felt they sometimes had to cope with problems beyond their competence or experience during evening handover as they could not access support.

GPST/ACCS: Trainees stated that consultants were available from 9am-9pm and support could be obtained from registrars out of hours. Trainees felt AMU had clear structures of escalation. Senior colleagues are approachable and trainees felt well supported.

ST: Trainees stated that there was always a consultant available in AMU and in interface. They found consultants to be supportive and approachable. 3 occasions were reported where trainees experienced difficulties contacting the on-call consultant overnight, for reasons such as switchboard not having the correct contact details or being unable to get through. Nonetheless, trainees never felt they needed to cope with problems beyond their competence or experience. Trainees felt it would be useful if the evening consultant passed on information about sick patients to the night registrar as they felt the information gained from other trainees was not always reliable.

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

Trainers: Trainers stated that they received “cheat sheets” every year explaining the current curriculum requirements for trainees under their supervision. Some trainers supervised multiple trainee groups and agreed that it could be hard to keep abreast of curriculum changes. Trainers felt they needed more support from the Deanery in terms of curriculum updates. Trainers reported spending their own time learning about curriculum changes as they did not have time during working hours. In terms of providing clinic attendance opportunities, ST3+ trainees have clinics included in their rota, however there were challenges in providing this for other grades due to lack of space. Trainees were rotated into ambulatory care when possible which was felt to provide similar experience.

FY: Trainees who had worked in Cardiology reported access to a clinic once per month. Trainees in Respiratory Medicine had not been offered clinic access in FY1, but had in FY2. Trainees felt they could probably join General Internal Medicine clinics if ward cover were available but this had not been the case so far. In terms of educational benefit, trainees reported spending a high percentage of their time doing office work – around 30% for FY1s – however some of this was felt to be educational such as writing referrals.

GPST/ACCS: GPST and ACCS trainees did not have access to clinics and felt that at least 40% of their training was educational.

ST: Trainees described being able to attend 1 clinic or ambulatory care clinic per month in General Internal Medicine, however they felt they gained similar experience in interface as around 50% of patients were discharged. Trainees in Geriatric Medicine attended 1 clinic per week unless on Hospital at Night. Trainees felt 80-90% of their work was educational, with interface and AMU providing more educational opportunities than the ward. Trainees felt their attendance at Hospital at Night handover could be superfluous as many items do not need to be facilitated by a registrar.

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

Trainers: Trainers felt that gaining sufficient clinic experience had been an issue for trainees, as had completing certain procedures. Mastery Skills simulation is now embedded within the rota which has been helpful.

FY: Trainees felt it was easy to obtain workplace-based assessments and they were well-supported in doing this.

GPST/ACCS: Trainees felt it was easy to obtain workplace-based assessments, but harder to practise clinical skills as some procedures were performed infrequently in the department. The Mastery Skills simulation was helpful in gaining experience of procedures.

ST: Trainees felt it was easy to obtain workplace-based assessments. They would like to also be able to complete assessments during Hospital at Night, but this is not possible due to lack of consultant presence.

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

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

Trainers: Trainers reported that the Quality Improvement (QI) lead provides a list of ongoing projects at the start of each block. Trainees are encouraged to participate in QI and supported throughout their projects. There are usually 10-15 projects being undertaken in the department and trainees are encouraged to submit results to national and international meetings.

All Trainees: All trainee groups felt there were ample opportunities available to pursue QI. They identified that the QI lead attended induction to present ongoing projects. Foundation trainees felt it was hard to find time to become involved in QI.

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: Trainers reported that during the day consultants review all patients so feedback is provided to trainees in real time. Following night shift trainees are expected to leave on time at 9am so feedback on differential diagnoses and management plans may be offered at 8:30am or when they return for their next shift.

FY: Trainees described feedback during the day as variable and dependent upon whether a consultant offers it. Following night shift, trainees stated that they sometimes receive feedback in the morning but if they would need to stay late for it they sometimes prefer to go home to sleep. They stated that this was the only opportunity for feedback following night shift as it was not offered when starting the next shift.

GPST/ACCS: Trainees reported receiving structured feedback only on workplace-based assessments. They felt that the ward round with the night team was of educational benefit.

ST: Trainees noted that they do not receive any feedback from Hospital at Night shifts as there is no consultant present. Trainees felt it would be beneficial for consultants on interface to arrive at 8:30am to receive handover from the Hospital at Night registrar.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: Trainers stated that a trainees' forum takes place twice per block. Attendance at this was described as variable. The forum is introduced to trainees at induction and supervisors advertise opportunities to attend.

FY: Not asked.

GPST/ACCS: Trainees were aware of a trainees' forum attended by trainee representatives.

ST: Trainees stated that a trainees' forum has been created and has had 3 meetings so far. The forum was described as leading to positive changes, for example the introduction of laptops on

each floor for use of the boarding team. Trainees also stated that nurses ask them for any relevant feedback prior to a weekly meeting with the Hospital at Night clinical lead.

2.12 Culture & undermining (R3.3)

Trainers: Trainers were not aware of trainees receiving unsupportive or undermining comments and felt the contemporary consultant body was supportive. Trainers noted that sometimes doctors in other specialties could have negative attitudes when receiving referrals and regular clinical director meetings address these concerns when they arise. Feedback from these discussions is passed on to trainees.

All Trainees: All trainee groups agreed that they had not witnessed bullying or undermining and stated they would speak to their supervisor, another senior doctor or the clinical director if they witnessed this.

2.13 Workload/Rota (1.7, 1.12, 2.19)

Trainers: Trainers reported that they engage with trainees about their rota and had trialled multiple iterations based upon trainee feedback. They also engage with the compliance team in NHS Lothian including for Less-Than-Full-Time rotas. Trainers felt that workload was an issue, but this was not unique to the site as many trainees currently have low morale and lack of continuity. Preferred rotas generally include longer shifts with more days off so trainees often work long hours which can be tiring. This is compounded by the lack of parking at the site meaning many trainees travel to and from work by bus.

FY: Trainees felt that the FY1 rota was good as there were many FY1s, but the FY2 rota was hard as there were middle grade gaps. Some of these gaps had been filled by clinical fellows and trainees had concerns that those employed in these roles were not suitably experienced.

GPST/ACCS: Trainees felt their rota was sympathetic, but there was a lack of continuity on General Internal Medicine wards. They reported gaps at the start of the year, but these had now been filled. Trainees had no concerns about the competence of clinical fellows in the department. Gaps due to unexpected sickness were covered internally.

ST: Trainees had no concerns regarding their workload or rota.

2.14 Handover (R1.14)

Trainers: Trainers reported that consultants oversee handover in the mornings and evenings. An electronic handover is completed on Trak. Trainers noted that waiting times are very long in the Emergency Department, giving examples of waits of up to 24 hours, and so they worry about the handover of these patients.

FY: Not asked.

GPST/ACCS: Trainees felt that morning handover was clearly explained by nursing colleagues, however evening handover could be less structured and was verbal only. The AMU handovers at 9am and 9pm were considered to be safe and effective. Weekend plans are made at a multi-disciplinary team (MDT) meeting on a Friday.

ST: Trainees felt there was a good process of handover in the evening from the wards to the HAN team, however they felt attendance at morning handover was unclear and could be improved. They felt the front door registrar did not need to attend the main evening handover and explained that trainees working in interface missed part of the back door handover which could be useful for them.

2.15 Educational Resources (R1.19)

Trainers: Facilities and resources to support learning were described as including bookable computers, access to the Royal College back catalogue for registrars, simulation programmes and sometimes programmes for International Medical Graduates (IMGs).

FY: Trainees felt they did not use many additional resources as they were focused on doing the basics of their jobs, however they commented that the intranet was useable and allowed them to find what they needed.

GPST/ACCS: Trainees described having access to rooms for teaching and the University library.

ST: Trainees reported that facilities in the medical education centre are good and include new computers. Simulation facilities are also well-equipped. They felt it could sometimes be difficult to find guidelines on the intranet.

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

Trainers: Trainers stated support available for trainees included support from supervisors, the clinical lead, the Deanery, the trainee's defence union, HR and Occupational Health. Trainers felt it was important to provide ongoing support to trainees in need even once they moved on from this post. Regular consultant meetings take place to discuss trainees, however trainers highlighted that this meeting discusses more positive topics than negative. Trainers felt the support available for IMGs was particularly good.

FY: Trainees felt this was a well-supported job with 1 trainee commenting that it was the best supported job they had had. Trainees felt the site did a good job of managing many people considering their difficulties with gaps.

GPST/ACCS: Trainees described the department as supportive. Hospital-wide support networks were highlighted at induction and on posters in the hospital.

ST: Trainees felt their supervisor would support them if they experienced difficulties and 1 trainee was able to give an example of good support being given to them when needed.

2.17 Educational governance (R1.6, 1.19, 2.1, 2.2, 2.4, 2.6, 2.10, 2.11, 2.12, 3.1)

Trainers: Trainers were not aware of a formal committee overseeing the management and quality of postgraduate training and education, however they noted that the person responsible for this was not available to attend the visit.

FY: Trainees felt they would talk to their consultants about any concerns with their training and described having done this regarding their access to teaching.

GPST/ACCS: Trainees stated they would raise any issues with their training with their supervisor or at the trainees' forum.

ST: Trainees noted that they had raised concerns about Hospital at Night with the associate director of medical education and felt these were taken seriously. They also felt able to contact their Training Programme Director (TPD) with concerns.

2.18 Raising concerns (R1.1, 2.7)

Trainers: Trainers reported that trainees are advised at induction how to raise concerns. Trainers felt the hierarchy was loose and trainees were encouraged to contact the nearest available consultant for support. Trainees are advised to raise concerns with a consultant in the morning if an issue arises overnight. The clinical director is also available for any concerns which cannot be raised through another route. Datix reports submitted by trainees are sent to their educational supervisor for information.

Trainees: Not covered.

2.19 Patient safety (R1.2)

Trainers: Trainers felt there were risks relating to the large number of boarded patients at the site. A dedicated team including 2 consultants and a group of trainees is responsible for boarders each week. A review of boarders takes place every morning and a decision is made on who will see them. Trainees on the host wards are responsible for day-to-day tasks for boarders such as bloods and discharge prescriptions. Decisions relating to boarders are not always discussed with their consultants which the team is working to resolve.

FY: Trainees would have concerns about their relatives or friends being treated by some of the clinical fellows working at the site, or if they were boarded which they agreed was unsafe. Trainees reported that boarded patients could wait 48-72 hours to see a consultant over the weekend and they witnessed unsafe boarding practices on every weekend shift.

GPST/ACCS: Trainees recognised that the system was strained, but this was widespread in the NHS and they felt their own consultants were safe. Whilst there is a specific boarding team, trainees described the process as risky due to high numbers, large areas covered, and long waits for specialty beds.

ST: Trainees would have concerns about their relatives or friends being treated overnight or in interface due to the long waiting times, however they felt this had improved a lot. They felt concerned that there was no process for regular prescribing in interface as the expectation was that patients would only stay for a few hours. Trainees reported instances where they had prescribed something to be given at a future time but it was given immediately as this is the only way the system has been set up. Trainees felt that the boarding team was sometimes

overwhelmed by workload, but there is a trainee and consultant responsible for boarding on each floor and boarded patients were seen by consultants 3 times per week.

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

Trainers: Trainers described adverse incidents being reported via datix and stated they encourage trainees to use this. Any incidents are discussed at handover. If a name is attached to a Datix report then that individual is given feedback on the case.

FY: Not asked.

GPST/ACCS: Trainees felt they would feel well supported if they experienced an adverse event as they have good senior support.

ST: Not asked.

3. Summary

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

The panel found a department where trainees felt well supported by their trainers and could easily receive help, both with clinical decision-making and with any difficulties in their training. Nonetheless, concerns were identified regarding patient safety and Hospital at Night processes which the panel agreed should be addressed. The panel also recognised that the number of trainees seen at the visit was smaller than anticipated due to differing understandings regarding the scope of the visit and a symposium taking place locally on the same date. This may have affected the findings of the visit.

Positive aspects of the visit:

- Consultants were universally described as supportive and approachable and trainees felt formal supervision was robust. Trainees were able to complete their required workplace-based assessments easily in this post.
- Trainees felt confident that if they had any issues they would be supported by their supervisors and by senior management including the clinical director.
- Trainees were aware of the local trainees' forum and were able to describe positive changes which had been implemented through this.
- Access to QI projects was commended and trainees described how ongoing projects in which they could become involved were presented at induction. The QI lead Anne Lockman was specifically mentioned as visible and helpful.
- Trainees were positive about the excellent rota co-ordinators and administrative team at the site.
- Simulation resources were described as accessible and valuable.

Less positive aspects of the visit:

- It was noted that boarding of medical patients was significant and trainees felt practices were onerous and unsafe. Boarded patients were described as sometimes not being seen by a consultant for several days.
- It was noted that patients often spend long periods in interface before being clerked. This creates problems for trainees in prescribing regular medications as interface is set up for immediate prescribing only.
- The information in the induction handbook and clinical guidelines were described as useful, but not always well sign-posted. Some trainees reported aspects of induction were lacking, such as induction to Hospital at Night and departmental tours for those who missed the initial induction.
- There was a lack of clarity regarding attendance at handovers. Trainees felt that attendance at evening handover left trainees exposed between 9pm and 10pm as senior support was unavailable during this time.
- Trainees reported that they did not receive feedback about cases they saw when working on Hospital at Night.
- Several incidents of consultants being inaccessible overnight were reported.
- Foundation trainees reported difficulties attending teaching due to workload.

- Concerns were raised regarding the competence of some clinical fellows at the site, specifically those who joined the team without prior experience of working in the NHS.

4. Areas of Good Practice

Ref	Item	Action
4.1	Access to QI projects for trainees is extensive and the support of the QI lead is commended by the panel.	

5. Areas for Improvement

Ref	Item	Action
5.1	A process for prescribing regular medications in interface should be devised.	
5.2	Attendance at handovers should be reviewed to ensure the appropriate staff are attending each handover and senior support remains available to trainees during handover periods.	
5.3	Processes for contacting on-call consultants overnight should be reviewed to ensure the hospital switchboard has correct contact numbers and consultants are contactable by phone to minimise delays when trainees are seeking advice.	

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	The site must develop an effective system of safe selection, tracking and managing boarded patients and ensuring appropriate clinical ownership & oversight of patient care.	24th August 2023	FY/GPST/ IMT/ACCS/ST
6.2	An induction or induction manual/guide must be provided to trainees who cover multiple specialties overnight, including induction to the Hospital at Night Team.	24th August 2023	FY/GPST/ IMT/ACCS/ST
6.3	A process for providing feedback to trainees on their input to the management of acute cases overnight must be established.	24th August 2023	FY/GPST/ IMT/ACCS/ST
6.4	Barriers preventing Foundation trainees attending their dedicated teaching sessions must be addressed.	24th August 2023	FY

Action undertaken by NHS Lothian to address requirements can be found by logging in to NHS Lothian's Medical Education Directorate website. See "Action Plan" - located at the bottom of the webpage.