Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	11th May 2023	**Level(s)**	FY, GPST, IMT, ST
Type of visit	Triggered visit	**Hospital**	Glasgow Royal Infirmary
Specialty(s)	Acute Internal Medicine, Cardiology, Respiratory Medicine	**Board**	Greater Glasgow and Clyde

Visit panel	
Dr Reem Al Soufi	Visit Chair – Associate Postgraduate Dean for Quality
Dr Tom Fardon	Associate Postgraduate Dean for Medicine
Dr Raj Parikh	College representative
Dr Susan McGeoch	Training Programme Director
Dr Duncan Henderson	Associate Postgraduate Dean for Foundation
Mr Bill Rogerson	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	7
Trainers in attendance	11
Trainees in attendance	FY 9; GPST 2; IMT 6; ST 7

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

Date report approved by Lead Visitor	31st May 2023

1. Principal issues arising from pre-visit review:

Following review and triangulation of available data at the 2022 Deanery Quality Review Panel (QRP), a visit to Acute Internal Medicine, Cardiology and Respiratory Medicine at Glasgow Royal Infirmary was requested around the following concerns:

- Acute Internal Medicine: Red flag for rota design and pink flags for facilities and induction on all trainee National Trainee Survey (NTS) data; red flag for rota design and pink flags for feedback, handover and study leave on ST NTS data; pink flag for team culture on all trainee Scottish Trainee Survey (STS) data; red flag for team culture on IMT STS data.
- Cardiology: Red flags for induction and local teaching and pink flags for adequate experience, educational governance, feedback, overall satisfaction, supportive environment and feedback on all trainee NTS data; red flag for educational governance and pink flags for educational supervision, induction and local teaching on ST NTS data; red flags for educational environment, induction, teaching and team culture and pink flags for clinical supervision and handover on all trainee STS data; red flags for educational environment, handover, teaching and team culture and pink flag for clinical supervision on IMT STS data.
- Respiratory Medicine: Pink flag for handover on all trainee NTS data; pink flags for clinical supervision out of hours, handover, induction, reporting systems, supportive environment and teamwork on ST NTS data. Inter-consultant friction noted verbally during QRP.

Accordingly, a triggered visit was arranged to Acute Internal Medicine, Cardiology and Respiratory Medicine at Glasgow Royal Infirmary. The scope included all trainees in Acute Internal Medicine, Cardiology and Respiratory Medicine at the site.

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 hospital induction takes place on the first Wednesday of August. Cardiology have a departmental induction pack, although this has not been updated for a while and they will be working with trainees to update this soon. Respiratory Medicine also have an induction pack which is updated each year and offer a face-to-face induction to all trainees, with those unavailable on the first day receiving an induction later from their supervisor. There is also online induction material for Respiratory Medicine that can be accessed throughout the year.

FY: Trainees reported that they received a half-day site induction of which half focused upon IT, however they did not find this very helpful as the pace was too fast and it was aimed at FY2 level and above. They did not have access to IT systems during FY1 shadowing. Some departmental inductions coincided with site induction so trainees could not attend both. Some trainees reported that induction to Respiratory Medicine was good, however trainees who missed the first day were not offered an induction in either Respiratory Medicine or Cardiology. FY1 trainees reported that they had no induction for Acute Internal Medicine whether they were based within the Acute Medicine team or covering acute take as part of their receiving block.

GPST/IMT: Trainees could not recall a hospital induction, however some received documents from the Acute Internal Medicine registrar induction which they felt would have been useful for all trainees. A trainee reported receiving a map of the site only. Trainees reported that Acute Internal Medicine and Cardiology provided induction booklets and Cardiology offered an informal induction lasting around 20 minutes. The Cardiology induction booklet was received the day prior to starting work and was described as out-of-date. There was a recorded Acute Internal Medicine induction for out-of-hours work that the trainees valued in addition to a short tour of the Acute Medical Admission Unit (AMU). Some trainees reported difficulties accessing IT systems.

ST: No issues were identified in the pre-visit questionnaire and all trainees had been in post for years (ST5-ST7) so induction was not explored with the senior trainees.

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

Trainers: Trainers were not aware of any issues in trainees accessing local or regional teaching. Trainers in Respiratory Medicine reported that all trainees attend local teaching unless on-call. Teaching is recorded and they are given time back in lieu to watch recordings if they cannot attend live. They ask the rota team for additional cover on these days and consultants cover for STs. Trainers in Cardiology reported that teaching sessions are embedded in the junior doctor rota, but they do not have access to additional staff to cover during teaching. Some sessions are recorded and provided online for trainees to catch up if they miss teaching. Trainers in Acute Internal Medicine reported that there are usually no issues in trainees accessing local teaching and consultants provide cover for them to attend. In terms of regional teaching, FY and IMT teaching is embedded in the rota.

FY: Trainees reported that they had difficulties accessing formal teaching due to workload. Trainees in Respiratory Medicine also described an additional challenge of the teaching location being a 15-minute walk from their ward base. Trainees felt they would manage to meet their ARCP requirements, but watched 50-80% of their teaching requirement in their own time. Teaching was not bleep-free, but generally they were not contacted during teaching if they informed nurses. Trainees in Acute Internal Medicine felt they could not access teaching while working in the department and had to catch up on recordings in their own time.

GPST/IMT: Trainees felt colleagues were supportive of them attending formal teaching, but they had poor access as low staffing levels did not allow them to leave the wards. Some trainees had only been able to watch recordings of teaching and those who had attended live had done so in a side room while doing other work. Trainees reported that there were various obstacles to accessing time in lieu to watch recordings and e-mails they had sent on this topic had not received a response. Teaching was not bleep-free and trainees noted that most trainees did not have bleeps anyway so had to give their personal mobile phone number if leaving the ward. GPSTs had good access to regional teaching which was notified well in advance, however IMTs struggled to attend their national teaching days due to staffing issues.

ST: Trainees in Cardiology and Respiratory Medicine had no issues attending formal teaching including national sessions. However, STs in Acute Internal Medicine had not managed to attend any local teaching and also struggled to attend regional teaching having only managed to attend 1-2 out

of 8 sessions so far. Acute Internal Medicine trainees reported that they had no local teaching provided at GRI and they could not attend the West of Scotland Acute Internal Medicine teaching which is one half day per month due to short staffing. These sessions were not recorded so not accessible online. Acute Internal Medicine STs carry the high dependency unit (HDU)/cardiac arrest page and so will not be able to leave the wards to attend teaching without a suitable cover. Acute Internal Medicine trainees felt local teaching had waned due to service pressures. They were aware of Grand Rounds, but did not feel these were relevant to their training needs.

2.3 Study Leave (R3.12)

Trainers: Trainers reported that trainees could have difficulty accessing study leave when departments were short-staffed. Trainee numbers are lower than usual in Respiratory Medicine this year, but they continue to ask the rota team for cover when needed.

FY: FY1 trainees do not have access to study leave. FY2 trainees expected to be able to access Tasters, but noted the process of obtaining these was challenging.

GPST/IMT: Trainees had managed to access study leave for essential activities such as exams and mandatory courses. However, they had only received confirmation of this being granted a few days prior and struggled to get study leave for any other activity including IMT national teaching and non-mandatory courses. They appreciated it was difficult to cover wards when someone was on study leave and had sometimes been asked to arrange their own cover. It was noted that GPSTs had all mandatory GP study days approved as study leave.

ST: Trainees had no issues accessing study leave, but noted the budget was limited.

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

Trainers: Trainers reported that they should have 0.25 Supporting Professional Activities (SPA) time per trainee as an educational supervisor, but some do not have this much. There is no specific SPA time for clinical supervision as this role is shared between consultants within the departments. FY1 supervisor allocations are organised by the postgraduate office. In Respiratory Medicine allocations for FY2+ trainees are organised by a single consultant, however the consultant previously responsible

has recently stepped down from this role. In Cardiology they use a spreadsheet to assign supervisors and this is a complex process as some supervisors are employed by NHS Golden Jubilee. In Acute Internal Medicine they divide trainees between consultants and each supervises usually 2-3 trainees. Supervisor allocations are sent to trainees before they start in the department.

FY: Trainees reported they have all had initial meetings with their educational supervisor and expect to see them 1-2 times per block.

GPST/IMT: Trainees had no concerns about their formal supervision and saw their educational supervisor at the start and end of each block. They felt their educational supervisor would be accessible if needed at another time. Trainees within Cardiology felt there was a lack of engagement with trainees below ST level in the department and felt they were seen as ward cover yet not embedded within the team. IMT trainees felt trainers lacked understanding of their curriculum requirements, such as clinic requirements, and did not understand the change in their training programme from CMT to IMT. This was supported during the visit by the use of “CMT” terminology from trainers within Cardiology. Delays of up to 2.5 months in being allocated a supervisor were also reported in Cardiology.

ST: Trainees had no concerns about their formal supervision and felt their supervisors were approachable if they needed support.

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 in Respiratory Medicine reported that trainees have access to tiered support and this is outlined to them at induction. An incident was described where trainees were unable to access support with inserting a chest drain out-of-hours and had to contact someone who was not on-call. Trainers in Cardiology reported that similarly trainees have tiered support in their department. However, where appropriate, trainees are encouraged to stretch their comfort zones and learn from the challenges they face in managing complex situations with accessible senior input if required. Trainers in Acute Internal Medicine reported that the service is consultant-led and a consultant is available on the ward 12 hours per day with a second available 8 hours per day. Trainees were supported out-of-hours by an ST or consultant on-call and this information was also provided during induction.

FY: Trainees felt they could always access support and had never had to cope with problems beyond their competence or experience.

GPST/IMT: Trainees felt well-supported in Acute Internal Medicine and Respiratory Medicine with reliable clinical supervision in- and out-of-hours. However trainees felt supervision was variable in Cardiology depending upon the location in which they were working; CCU and the Cardiology admission unit were perceived to be well supported and access to clinical supervision was adequate. The situation in Ward 43B was described as challenging as it was a semi-step-down ward with high turnover of patients and twice weekly consultant ward rounds. Trainees felt STs were reluctant to give support to ward 43B when the GPST/IMT is unable to access the consultant between ward round days. Ward 19 was also described as challenging as sometimes the most senior person on the ward was an FY or IMT trainee while nurses based in ward 19 were perceived to be less experienced in Cardiology compared to CCU and the admission unit. Trainees felt the STs in Cardiology were supportive and worked hard, but they did not know how to access consultant support directly, partly due to the culture within the department being non-inclusive of doctors who are not Cardiology trainees. Trainees reported that not all Cardiology consultants talk to each other, making it difficult to access help from a consultant when a colleague is on annual leave or working off-site e.g. in NHS Golden Jubilee.

ST: Trainees felt well supported in Respiratory Medicine. Trainees in Cardiology noted that they receive initial calls from Inverclyde Royal Hospital, Greenock, and the Royal Alexandra Hospital (RAH), Paisley, as they do not have out-of-hours consultant cover in Cardiology at these sites so trainees from ST4 level upwards sometimes need to provide support. There is no written agreement or standard operating procedure (SOP) on who is the consultant responsible for those patients in RAH/Inverclyde Royal Hospital who require Cardiology input out-of-hours. Cardiology STs described it as an uncomfortable grey zone.

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

Trainers: Trainers in Respiratory Medicine reported that they have a clinic rota and encourage trainees to attend additional clinics when possible. They take particular note of trainees who require specific clinic numbers such as IMTs. Trainers in Cardiology reported that they have different clinic rotas for different grades and available clinics are described in the induction pack. Trainers in Acute

Internal Medicine reported that clinic access is via ambulatory care. Trainees also have opportunities to practice procedures as they rotate around different areas and 2 consultants are Focused Acute Medicine Ultrasound (FAMUS) supervisors. There are no formal arrangements for trainees to attend clinics in other specialties.

FY: Trainees reported that they have no access to clinics (relevant only to FY2) or procedural lists. Trainees struggled to obtain their Developing the Clinical Teacher (DCT) competency as there was no departmental teaching in Cardiology and, whilst trainees were offered the opportunity to teach in Respiratory Medicine, teaching slots were often after the ARCP deadline. Trainees felt most of their role was service provision focusing on ward rounds and ward jobs only. There were twice weekly consultant-led ward rounds in Respiratory Medicine and 8 consultant-led ward rounds across 6 days in Cardiology. Trainees felt that their senior colleagues often saw the more interesting patients and they would be allocated a simpler case to see instead.

GPST/IMT: Trainees reported that Respiratory Medicine has allocated clinics and STs are supportive of their attendance. In Acute Internal Medicine and Cardiology trainees were given a list of available clinics, but there was no clinic rota. GPSTs did not have access to clinics. Trainees in Cardiology felt shifts in the CCU had a very high percentage of non-educational jobs, for example they were responsible for bloods as there were no phlebotomists. There were more positive experiences of accessing phlebotomists in Acute Internal Medicine and Respiratory Medicine.

ST: Trainees had no difficulty accessing clinics in Respiratory Medicine and Cardiology nor in accessing ambulatory care in Acute Internal Medicine. Trainees had difficulties accessing ultrasound training in Acute Internal Medicine as they were too busy and noted they should have protected time for their specialist skills and FAMUS training which they do not get. Trainees were not expected to do tasks of little educational benefit such as taking bloods.

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

Trainers: Trainers felt there were ample opportunities to complete workplace-based assessments in Respiratory Medicine and Cardiology. Trainers in Respiratory Medicine noted that they start their ward rounds by asking trainees what assessments they need, particularly for FYs. Trainers in both

specialties felt that trainees did not always take advantage of opportunities available to them to complete assessments. They also observed that Grand Rounds were poorly attended by trainees.

FY: Trainees reported that they could have assessments completed by middle grade trainees in Respiratory Medicine and Cardiology and had easy access to consultants in Acute Internal Medicine as they did 2 ward rounds per day.

GPST/IMT: Trainees felt that trainers were willing to complete assessments in all specialties, however willingness was more variable in Cardiology. Some trainees in Cardiology felt that colleagues did not know their names or grade and noted that some consultants would refuse to complete workplace-based assessments as they felt they were “tick-box exercises” which lacked value.

ST: Trainees reported that it was easy to complete workplace-based assessments in Acute Internal Medicine, Respiratory Medicine and Cardiology. They noted the regular post-take ward rounds in Acute Internal Medicine made this easier.

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 in Respiratory Medicine reported that they give feedback to trainees during ward rounds and in clinics as well as by completing their supervised learning events (SLEs). They noted that lack of continuity could make it harder to give feedback as trainees are moved around frequently to cover gaps. Trainers in Cardiology reported that they give feedback during ward rounds and board rounds. Trainers in Acute Internal Medicine reported that they give feedback to trainees during ward rounds and board rounds as well as informally on the wards as they are present all day. Trainers noted that they encourage IMTs and STs to develop leaderships skills and ensure they have opportunities to complete Acute Care Assessment Tools (ACATs). Any issues which have occurred during night shifts are discussed with trainees in the morning.

FY: Trainees reported that they received patchy informal feedback during the day but did not receive any during out-of-hours as they worked separately from their seniors. They reported that their support came from middle grade trainees during out-of-hours and they felt these trainees would tell them if their performance was inadequate. The FY trainees often felt inclined to start treatment plans without receiving feedback on them from the middle tier as they could not readily access them due to high workload during nights.

GPST/IMT: Trainees felt they received helpful and proactive feedback in Acute Internal Medicine and Respiratory Medicine, however feedback in Cardiology was generally limited to the CCU and Cardiology admission unit and was not as constructive as in other departments. Trainees felt that the ward rounds in Cardiology which alternate between consultant-led and trainee-led leave a vacuum of feedback in the downstream wards (43B and 19). They felt the best way to obtain feedback in Cardiology was at the daily board round in CCU and the Cardiology admission unit and was mainly provided by Cardiology registrars rather than the consultants.

ST: Trainees felt they got a lot of feedback during the day and had regular discussions with consultants. However, they did not get feedback in the mornings on their out-of-hours work, unless they actively sought it.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: Trainers in Respiratory Medicine reported that they have conducted questionnaires about trainee experiences which have shown positive results and have meetings throughout the year with trainees which are led by 2 consultants. Trainers advised that the friction described between Respiratory Medicine consultants was due to the department being asked to cover an extra ward which has caused tension as some were willing to do this and others were not. Trainers in Cardiology advised that they have re-started in-person unit meetings recognising that the pandemic has eroded social aspects of their work which has decreased support for trainees.

FY: Trainees reported they could give feedback to their trainers during supervisor meetings and they were not aware of other opportunities to do so. They were not aware of a trainees' forum or the chief resident's role.

GPST/IMT: Trainees felt there was no structured way for them to provide feedback. They reported there was no trainees' forum and no chief residents as no-one wished to have responsibility for the long-standing problems in the departments. They also noted that the clinical director responsible for liaising with the chief residents had resigned and had not been replaced.

ST: Trainees were not aware of any formal processes for them to give feedback to trainers. However, they were aware they could give feedback via the training surveys they receive.

2.12 Culture & undermining (R3.3)

Trainers: Trainers were not aware of any specific incidents of bullying or undermining and felt the departments were supportive. Trainers in Respiratory Medicine reported that they explain during induction where trainees can raise concerns regarding bullying or undermining. Trainers in Cardiology noted that the work could be daunting, and turnover was high so trainees could find themselves under pressure to discharge patients. They also felt they would benefit from further guidance in how to give feedback to under-performing trainees.

FY: Trainees commended Respiratory Medicine for being the most supportive department in which they had worked as well as offering the best learning opportunities such as chest x-ray meetings and frequent checks by email if a consultant was not available on the ward. Trainees reported an incident of undermining in Acute Internal Medicine relating to trainees being put under pressure to complete less urgent tasks. They noted this was a one-off incident however, trainees felt there was a culture of expecting them to do all tasks promptly, even when time is limited, and they felt forced to prioritise more urgent tasks. Trainees felt they could be reprimanded if they had not completed all tasks. They were confident trainers would listen to their concerns but felt it could be difficult to raise concerns relating to a colleague.

GPST/IMT: Trainees reported that they had witnessed undermining within Cardiology comprising repeated incidents by specific consultants. They felt their more junior colleagues suffered from this more, for example being mocked for not having time to complete certain tasks. They reported hearing negative comments made including assumptions that trainees below ST level were there for service only and subsequently felt excluded from the Cardiology team and training opportunities. Trainees felt other consultants were aware of these concerns but did not act against them.

ST: Trainees had no concerns regarding Acute Internal Medicine or Respiratory Medicine. They were aware of reports of undermining behaviours in Cardiology although they had not personally witnessed them.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Trainers in Respiratory Medicine reported that they embed clinics and procedures on the rota, but this is increasingly difficult to maintain due to low staffing. Trainers in Cardiology reported that they plan to include clinics in the rota, but agreed that staffing challenged this. Trainers in Acute Internal Medicine reported that they have 1 trainee allocated to ambulatory care and incorporate boot camps and training dates when possible. Procedures were completed ad hoc, but they felt the rota allowed trainees good access to them. Trainers noted that it was hard to incorporate regional FY2 teaching in the rota as dates were usually received late. FY1s have a week on the rota dedicated to teaching which has been incorporated to improve their access to this.

FY: Trainees felt the receiving block compromised their wellbeing as it did not allow any work-life balance. Trainees reported that they end their downstream working with a 7-day stretch and then commence a receiving block where they work a high percentage of weekends. Trainees on this block felt they had no life outside the hospital.

GPST/IMT: Trainees reported that their rota generally incorporated specific learning opportunities linked to their curriculum, however they did not have access to clinics in Cardiology. Trainees noted that they were usually the only doctor on the ward in Cardiology except in ward 19, however this ward had other issues. They reported that they rely on ambulatory care opportunities during the receiving block to make up their clinic hours when in Cardiology. However, this is unsatisfactory as the experience in ambulatory care is not the same as in clinics. In ambulatory care they see patients with acute issues such as headaches and mild chest pain rather than chronic conditions more suited for clinics. Trainees highlighted the receiving rota as challenging as they alternate between long days and night shifts with only 1 day off in between. This rota pattern is a 3-week stretch every 8 weeks. Trainees found this exhausting and worried that frequently moving between days and nights impaired their judgement as well as their wellbeing. It was noted that the WeCaRE quality improvement framework is only being applied to the FY rota in AMU to establish areas for improvement.

ST: Not asked.

2.14 Handover (R1.14)

Trainers: Not asked.

FY: Trainees felt evening handover was good, however morning handover was inefficient as the night team would hand over all patients to a single FY1 and the FY1 would then hand each patient over to a relevant member of staff. Trainees noted that the FY1 could not then answer questions about patients as they did not know them. There is no electronic record kept of handover and no formal structure, but generally the model of “Situation, Background, Assessment, Recommendation” (SBAR) is used. Trainees felt the system of transferring patients to downstream wards was unsafe as there was no formal doctor-to-doctor handover and they often did not know about new patients who had arrived. Trainees reported that introducing a continuous flow model had made this worse as patients could be moved at short notice from AMU when a bed space became available in downstream wards. Some trainees also noted that they do not have access to the Sky Gateway system which causes problems in Cardiology.

GPST/IMT: Trainees felt downstream handovers were chaotic and were concerned about patients’ safety.

ST: Trainees generally felt that receiving handovers were acceptable, but downstream handovers were chaotic. In Respiratory Medicine they reported that receiving handover took place in the high dependency unit (HDU) in the morning and evening and a downstream handover took place in the morning, at 4:30pm and in the evening. Trainees noted that staff sometimes joined by phone rather than attending downstream handover. Trainees in Cardiology reported that there was no formal handover process and they phoned specific people to whom they wished to hand over patients; this would include other cardiology STs, medical registrars or senior Cardiology nurses in CCU or the Cardiology admission unit (but not GPST/IMT covering CCE or the admission unit). It was noted that Cardiology STs felt that their handover arrangements worked well for them despite the lack of structure and documentation. Trainees in Acute Internal Medicine agreed that their receiving handover was fine, but downstream handover was poor.

2.15 Educational Resources (R1.19)

Trainers: Not asked.

FY: Trainees reported the hospital lacks computers and they have raised this with nurses. Trainees felt IT resources in Acute Internal Medicine were good, however there were issues in wards 43 and 46 as they do not have a staff room or office space so they need to work in the corridor which is problematic for patient confidentiality.

GPST/IMT: Not asked.

ST: Not asked.

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

Trainers: Trainers felt the wider hospital communicates well about trainees with difficulties. They highlighted the beneficial presence of Training Programme Directors (TPDs)/Foundation Programme Directors (FPDs) in departments including Respiratory Medicine and Cardiology and noted that they could access support from Occupational Health and could make trainees supernumerary if needed.

FY: Trainees reported that the hospital uses paper notes which can be problematic for staff with dyslexia. They had not been approached to ask if they needed any reasonable adjustments.

GPST/IMT: Trainees felt the less-than-full-time application process was supportive.

ST: Not asked.

2.17 Educational governance (R1.6, 1.19, 2.1, 2.2, 2.4, 2.6, 2.10, 2.11, 2.12, 3.1) – Not covered

2.18 Raising concerns (R1.1, 2.7)

Trainers: Trainers reported that they are often approached by trainees to discuss issues informally and are happy to do this. When a trainee completes a Datix their educational supervisor or another

consultant is involved throughout the process, although they noted that Datix processes can take months so trainees have often moved onto another post by the time feedback is available. Morbidity and mortality meetings (M&Ms) are also an opportunity to discuss adverse events.

FY: Trainees knew how to raise concerns and had experience of the Datix process.

GPST/IMT: Covered in 2.20.

ST: Covered in 2.20.

2.19 Patient safety (R1.2)

Trainers: Trainers felt that the departments were as safe as possible and trainees always had senior support available, however there was significant service pressure due to insufficient staffing. They felt the acute assessment unit can feel unsafe as they often found 30 patients waiting for a bed in the morning and noted that boarding wards had to be accommodated without additional staff. Trainers felt that senior management did not adequately engage with them to hear their concerns and described being discouraged from repeatedly reporting concerns as this would be disruptive. The trainers who attended the Deanery visit – 11 consultants across 3 specialties – had never met the chief executive of NHS Greater Glasgow and Clyde and did not recall engaging with the medical director in a conversation around their concerns. During the feedback session Dr Scott Davidson, the Deputy Medical Director for Acute Sector, reiterated that his door is always open and he is available to meet with the consultant body to discuss their concerns.

FY: Trainees described being asked to see medical boarders in surgical wards overnight despite being told that surgical doctors were responsible for them; there seemed to be a lack of clarity around roles and responsibilities for boarded patients in Surgery. A trainee had a positive experience following an incident in which they were involved when the senior doctors took time to do a cold debrief and they felt supported during and after the incident.

GPST/IMT: Trainees reported that they are sometimes asked by bed managers to attend A&E and board patients who have not yet been seen or do not meet the criteria for boarding. They also described pressure being put on FYs to make decisions about boarding and felt the tone used in

these requests was inappropriate. Trainees had concerns due to the bed managers putting pressures on them to deviate from the selection criteria and the tone of communication involved. They had no feedback yet on the outcome of raising these concerns.

Trainees felt supported by their consultants when raising concerns but did not feel that the wider organisation provided adequate support.

ST: Trainees reported that they get lists of boarders by e-mail, but thought patients were missed from this list roughly every week. They acknowledged that boarding is not ideal but a necessity due to capacity pressures.

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

Trainers: Not asked.

FY: Trainees would speak with the peri-arrest team if they experienced an adverse incident and reported good support from IMT and ST colleagues when they had experienced adverse events previously.

GPST/IMT: Trainees did not feel they were adequately supported when they experienced adverse events and described an incident where they were involved in an adverse event and expected to continue working afterwards. Trainees had limited awareness of M&M meetings with some trainees aware of a quarterly meeting in Acute Internal Medicine where discussion was felt to be robust, but changes were not always forthcoming.

ST: Trainees reported that they would raise adverse events with consultants within their department who they felt were responsive.

2.21 Other

In addition to the use of “CMT” terminology noted by consultants within Cardiology, there was widespread use of the term “SHO” throughout the visit.

3. Summary

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

Overall, the panel found all three departments delivering training within a challenging environment of high service pressures. Training opportunities were rich for ST trainees in Cardiology, Respiratory and Acute Internal Medicine. However the panel had some concerns about the opportunities available to other grades, particularly within Cardiology. There were also general concerns regarding sufficiency of staffing, downstream handover and the receiving rota, including the implications of these for patient safety.

The panel heard how service delivery in Cardiology was challenged by the wider geographical area in which they operate in the aftermath of COVID rearrangements, affecting delivery of training and clinical supervision for the junior tier working across CCU, the admission unit, ward 43B and ward 19.

Additionally, a significant proportion of the Educational Supervisors (around 50%) are employed by NHS Golden Jubilee and not NHS Greater Glasgow and Clyde. Several had 9+1 job plans with no dedicated time for training commitments.

Covering CCU and the Cardiology admission unit was part of the acute take receiving block which meant that FY/GPST/IMT doctors frequently rotated through these areas for short periods limiting continuity of care and ability to bond with the Cardiology team.

Consultants' engagement with non-Cardiology trainees was perceived to be poor; consultants and STs would see the more complex cases without involving the juniors (FY/GPST/IMT), handover of unwell patients would involve CCU nurses but not juniors covering CCU, and trainers in Cardiology were not aware of FY/GPST/IMT curricular requirements.

The Acute Internal Medicine team was delivering good training opportunities despite the service pressures, however access to formal teaching, ultrasound training and clinics needs to improve.

The Respiratory Medicine team was providing excellent training for all tiers despite service challenges; the panel did not identify any areas of concern within Respiratory Medicine.

Strengths

- Training is being delivered in a high service-demand environment.
- Trainees reported that they would feel comfortable if a friend or relative was admitted to their department despite the service challenges being experienced.
- Most consultants were described as supportive and approachable in Respiratory Medicine and Acute Internal Medicine.
- The training experience for ST trainees across Cardiology, Respiratory Medicine and Acute Internal Medicine was rich and supported.
- Trainees generally reported an excellent training experience in Respiratory Medicine.
- Induction materials in Respiratory Medicine and Acute Internal Medicine were praised and trainees valued the recorded induction for Acute Internal Medicine.
- Trainees received ample constructive feedback in Acute Internal Medicine and Respiratory Medicine.

Weaknesses

- Workforce challenges, including limited access to non-training doctors and Advanced Nurse Practitioners, underpinned issues faced by trainees accessing training opportunities. This included access to teaching, clinics and study leave.
- Downstream handover remained a challenge due to variability and lack of structure, particularly following the introduction of a continuous flow model when patients are transferred from AMU to downstream wards without medical handover. Consultant support with the handover improvement process would be beneficial.
- Whilst there is an SOP for boarding, bed managers were described as putting pressure on trainees to board patients who were unsuitable for boarding. This included trainees as junior as FY2.
- FY and IMT trainees in Cardiology felt they were less valued than ST trainees and were not incorporated within the team.
- Trainees in Acute Internal Medicine had access to ambulatory care, but this did not offer the same experience as clinics.

- There is an expectation to “do all the jobs” even when time is limited and if juniors are unable to complete tasks they get verbally reprimanded in Cardiology and Acute Internal Medicine.
- No interest from current specialty trainees in engaging with trainee forums or taking up chief resident posts – the post remains vacant as perceived to have “no impact and a lot of heat”.
- Receiving block is undermining trainees’ wellbeing; 3 in 8 weeks, very intense, 3 weekends in a row for some trainees, one day off between long runs, shifting from nights to days within 24 hours.

4. Areas of Good Practice

Ref	Item	Action
4.1	Respiratory Medicine engagement with their trainees despite service pressure, particularly frequent e-mail checks on junior doctors based in the wards when the consultant is in clinic or off-site.	
4.2	Acute Internal Medicine induction material including video recording and medical registrar induction booklet.	

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 in Acute Internal Medicine would benefit from opportunities to access clinics in other specialties in addition to ambulatory care.	
5.2	Re-engaging with the trainees to promote the trainee forum and the chief resident role. Pastoral support from a senior leader and protected time would be helpful.	

6. Requirements - Issues to be Addressed

Requirements applicable to all: Acute Internal Medicine, Respiratory Medicine and Cardiology

Ref	Issue	By when	Trainee cohorts in scope
6.1	Medical staffing must be reviewed to ensure this is appropriate to safely manage the workload.	11th February 2024	FY, GPST, IMT, ST
6.2	Barriers preventing trainees attending their dedicated teaching days must be addressed to allow them to attend the required quantities as per table 1.	11th February 2024	FY, IMT, AIM ST
6.3	Handover for downstream wards must be revised to ensure there it is reliable, structured and well-attended handover. There should be adequate documentation of patient issues, senior leadership and involvement of all trainee groups. This is particularly relevant to the 16:45 handover from downstream wards and the morning handover from the night team back to the day team covering the downstream wards. Following the introduction of a continuous flow model, the transfer of patients from ED or acute units to a downstream ward must include a medical handover to the downstream ward doctor.	11th February 2024	FY, GPST, IMT, ST
6.4	There must be a policy in place, that trainees are aware of, regarding the selection of patients who are potentially suitable for boarding. This policy should be respected by bed managers and pressure should not be put on trainees to board patients against the policy, particularly for trainees at FY level.	11th February 2024	FY, GPST, IMT, ST
6.5	All staff must behave with respect towards each other and conduct themselves in a manner befitting Good Medical Practice guidelines. FYs should not be reprimanded for not completing all jobs when time is tight, and a more	11th February 2024	FY, GPST, IMT, ST

	understanding attitude should be encouraged. Bed managers interactions with trainees should be respectful.		
6.6	The receiving rota structure is perceived to be undermining wellbeing due to a combination of factors (3 in 8 weeks, very intense, 3 weekends in a row for some trainees, one day off between long runs and changing from nights to days with 24-hour recovery period) and this must be addressed. The WeCaRE QI framework should be extended to all rotas in addition to the Acute Internal Medicine FY rota.	11th February 2024	FY, GPST, IMT

Requirements specific to Cardiology:

Ref	**Issue**	**By when**	**Trainee cohorts in scope**
6.7 (Cardiology)	Induction for Cardiology should cover roles and responsibilities within the different clinical areas (CCU, admission unit, 43B and 19). Induction should also cover how to access senior support in the different areas and where relevant training opportunities exist for all training grades, e.g. clinics and departmental M&M.	11th February 2024	FY, IMT, GPST
6.8 (Cardiology)	Review and clarify the Clinical Supervision arrangements for ward 43B and 19 to ensure a clear understanding of who is providing supervision and how the supervisor can be contacted.	11th February 2024	FY, IMT, GPST
6.9 (Cardiology)	Trainers should provide constructive feedback to non-Cardiology trainees and include them in ward rounds and subsequent discussions.	11th February 2024	FY, IMT, GPST
6.10 (Cardiology)	The Cardiology department must increase relevant training opportunities for FY, IMT and GPST trainees.	11th February 2024	FY, IMT, GPST

6.11 (Cardiology)	Educational supervisors must understand curriculum and portfolio requirements for their trainee group.	11th February 2024	FY, IMT, GPST
6.12 (Cardiology)	There should be formal written guidance on Cardiology support out-of-hours for RAH and Inverclyde Royal Hospital which is available to STs.	11th February 2024	ST

Requirements specific to Acute Internal Medicine:

Ref	**Issue**	**By when**	**Trainee cohorts in scope**
6.13 (AIM)	Departmental induction must be provided (for all grades including FY1) which ensures trainees are aware of all of their roles and responsibilities and feel able to provide safe patient care. Handbooks or online equivalent may be useful in aiding this process but are not sufficient in isolation. The induction material for the medical registrar is well received but not widely circulated to other grades.	11th February 2024	FY, IMT, GPST
6.14 (AIM)	Barriers preventing trainees attending their dedicated teaching days must be addressed to allow them to attend the required quantities as per table 1.	11th February 2024	FY, IMT, ST
6.15 (AIM)	Trainees must have access to specialty-specific training opportunities such as Acute Medicine ultrasound training and specialist skill protected time, to enable them to meet the requirements of the curriculum and to achieve satisfactory ARCP outcomes.	11th February 2024	ST