Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	23rd and 24th March 2023	**Level(s)**	FY1, FY2, GPST, IMT, ST
Type of visit	Enhanced Monitoring re-visit	**Hospital**	Queen Elizabeth University Hospital
Specialty(s)	General Internal Medicine	**Board**	Greater Glasgow and Clyde

Visit panel	
Professor Alastair McLellan	Visit Chair - Postgraduate Dean
Dr Reem Al Soufi	Associate Postgraduate Dean for Quality
Ms Kate Bowden	GMC representative
Dr Duduzile Musa	College representative
Dr Jane Rimer	Training Programme Director
Dr Muhammad Awais Riaz	Foundation Programme Director/GP representative
Dr Clementina Calabria	Trainee Associate
Ms Sarah Chiodetto	Lay representative
Ms Gillian Carter	Quality Improvement Manager
In attendance	
Ms Claire Rolfe	Quality Improvement Administrator

Specialty Group Information	
Specialty Group	Medicine
Lead Dean/Director	Professor Alastair McLellan
Quality Lead(s)	Dr Greg Jones, Dr Alan McKenzie, Dr Reem Al Soufi
Quality Improvement Manager(s)	Ms Gillian Carter
Unit/Site Information	
Non-medical staff in attendance	5
Trainers in attendance	24
Trainees in attendance	F1 13; F2 5; GPST 3; IMT 6; ST 5

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

Date report approved by Lead Visitor	14th April 2023

1. Principal issues arising from pre-visit review:

General Internal Medicine (GIM) at the Queen Elizabeth University Hospital, Glasgow (QEUH), has been under the GMC Enhanced Monitoring process since 2016.

The last visit to QEUH took place on 30th and 31st March 2022. The visit panel found that QEUH continued to be challenged by the significant service pressures created by the covid-19 pandemic, which continued to have an impact on staffing (at all levels) as well as training. Despite these challenges the visit panel acknowledged the significant efforts the local training team and postgraduate medical team had put into supporting postgraduate medical training.

The visit identified 8 requirements which were:

- The scope of the ward cover and the associated workload for Foundation Trainees at weekends (in the wards in 'the stack') must be reduced as currently they are perceived to be very demanding (this applies in particular to Endocrinology and Diabetes wards 5A & 5B and the Gastroenterology wards 8B, 8C and 8D) .
- The rota pattern that required 7-day stretches of long days on the rota with one day break and then back on to another 7-days of long days must be revised as it is impacting on trainees' well-being.
- Handover of care of patients transferred from the Emergency Department (ED) to pods must be provided to support safe continuity of care and to ensure unwell patients are identified and prioritised.
- All handovers of cases between acute receiving and the downstream wards must be more structured (with doctor-to-doctor interaction) and more robust written or electronic documentation.
- Work must be undertaken to ensure that FY1, FY2, GPST, IMT and ST trainees are supported to attend local teaching opportunities without compromise because of service needs.
- Work must be undertaken to ensure that FY2, GPST and IMT trainees are supported to attend clinics without compromise because of service needs.
- Work must continue to ensure sufficient staffing including medical staffing is available for the workload and to ensure trainees have access to quality training.

- Trainees must receive feedback on the incidents they raise and there must be a forum for learning from adverse events.

This visit aims to review progress against these 8 requirements and also take the opportunity to gain a broader picture of how training is carried out within the department visited and to identify any points of good practice for sharing more widely.

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: Trainers reported that a corporate induction is available prior to trainees' start dates and for 1 month after they start. This includes online modules such as infection control and wellbeing. Trainees are also asked to complete mandatory modules on LearnPro. A medicine induction is offered in addition to departmental inductions. Access to key content is provided also via the General Medicine app that includes information such as role cards.

All trainees: FY1 Trainees reported that the shadowing period was useful and prepared them well to start work. The General Medicine app was reported to be very informative and commended by all groups of trainees for inclusion of relevant content including role descriptors; some suggested benefit from inclusion of additional content such as a section about GP referrals. Departmental inductions were generally reported to be relevant and helpful, and particularly so in Acute Medicine, Cardiology, Endocrinology & Diabetes, Gastroenterology, Infectious Diseases, Rheumatology and Respiratory Medicine. Content was shared suitably in advance of starting. Some trainees reported a delay between starting work and accessing departmental induction in some departments and suggested it would have been more useful if the induction had taken place closer to their starting date; nonetheless, trainees felt their departmental inductions were useful. Some suggested it would have been helpful to have included a tour of the Acute Internal Medicine department.

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

Trainers: Trainers reported that departmental teaching is built into the rota in Respiratory Medicine, Acute Internal Medicine and in Infectious Diseases. Consultants in Acute Internal Medicine reported that the loss of their teaching space has made it more challenging to provide teaching. Trainers noted that it was easier to support attendance at regional teaching by building this into the rota when dates are received well in advance and they have raised the issue of late notification of dates for GPST teaching. IMT2 trainees are also offered simulation training in the High Dependency Unit (HDU) during their rotation.

FY1: Trainees reported that their attendance at departmental teaching was limited by ward workload pressures or by shift patterns such night shifts with attendance averaging at about 1 hour per week. Most departmental teaching took place at lunchtime, however in Cardiology it was particularly difficult to attend as it took place at 8:30am, which was before trainees' shifts started. Trainees estimated that they could attend less than half of their regional teaching but were able to catch up via recordings but generally only outside working hours.

FY2: Trainees reported that they could access at least 1 hour of departmental teaching in Cardiology, Respiratory Medicine and Rheumatology. Trainees felt it was difficult to attend regional teaching due to their heavy on-call rota and would often need to work late to catch up after attending teaching. Regional teaching is recorded so they often watched it outside of working hours.

GPST: Trainees reported that they can generally attend teaching when on the wards, but not when on-call, on receiving or on nights. These trainees also access on average around 1 hour per week of local education meetings. Trainees noted that the teaching in Gastroenterology was aligned with the weekend handover on a Friday; this made attendance easier. In terms of regional teaching, trainees thought they could attend around 50%, however as the programme was the same for ST1 and ST2 they would manage to attend everything by the end of ST2.

IMT: IMT trainees echoed the concern raised by FY1s regarding Cardiology teaching being outside working hours. Trainees reported that there was no formal teaching in HDU and there was initially no formal teaching in Endocrinology and Diabetes however a peer-led programme has now been set up. Grand rounds take place on a Wednesday lunchtime, however the timing can coincide with ward

rounds. Staffing pressure was an obstacle to attending teaching and half of trainees present could not manage to attend a minimum of 1 hour per week of departmental teaching. Trainees reported that they needed to apply for study leave to attend regional teaching and this was not embedded in the rota as at other sites. Trainees unable to attend for reasons such as being on leave were able to apply for a day or half day in lieu to watch a recording of regional teaching.

ST: Trainees reported that they needed to be proactive to attend teaching, but much was available. Sometimes busy receiving ward rounds prevented them from attending teaching. Trainees were encouraged to attend multi-disciplinary team meetings and there were amply opportunities to do this. Trainees were able to attend more than 50% of regional teaching, but felt that sometimes regional teaching was not universally understood within their departments and they could feel like they were an inconvenience when asking for time away to attend.

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 stretched in providing formal supervision as some did not have sufficient time in their job plans and were clinically under significant pressure. Trainers felt that the Training Programme Directors (TPDs) based at QEUH were helpful in supporting them in their trainer roles, citing specifically Drs McGrory and Freel.

Trainees: Not asked.

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 support is always available for trainees, however they knew trainees often felt stretched by their workload, particularly at the weekend, and may perceive this as lack of support. Trainers also felt that more junior trainees were less experienced than is typical for their stage of training due to the impact of the covid-19 pandemic. Whilst the size of the hospital can be a disadvantage in terms of geography and signposting support, consultants also felt it was an advantage as there are many consultants and STs on site to help more junior trainees. Acute Medicine consultants often “act down” to support trainees with their workload. In Endocrinology and

Diabetes consultants are seeking to change their working pattern to offer more support to trainees as they have limited numbers of STs, but this change will increase pressure upon consultants.

FY1: Trainees reported there was always senior support available and they never felt they needed to deal with problems beyond their competence or experience. Trainees felt their supervision ensured patient safety.

FY2: Trainees felt they were well supported, but the workload was high for STs and there was only 1 available on the ground floor so sometimes they were unavailable. Trainees felt their clinical supervision was as safe as it could be considering the high volume of patients. Trainees reported that they see a lot of patients independently, but can always discuss them with a consultant or ST when needed.

GPST: Trainees felt they sometimes needed to cope with problems beyond their competence and experience at the weekend due to the volume of patients needing to be seen. Trainees reported that Respiratory Medicine has a dedicated ST on the 7th floor so this area has better support than others. In other departments it can be harder to find support out-of-hours, but trainees confirmed that consultants are always supportive when contacted.

IMT: Trainees reported that senior colleagues were always available and escalation routes were clear. They felt their supervision typically ensured safe care for patients. Trainees reported that the Initial Assessment Unit (IAU) is generally well supported, but if the ST trainee is pulled away this can feel less supported.

ST: Trainees reported that they receive very good support from consultants who are visible and approachable. Trainees felt confident about who to contact for support overnight and never felt reluctant to phone a consultant for help out-of-hours.

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

Trainers: Trainers reported that clinics are built into the rota for GPSTs, IMTs and STs in Respiratory Medicine and for STs in Gastroenterology. There is limited access to scopes in Gastroenterology. There are no clinics in Acute Internal Medicine, however trainees have dedicated time in the rota for

their specialist skill. Trainers felt it would be better if Endocrinology and Diabetes had 3 wards rather than 2 wards and 2 half wards as they felt the geography negatively impacted their ability to function as a cohesive unit. In Endocrinology and Diabetes there is insufficient consultant time to schedule clinics into the trainees' rota and its clinics tend to be run in locations outside the QEUH which is an additional challenge, but STs can generally attend clinics.

Trainers had some concerns about IMT trainees attending sufficient clinics, however IMTs now have a block in HDU and within that block they are scheduled to spend some time at outpatient clinics in Gartnavel General Hospital.

Trainers were not aware of concerns regarding clinic attendance at ARCPs.

FY1: Trainees reported they had no issues obtaining their curriculum competencies. Trainees had good exposure to acutely unwell patients out-of-hours, although sometimes felt they were de-skilling on daytime shifts due to lower exposure. Trainees reported that they tend to work on a single ward in Respiratory Medicine which is helpful for building relationships, feeling part of the team and getting constructive feedback. While in Gastroenterology, trainees are based in one ward – they work with seniors who change day to day and week to week. Trainees in ID enjoyed some stability of their ward base. Trainees moved more frequently in Cardiology which limited their rapport with the team. Trainees felt it would be best to work in a single location for a minimum of 2 months.

FY2: Trainees felt they had good training opportunities, particularly in receiving. They got adequate experience in managing acutely unwell patients, however the rota did not allow them to attend any clinics. Trainees felt their placements were long enough to allow them to get to know colleagues.

GPST: Trainees reported they had no issues obtaining their curriculum competencies and had good exposure to acutely unwell patients. Access to clinics was variable with some GPSTs having attended no clinics so far. However, GPSTs in Respiratory Medicine had attended clinics because their attendance was scheduled into their rota.

IMT: Trainees had good exposure to acutely unwell patients, but struggled to obtain their procedural competencies such as pleural and central lines. They got good access to clinics during their time at Gartnavel General Hospital, however this took place during their 4 months in HDU so further reduced

their exposure to procedures. Trainees reported there were no clinics in Acute Internal Medicine, but they could access ambulatory care services that offered opportunities that were analogous to clinics.

Trainees felt they knew the consultants best in Acute Internal Medicine as they did so many on-call shifts and therefore got helpful feedback from them. Trainees reported often being moved to different wards when working in Cardiology and this disrupted learning and feedback opportunities.

ST: Trainees reported being able to access sufficient opportunities to meet curricular requirements. There were plenty of opportunities to support learning around the management of acutely unwell patients. Trainees noted that the new "specialty registrar (SpR) of the week" model allows specialty registrars to spend 1-2 week blocks in Acute Internal Medicine which is essential for their General Internal Medicine training but also provides support for learning through provision of feedback and assessments. Those trainees requiring procedural competences reported access to sufficient numbers of lists including, for example, of endoscopic procedures. Acute Medicine trainees were struggling (as many were around Scotland) to get sufficient POCUS ultrasound training due to a lack of supervisors (across Scotland). Trainees described having good exposure to acutely unwell patients. Those in Acute Medicine reported access to sufficient ambulatory care opportunities, and in general others had sufficient outpatient clinic access, made easier in Gastroenterology and in Respiratory Medicine by virtue of the clinic rota.

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

Trainers: Trainers felt it was easy for trainees to complete their workplace-based assessments due to the proactivity of consultants.

FY1: Trainees felt it could be hard to complete their assessments during working hours and often had to work on these at home. They felt they often needed to chase colleagues for responses to tickets due to time constraints. Trainees reported difficulties completing their PSG when on a rota with heavy out-of-hours commitments as colleagues did not get to know them so well. This has been raised with a senior colleague.

FY2: Trainees felt it was easy to complete their assessments if they chased up tickets. They felt the quality of the feedback they received was variable.

GPST: Trainees felt they had sufficient opportunities to complete their workplace-based assessments. Trainees echoed the comments made by FY1s regarding completing assessments at home and noted that when in GP practices they had dedicated time for their portfolio which was helpful. Trainees reported they often encounter issues with consultants being unable to access the GP portfolio.

IMT: Trainees generally had no issues completing workplace-based assessments, but could foresee potential issues in HDU due to consultants changing every day and some of the block being spent at Gartnavel General Hospital.

ST: Trainees reported that trainers were proactive in offering to complete assessments. Trainees noted that the new SpR of the week model allows them all to spend 1 week in Acute Internal Medicine which they find helpful for completing assessments.

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: Trainers felt it was easy to give feedback to trainees when they were present, but hard to give this retrospectively due to volume of trainees.

Acute Internal Medicine and Respiratory Medicine have 8am ward rounds which allows consultants to give feedback to trainees following night shift. HDU also has a daily consultant ward round.

Trainers felt it was easy for trainees to complete their workplace-based assessments in Acute Internal Medicine due to volume of patients and proactivity of consultants. Trainers sometimes felt frustrated as they perceived certain curriculum requirements to lack value, for example the PSG which forms part of the Foundation curriculum.

FY1: Trainees felt that receiving shifts and night shifts provided them with good opportunities to receive feedback as they made more clinical decisions on these shifts. Trainees felt they made few independent decisions during the day on the wards. Feedback was not always available at handover due to lack of senior colleagues, however most trainees felt they got feedback on at least 25% of cases.

FY2: Trainees reported receiving adequate feedback on their decision-making. Feedback was felt to be particularly accessible in Acute Medicine due to the consultant presence from 8am-9pm and the consultants were keen to take them on their morning ward rounds to review the patients they have seen and to provide feedback to them on their decision-making. In general in the downstream wards the twice weekly consultant ward rounds present opportunities for Foundation trainees to participate and to receive feedback.

GPST: Trainees reported receiving informal feedback on their decision-making during the day and sometimes out of hours depending upon the senior colleagues with which they were working. Trainees felt feedback was also freely given when requested.

IMT: Trainees reported receiving feedback on around 25-50% of the cases they saw in the IAU and the ARUs; this feedback informed their learning. They felt generally it could be more challenging to receive feedback on night shift workload.

ST: Trainees reported receiving feedback frequently on their decision-making, as all cases they saw were reviewed during ward rounds that they could participate in.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: Trainers reported that there is a junior doctors forum run by 2 chief residents as well as drop-in sessions with the rota team, but the latter tends not to be well attended. Improvements have been made based upon feedback received at the junior doctors' forum, such as the introduction of cardiac arrest huddles. Each department also has its own mechanisms for feedback including; informal feedback sessions in Acute Internal Medicine; end-of-rotation surveys in HDU with any issues arising escalated to consultant meetings as needed; trainee representative attending the unit

business meetings in Gastroenterology with a standing agenda item for their feedback; end-of-rotation feedback meetings and appointment of a pastoral lead in Respiratory Medicine.

FY1: Trainees reported that they received an e-mail about a recent meeting of the junior doctors' forum, but notice was late (only 1-2 days prior to the meeting) and the timing of 4pm was challenging as trainees are preparing for handover at this time. The meeting was described as only having 4-5 trainees in attendance and organisers stated this was the highest attendance they had had. Trainees noted there was a tab on the General Medicine app for the forum, however the information was not particularly helpful as it stated the meeting took place "once per month every Wednesday".

FY2: Trainees felt they could raise issues with supervisors and their teams were approachable. They also knew that they could give feedback by completing the NTS and STS surveys.

GPST: Trainees were aware of the monthly trainees' forum, but could not always attend this due to shift patterns. They knew they could contact the chief registrars regarding any issues which they wanted to be raised within the forum even if unable to attend. Trainees were also aware of the NTS and STS surveys.

IMT: Trainees were aware of the junior doctors' forum and had received an invitation to attend this. They were also aware of their chief residents. Trainees felt consultants were supportive and they could speak to them directly about any issues. The introduction of a peer-led teaching programme in Endocrinology and Diabetes was cited as an example of a positive change which had occurred following direct feedback to consultants.

ST: Trainees felt they could give feedback directly to consultants, but were also aware of the junior doctors forum and their chief residents. The ST responsible for the junior rota attends a consultant meeting to give feedback in this capacity.

2.12 Culture & undermining (R3.3)

Trainers: Trainers reported that the size of the hospital can make it challenging to create a team culture, however departments take various steps to promote this and the hospital has a flat hierarchy where first names are used for all staff. All teams have nights out at consultants' homes and some

have other activities such as weekly meetings, Christmas events and baking rotas. A pastoral support team is available for Foundation trainees (run by Dr Sarvesvaran, a consultant in Respiratory Medicine). Trainees on extensions to training time are offered additional support and trainers were alert to the potential need for additional support for International Medical Graduates. Trainers in Endocrinology and Diabetes felt the geography of their department (split over 3 different locations) made it more challenging to promote a team culture within their unit and suggested that a smaller footprint would be more conducive to providing a supporting training environment.

FY1: Trainees reported they would contact their supervisor if they experienced or witnessed bullying or undermining. Trainees gave an example of an issue with the Hospital at Night (HAN) team which had been escalated and was managed appropriately. Trainees generally reported not experiencing bullying or undermining, but some noted that use of phrases such as “just an FY1” felt a bit undermining.

FY2: Trainees felt there was a positive working culture within their teams and felt consultants and senior trainees were supportive and approachable. They would feel confident accessing support if they had any concerns.

GPST: Trainees felt their teams were very supportive and they would feel comfortable raising any issues with them.

IMT: Trainees had no concerns regarding culture and felt that generally their experiences of seeking support had been positive. Trainees identified that there were some members of their teams they would not feel comfortable approaching for support.

ST: Trainees felt the culture in their departments was excellent and would have no concerns about raising issues if they arose.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Trainers noted that there were gaps in the rota and the current clinical pressures were compromising the wellbeing of all staff groups. Trainers felt the working conditions were not sustainable, but recognised that they were common to all hospitals nationally at the moment.

FY1: Trainees reported that staffing was insufficient for the workload and there were also regularly uncovered gaps. Trainees described long-standing gaps not being filled and concerns were expressed about the pressures put upon them to cover gaps. An added issue that fuelled tension was awareness of the level of remuneration that was being offered (locum rates or not) for filling gaps at short notice. Trainees reported being regularly moved around to cover gaps and felt under pressure to cover additional shifts.

Trainees continue to report that weekend long days were their worst shifts due to the overwhelming workload as there is only 1 FY1 and 2 middle tier doctors per floor covering 120 patients, in addition to 1 “medical registrar” for the stack. The middle-grade trainees can also be pulled away if issues arise elsewhere.

Trainees highlighted that the shift pattern in acute receiving which is a 7-day stretch of which 5 are long days with 2 normal days in the middle followed by 1 zero day at the end is exhausting.

Trainees felt the staffing was unsafe and had a significant negative impact on their wellbeing.

FY2: Trainees described their rota as over-whelming with lots of 12-hour days and transitions between days and nights. They reported that the staffing level fluctuates, at times being too low which was thought to be frustrating given that their annual leave is fixed and allocated. They are often pulled to other wards to cover gaps.

Trainees also highlighted the 7-day stretch mentioned by FY1s as exhausting.

Trainees reported that it was hard to take training opportunities when the workload was so high and they were often too exhausted to learn.

GPST: Trainees echoed the comments made by Foundation trainees regarding the rota pattern comprising the 7-day stretch which they described as “horrendous”. They described this shift pattern occurring about once per month.

As they have fixed annual leave allocated without preference, trainees noted that they cannot use leave to mitigate the effect of the rota.

They also had difficulties contacting the rota team and usually waited 4-5 weeks for responses to e-mails.

Trainees reported that it was hard to attend clinics when they were the only middle tier on a ward with an FY1, and out-of-hours it was hard to do any learning as their priority was keeping patients safe.

IMT: Trainees similarly raised the rota pattern comprising the 7-day stretch as unsafe and reported they had witnessed increased prescribing errors made by trainees at the end of this week. They noted that staffing was tight when fully staffed and there were frequent gaps. They felt there was not a clear process for managing these gaps as consultants did not seem to be aware of who could authorise higher rates for critical gaps. Trainees felt that gaps were often advertised too late and locum rates offered too late to fill them. The rota gaps were described as unsafe and demoralising.

Trainees also raised the lack of phlebotomy cover which increased the workload for FY1s beyond manageable levels and noted that this has been raised at the junior doctors' forum.

ST: Trainees were aware that there were often unfilled gaps on the rota and felt there was a lack of FY1 and middle tier trainees compared to other hospitals. Trainees reported that weekend shifts were very busy and they knew that more junior trainees, particularly FY1s, found these shifts over-whelming, however they emphasised that consultants are very supportive and will try to help ease the workload.

2.14 Handover (R1.14)

Trainers: Trainers reported that each department has their own handover processes and timings, however there is currently no process for doctor-to-doctor handover and they are unsure how to implement this. Trainers felt that handover was safe and used as a learning opportunity as interesting cases are discussed at hospital-wide handover at the weekend as well as some departmental handovers.

All trainees: Trainees highlighted several areas where lack of robust handovers compromised or had potential to compromise quality and safety of care. These included:

- the absence of handover of unwell patients transferred to ward corridors or dayrooms to await assessment and treatment under the GlasFLOW model was highlighted as a particular safety concern, as is described in more detail in section 2.19.
- the absence of robust handovers after FY nightshifts in the stack resulting in FY doctors having to walk around the stack wards in the morning to find someone on each ward to handover to, prior to them leaving the hospital.
- the lack of consistent handover of patients noted to be unwell in the Emergency Department (ED) to support continuity of care as these patients are transferred to the pods remains an issue. Work to address this was reported by service leads in the introductory section of the visit, but there was little recognition by trainees of progress around this.

Post-receiving handovers, however, worked well. These also afforded learning opportunities at times.

2.15 Educational Resources (R1.19) – Not covered

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) – Not covered

2.18 Raising concerns (R1.1, 2.7)

Trainers: Trainers encourage trainees to speak to their supervisors about any concerns and felt that the presence of several TPDs in the hospital allowed training issues to be heard at an early stage. Trainers reported that patient safety concerns could be raised at handover or by completing a Datix report. The Datix system is now better publicised than previously as it is highlighted at induction and advertised on posters and QR codes around the hospital. Trainees submitting Datix reports will be invited to discuss them with the clinical director and their educational supervisor will be informed. Individual departments had morbidity and mortality (M&M) meetings which trainees could attend to discuss adverse incidents. Morning ground floor handover is also attended by a member of the rota team so issues relating to the rota can be raised with them.

FY1 & FY2: Trainees would raise concerns with their supervisor, another consultant or the rota lead. Trainees had patient safety concerns regarding capacity, but had not raised these as they felt they were widely appreciated.

GPST: Trainees reported that they would raise concerns with an ST, consultant or senior nurse or would complete a Datix report.

IMT & ST: Trainees reported they could raise concerns with consultants who they felt were approachable and would be happy to help them. Trainees were also aware of the Datix process.

2.19 Patient safety (R1.2)

Trainers: Trainers reported that pressure had been high over winter and night shifts were especially challenging for trainees. Trainers have been asking hospital management for help and lobbying on behalf of trainees but so far have not perceived any improvement. Regarding boarding, trainers confirmed that the hospital has a boarders' team and criteria for suitability for boarding so this process has been improved. The boarders team includes acute medicine consultants, STs, middle-tier trainees and Advanced Nurse Practitioners (ANPs).

Trainers & trainees: The visit panel heard from the management team that the GlasFLOW system has been a well-considered response to risk management of the hospital's patient flow issues given the long-standing issue of risk due to substantial backlogs of patients within IAU who were awaiting assessment by the medical team. The principle underlying the model is the redistribution of the risk to patient safety from patients queuing for assessment in a single location in the IAU to spreading the queuing for assessment in corridors or day rooms in multiple ward areas in the stack. The trainers and all groups of trainees expressed concerns about the safety of the model. Trainers reported that patient safety risk had merely been relocated to the ward areas, but not reduced. They reported additional stress upon medical and nursing staff in managing these patients, and their distressed relatives in unsuitable areas. Trainees also reported a number of concerns:

- Lack of awareness of how unwell were patients transferred under this model to ward corridors or dayrooms in the stack due to lack of handover prior to transfer.
- Concerns were expressed about the suitability of some of these patients to have been transferred and about lack of clinicians' input to the decision-making.

- Concerns about the suitability of corridors and day rooms as holding areas for unwell patients, for example, patients whose need for oxygen could only be supplied via oxygen cylinders.
- Adverse outcomes in patients who were discovered to be extremely unwell.
- The lack of recording of observations on these patients while awaiting access to a bed.
- This created a stressful working environment and there was a lack of private spaces to have conversations with patients and relatives who were waiting in corridors.

Post-visit note – 9th May 2023, informed by SMART objective-setting meeting 4th May 2023 and an ad hoc meeting with Arwel Williams, Wesley Stuart, Colin Perry, Gillian Carter & Alastair McLellan on 9th May 2023.

- ***The GlasFLOW model is designed for patients in IAU/ARUs who have been assessed and who have undergone consultant review. Occasionally patients can slip through without undergoing assessment, but this is being monitored.***
- ***In this model patients who traditionally would have waited in IAU or in ARUs are transferred to stack wards to await access to a bed (the numbers transferred are based on modelled projections of typical numbers of discharges). The risk associated with waiting for a suitable bed is transferred from waiting in IAU/ARU to waiting within a ward area (corridor or day room), easing flow through IAU.***
- ***A traffic-light system was introduced 1 month ago for patients who can be transferred. Those deemed too unwell are not managed under the traffic light system, and if transferred are subject to individual transfer arrangements with handover. A "red light" is used to denote those who on transfer must be transferred to a bed immediately (based on acuity, infection control/nursing/medical management - monitoring - treatment need/imminence of death); these patients have an electronic SBAR nurse-nurse handover. Those transferred under a green light are deemed appropriate to wait for an available bed within the ward area.***

Trainees: All cohorts of trainees reported concerns about the volume of patients and the staffing levels for the workload. Particular concerns related to the workload for FY trainees in the stack (especially in relation to the 5th & 8th floors) at weekends and the workload managed during nightshifts; these concerns were exacerbated by staff absences and shortages.

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

Trainers: Trainers reported that trainees were encouraged to use Datix to report adverse events and would be offered a meeting with the clinical director to discuss reports submitted. Educational supervisors would also be involved when trainees experienced adverse events to provide support.

FY1: Trainees had some experience of completing Datix reports, but had not received feedback on them. No FY1 trainees had attended an M&M meeting, but invitations to attend had been received in Respiratory Medicine. Trainees had received an e-mail about a transfusion near-miss.

FY2: Trainees had no experience of submitting Datix reports. Trainees had attended an M&M meeting in Respiratory Medicine and thought they had also been invited to one in Rheumatology. Trainees reported sometimes receiving e-mails about adverse events.

GPST: Trainees had experience of submitting a Datix report and being offered an opportunity to discuss this with their supervisor. Trainees had attended M&M meetings in Gastroenterology and Endocrinology and Diabetes and found these useful. Trainees felt the group of GPSTs within the hospital was supportive and they made a habit of sharing learning together.

IMT: Trainees had no experience of submitting Datix reports. Trainees were aware of M&M meetings in Rheumatology and Respiratory Medicine and had managed to attend some.

ST: Trainees had submitted Datix reports and received feedback on these from the clinical director and head of department. All trainees had attended an M&M meeting and it was noted that HDU are currently promoting trainee attendance at these.

3. Summary

Is a revisit required?	Yes	No	Dependent on outcome of action plan review

Overall the panel saw improvements from the last Deanery visit and observed positivity and high morale despite the clinical pressures under which all staff were working. Trainees were unanimous in feeling

well-supported by their consultant colleagues and there was close alignment in the accounts given by trainers and trainees, suggesting trainers have a keen awareness of the challenges experienced by trainees. The panel expressed disappointment at the low number of trainees attending the visit compared with the numbers expected and would hope to see greater numbers on any future visit to the department.

Strengths

- Supportive and accessible trainers provide enthusiastic supervision and are proactive in supporting formal assessments. Some trainers reported insufficient time in their job plans for supervision and, whilst the panel noted this issue, it was not reflected in trainee comments where easy access to supervision was described.
- The General Medicine app was described as a vehicle and enabler of solutions to challenges such as providing induction materials and access to processes and documents.
- The new SpR of the week model has been beneficial in allowing trainees greater access to the training opportunities and support available in Acute Internal Medicine.
- All trainees have good exposure to managing acutely unwell patients.
- There are excellent training opportunities available for ST3+ trainees.
- Particularly positive learning environments were described in Respiratory Medicine, the HDU, Rheumatology, Acute Internal Medicine and Infectious Diseases.
- Acute Internal Medicine was commended by all cohorts of trainees for providing excellent training and teaching.
- The work done within the department to improve awareness of clinical governance processes has been effective as trainees know how to use the Datix system and report receiving feedback on reports submitted. The structure of M&M meetings is also more visible than previously although not all trainees have accessed these yet.
- The ongoing commitment by the department to addressing the requirements of previous Deanery visits is admirable and the use of data to demonstrate improvement is helpful.

Weaknesses

- The panel recognise that the GlasFLOW system has been a well-considered response to the hospital’s patient flow issue and does not offer any view on the merits of the system, however trainers and trainees alike had anxieties about the continuous flow model including:

    - Concerns about unwell patients being transferred from the ED
    - Concerns about lack of shared awareness of patients and how unwell they were before arriving in the ward
    - Concerns about the suitability of corridors and day rooms as accommodation considering the acuity of some patients [See report section **2.19 Patient safety (R1.2) and Post-visit note – 9th May 2023 for subsequent risk mitigations]**
- The scope of ward cover at the weekends remains an issue particularly for FY1s, but also for middle grade trainees.
- The rota pattern which comprises a 7-day stretch of which 5 are long days and 2 are normal days followed by 1 zero day is comprising trainee wellbeing for all cohorts on this rota. The impact of this rota pattern is compounded by the practice of allocating fixed annual leave without offering trainees a choice of their lines on the rota.
- Access to outpatient clinics has improved, however some trainees are still struggling to attend, particularly GPSTs.
- Access to learning opportunities has improved, however FY, IMT and GPST trainees still struggle to access these opportunities due to workload.
- The system of handover from ED to the pods was understood by ST trainees, but not by other cohorts who did not recognise any doctor-to-doctor handover or awareness of acuity.
- There has been an improvement in management of gaps, however there appeared to be a lack of awareness of where the authority sat to authorise enhanced funding to try to fill weekend gaps.
- The FY1 morning handover process could be improved to offer a single point of contact for trainees as currently they are required to seek out individuals to whom they can hand over patients.

Progress against 2022 visit requirements

Requirement	Status
The scope of the ward cover and the associated workload for Foundation Trainees at weekends (in the wards in 'the stack') must be reduced as currently they are perceived to be very demanding (this applies in particular to Endocrinology and Diabetes wards 5A & 5B and the Gastroenterology wards 8B, 8C and 8D).	Not yet met
The rota pattern that required 7-day stretches of long days on the rota with one day break and then back on to another 7-days of long days must be revised as it is impacting on trainees' wellbeing.	Met
Handover of care of patients transferred from the ED to pods must be provided to support safe continuity of care and to ensure unwell patients are identified and prioritised.	Partially met
All handovers of cases between acute receiving and the downstream wards must be more structured (with doctor-to-doctor interaction) and more robust written or electronic documentation.	Not yet met, see section 3 regarding feedback on new GlasFLOW model
Work must be undertaken to ensure that FY1, FY2, GPST, IMT & ST trainees are supported to attend local teaching opportunities without compromise because of service needs.	Partially met
Work must be undertaken to ensure that FY2, GPST & IMT trainees are supported to attend clinics without compromise because of service needs.	Partially met
Work must continue to ensure sufficient staffing including medical staffing is available for the workload and to ensure trainees have access to quality training.	Not yet met
Trainees must receive feedback on the incidents they raise and there must be a forum for learning from adverse events.	Met

4. Areas of Good Practice

Ref	Item	Action
4.1	General Medicine app as a means of sharing key information including around roles and responsibilities (role cards).	

5. Areas for Improvement

Areas for Improvement are not explicitly linked to GMC standards but are shared to encourage ongoing improvement and excellence within the training environment. The Deanery do not require any further information in regard to these items.

Ref	Item	Action
5.1	The F1 morning handover process for the stack could be improved to offer a single point of contact for trainees as currently they are required to seek out individuals to whom they can hand over patients.	
5.2	Work should continue to embed an effective handover process supporting handover of care of patients transferred from the ED to pods to ensure safe continuity of care and to ensure unwell patients are identified and prioritised in the pods.	
5.3	The new rota pattern (that requires 7-day stretches of long days on the rota with 2 normal days in the middle followed by 1 zero day at the end) should be reviewed and revised with input from doctors in training to mitigate the trainees' concerns around its impact on their wellbeing.	
5.4	Building on the improvement in management of rota gaps, clarity around the process for authorising enhanced funding to support filling weekend gaps should be provided.	

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	The effectiveness of measures, including the introduction of the traffic-light system, implemented to address the patient safety concerns reported in association with the continuous flow (GlasFLOW) must be demonstrated to ensure the safety of care of unwell patients transferred to wards under this system.	3rd January 2024	FY1, FY2, GPST, IMT, ST
6.2	The scope of the ward cover and the associated workload for Foundation Trainees at weekends (in the wards in 'the stack') must be reduced as currently they are perceived to be very demanding.	3rd January 2024	FY1, FY2
6.3	Work must be undertaken to ensure that FY1, FY2, GPST & IMT trainees are supported to attend an average of ~2 hours per week of local teaching opportunities without compromise because of service needs.	3rd January 2024	FY1, FY2, GPST, IMT
6.4	Work must be undertaken to ensure that GPST trainees are supported to attend sufficient clinics without compromise because of service needs.	3rd January 2024	GPST
6.5	Work must continue to ensure sufficient staffing including medical staffing is available for the workload and to ensure trainees have access to quality training.	3rd January 2024	FY1, FY2, GPST, IMT, ST