Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	30th November 2022	**Level(s)**	Foundation, Core, Specialty
Type of visit	Revisit	**Hospital**	Glasgow Royal Infirmary
Specialty(s)	General Surgery	**Board**	NHS Greater Glasgow & Clyde

Visit Panel	
Dr Marie Mathers	Visit Chair – Associate Postgraduate Dean (Quality)
Dr Kerry Haddow	Associate Postgraduate Dean (Quality – Surgery)
Mr Alastair Moses	Training Programme Director
Mr Eddie Kelly	Lay Representative
Mrs Sarah Chiodetto	Lay Representative (shadowing)
Mrs Jennifer Duncan	Quality Improvement Manager
In Attendance	
Mrs Gaynor Macfarlane	Quality Improvement Administrator

Specialty Group Information	
Specialty Group	Foundation
Lead Dean/Director	Professor Clare McKenzie
Quality Lead(s)	Dr Fiona Drimmie & Dr Marie Mathers
Quality Improvement Manager(s)	Mrs Jennifer Duncan
Unit/Site Information	
Trainers in attendance	6
Trainees in attendance	31 (F1 – 19, F2 - 3, Core - 0, ST - 9)

Feedback session: Managers in attendance	Chief Executive	0	DME	0	ADME	0	Medical Director	0	Other	11

Date report approved by Lead Visitor	Dr Marie Mathers 25th January 2023 Professor Clare McKenzie 27th January 2023

1. Principal issues arising from pre-visit review:

Background information

Following a Deanery visit in November 2021 several concerns were raised regarding Foundation training in General Surgery at Glasgow Royal Infirmary. After further review and triangulation of available data, including the NES Scottish Trainee Survey, the Foundation Quality Review Panel (5th October 2022) agreed that a revisit should take place due to further decline in data.

Survey Data

NTS:

NTS Level Triage List 2022 – F1 Surgery – Bottom 2% - number of red flags, significantly low scores, persistently low scores.

F1 Surgery – Red Flags – adequate experience, clinical supervision, clinical supervision out of hours, educational environment, educational supervision, facilities, feedback, induction, overall satisfaction, reporting systems, rota design, supportive environment, teamwork, workload.
F2 Surgery – Pink Flags – feedback, handover.
Core Surgical Training – All Grey Flags.
ST – Red Flag – facilities. Pink Flag – regional teaching.

STS (combines F1 and F2):

STS Level Triage List 2022 – General Surgery – Bottom 2% - number of red flags, significantly low scores.

Foundation General Surgery – Red Flags – educational environment, teaching, team culture. Pink Flags – handover, workload.
Core Surgical Training – All Grey Flags.
ST – All White Flags.

At the pre-visit teleconference the visit panel agreed that the focus of the visit should be around the areas highlighted in the survey data and pre-visit questionnaire.

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.

Department Presentation:

The visit commenced with a presentation led by Mr David Mansouri, Colorectal Consultant and F1 Clinical Lead. The presentation provided a useful overview of good practice, areas for improvement and focused on progress made against the requirements from the previous visit report.

2.1 Induction (R1.13):

Trainers: Trainers commented that F1 induction provides a good overview of the department with a focus on the F1 role and educational components of the post. The session includes the nursing team, an outgoing F1 and member of the pharmacy team. Induction sessions were recorded however now that induction has returned to face-to-face slides will be made available and the F1 clinical lead will meet with any trainees who missed the session. They are confident that induction prepares all training grades to work in the department during the day and out of hours.

F1 Trainees: Trainees confirmed receiving hospital induction. They described 3 days of shadowing and received an introductory talk, handbook, map, and brief talks on the department. They did not perceive this as a specific induction to general surgery. Difficulties were noted with IT system access and passwords with only 5 out of 20 trainees having access to Hospital Electronic Prescribing and Medicines Administration (HEPMA) system on the first day in post. No catch-up induction was provided for those who started on nights. Trainees commented on feeling unprepared and were surprised at how alone they were on the ward as seniors were in theatre.

They also described difficulties with downstream and upstream escalation pathways with uncertainty as to who to contact for support. Comments were made that the Microsoft Teams channel can be helpful however it is not typical of how the department works. There are 5 teams within the department, and it can be a cumbersome process trying to determine who to contact. Contact is via personal mobiles instead of bleeps however there are major problems with signal especially for seniors in theatre. They find OOH much simpler with bleeps available for the first on-call registrar and first and second on-call middle grades. Comments were made on providing cover in urology OOH which is in a different building with a different team which can be extremely challenging. They also provide cover within the High Dependency Unit (HDU) at weekends where they feel exposed due to their level of experience. There is no Hospital@Night (H@N) cover on the surgical floor except for downstream wards. They commented that there are surgical nurse practitioners (SNPs) who are very helpful however there are not enough of them to cover all shifts.

F2 and Core Trainees: Trainees reported receiving a comprehensive hospital and departmental induction which covered subspecialties and their roles well. They had no concerns about induction or suggestions for improvement.

ST Trainees: Trainees reported attending hospital and departmental induction. The only concerns raised were regarding IT passwords which were not in place on the first day in post.

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

Trainers: Trainers advised that there is mandatory foundation teaching on a Thursday which is mapped to the foundation curriculum. There are also regular lunchtime pharmacy teaching sessions along with extended induction talks which are based on what a foundation doctor is expected to know in colorectal, upper gastrointestinal (UGI) and hepato-pancreato-biliary (HPB). ST teaching is on a Friday with a good variety of topics. Dates are released at the start of the training year and efforts are made to encourage attendance by adding these to the rota and utilising clinical fellows to release ST trainees. Difficulties were noted in getting trainees to attend as their preference is often to attend live theatre sessions. The ST teaching programme recently moved from a full virtual programme to a hybrid programme in a bid to maximise attendance. Comments were also made on hospital wide clinical governance sessions which were delivered however were moved to departmental and are not as effective. There was a desire to have these move back to a hospital wide setting.

F1 Trainees: Trainees noted 1 hour of teaching on a Thursday which is recorded should they need to catch up later. They also note that teaching is held in rooms quite a distance from the ward. Workload and ward rounds can prevent attendance. Pharmacy sessions were also held however they stopped after 5-6 weeks.

F2 and Core Trainees: Trainees stated that there is no formal departmental teaching. They have attended 2 evening sessions in this block. Adhoc teaching in clinic and theatre is very well received. Regional teaching is recorded and can be watched at any time however clinic and theatre take priority over attending teaching. They are also invited to attend departmental meetings such as weekly UGI meeting, Multidisciplinary Team (MDT) meetings, Morbidity and Mortality (M&M) meetings and Clinical Governance (CG) meetings.

ST Trainees: Trainees commented that locally delivered teaching was provided on a weekly basis however became problematic due to differing demands from subspecialties. ST teaching is now held in the evening after work, which has been well attended and received. This is open to all training grades. Colorectal also provide regular teaching and STs can also attend journal clubs. They have no issues attending deanery teaching with study leave granted even with gaps in the rota. On-call and nights may affect attendance.

2.3 Study Leave (R3.12)

Trainers: Trainers are not aware of any difficulties that trainees may face in taking study leave.

F1 Trainees: Not applicable.

F2 and Core Trainees: Not asked.

ST Trainees: Trainees reported no concerns in obtaining study leave.

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

Trainers: Trainers stated that they all have protected time within their job plans for the roles of clinical and educational supervisor.

F1 Trainees: Trainees confirmed having designated educational supervisors who they have meet once since starting in post.

F2 and Core Trainees: Not asked.

ST 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 weekly plans clearly document who is on duty with contact information for those who are in theatre and on the wards. It is considered a straightforward easy to access document which all trainees are sited to. There can be short notice changes for varying reasons however these are clearly laid out. There is a written handbook circulated to F2 trainees and above which details clear escalation policies and contacts. Support is also covered at F1 induction where trainees are encouraged to contact consultants at any time. There is also a designated weekly unit rota contact and HDU research fellow along with the on-call team during the day for support if required. Staffing is reduced out of hours (OOH) and therefore middle grade escalation between 5-9pm is via the first and second on-call registrars. Overnight there is one senior and middle grade trainee again with clear escalation pathways. Support is also available via the SNP team and medical team should there be a medical issue along with the H@N team and resus team. SNPs are an excellent resource however they do not provide cover in downstream wards they clerk patients and help with non-educational ward-based tasks overnight.

F1 Trainees: Trainees reported that when they can get hold of consultants, they are very helpful. They commented on a very positive experience with support from middle and senior grade trainees. They described very little interaction with consultants which is due to F1 trainees being ward based and all other training grades and consultants being team based. They feel that rotas are designed to provide the largest number of F1s on shift on the floor at any given time. They are moved frequently which provides no continuity of care with patients. Ward rounds are rapid and therefore it can be difficult for F1s to get a clear pathway of what to do.

F2 and Core Trainees: Trainees stated that they always know who is available to provide support and are not expected to work beyond their level of competence. There are clear escalation routes for on-call. In hours due to being team based it is easy to access support as you work directly with seniors who are easily accessible and approachable. The rota details clear lines of contact for support which is covered well at induction. They commented that the department use mobile phones instead of bleeps and agreed that signal can often be an issue. They felt it would be more useful for escalation purposes if bleeps were carried. They also commented that escalation from downstream to F2/middle grade can be problematic. There is no phone signal in theatre and the rota does not necessarily clearly indicate the chain for support should the first point of contact be uncontactable.

ST Trainees: Trainees stated that they always know who is available to provide support and are not expected to work beyond their level of competence. Seniors are accessible, approachable, and happy to provide support. They do not believe F1 trainees have any issues in contacting them for support should they require it.

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

Trainers: Trainers reported they are aware of changes to both the foundation and surgical curricula. They are confident that trainees are attending a satisfactory number of clinics and theatres. When trainees commence in post learning requirements are reviewed with sessions allocated fairly to meet specific experiences. For those trainees about to complete training learning requirements are mapped against a checklist to help optimise learning requirements. They believe the department provide a huge range of learning opportunities to allow F1s to easily meet requirements for the post.

F1 Trainees: Trainees reported difficulties in obtaining Supervised Learning Events (SLEs) from consultants as they have very little interaction with them. OOH can provide a better setting for completing assessments with some consultants who are very proactive in providing learning opportunities. They commented on evening teaching sessions provided by STs which were very good and well prepared. Also, the extended induction talks were useful. They believe efforts are made to encourage learning. They stated that support at the beginning of the post was lacking which pushed trainees learning however agreed that the post does allow development of skills in managing acutely unwell patients. They are well supported OOH with clear escalation pathways. They would however welcome regular focused feedback during the day. They believe the post is heavy on service

provision with a high turnover of patients and that around 80% of their time spent carrying out duties which are of little or no benefit to their training or development.

F2 and Core Trainees: Trainees commented on broad ranging units with no issues in achieving curriculum targets. They can attend outpatient clinics; theatre sessions and they provide teaching sessions for undergraduate medical students. As they are part of the middle grade rota, they can attend up 2-3 theatre sessions and 1 clinic per week. They also commented on excellent training opportunities within HDU.

ST Trainees: Trainees raised concerns that waiting list initiatives are taking away opportunities for trainees to complete straightforward surgeries like hernias and gallbladders. They have no concerns in accessing more complex cases or attending clinics. They believe the post supports the development of their skills in managing the acutely unwell patient and very little time is spent carrying out tasks of little or no benefit to their training.

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

Trainers: Trainers reported no concerns in trainees achieving reasonable assessment numbers with lots of opportunities available to them. SLEs are generally completed by registrars and middle grade trainees rather than consultants. For F2 trainees this is due to how they interact with registrars on the ward.

F1 Trainees: Trainees stated that it is easier to complete workplace-based assessments OOH as they work within a small team with a middle grade and senior ST. There are also good opportunities in Urology. It can be difficult for trainees to find someone to observe the assessment and must be proactive and recognise opportunities as early as possible. They commented that the post can be intimidating as a first post for an F1.

F2 and Core Trainees: Trainees have no issues in obtaining workplace-based assessments. Most assessments are completed by registrars who take the time to teach and encourage trainees to ticket them for assessments. They have no concerns in requesting assessments from consultants.

ST Trainees: Trainees have no issues in obtaining workplace-based assessments. Consultants are happy to support and provide a lot of training opportunities.

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

Trainers: Not asked.

Foundation/Core/ST Trainees: Not asked.

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

Trainers: Not asked.

Foundation, Core & ST: Not asked.

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: Trainers commented that consultants meet with registrars at 8am after an overnight shift to go over what has come in overnight. This could be used as a constructive feedback session if there has been an interesting case. They commented that lots of feedback opportunities are available to F1s however these would be more frequent if trainees were team based. They commented that evening handover and weekend upstream handover is performed with a registrar and F1. They consider evening handover to work well however recognise gaps in overnight upstream and downstream handovers.

F1 Trainees: Trainees reported that they rarely receive constructive feedback. On occasion when feedback is given it is focused on the negative aspects only. They often do not understand why they are being asked to request scans which can cause difficulties with radiology. They find OOH a better environment to receive feedback as they work in small teams with clear outline of duties.

F2 and Core Trainees: Trainees confirm receiving feedback on clinical decisions during the day and OOH which is constructive and meaningful. They commented on a constant flow of feedback. They also commented on taking part in ward rounds and creating management plan in HDU.

ST Trainees: Trainees confirm receiving feedback on clinical decisions during the day and OOH which is constructive and meaningful.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: Trainers reported that there is a chief resident who is very involved with all training grades. F1 trainees are ward based and not team based and have therefore been allocated a buddy who can be a trainee from F2 to ST8. They meet once a month and are encouraged to raise any concerns they may have.

F1 Trainees: Trainees reported attending 2-3 meetings with the management team which initially were productive however did not produce any good outcomes. Trainees noted that they did not consider these meetings to be a safe space to raise any concerns. They describe feeling scared and it is perceived that should a trainee raise a problem then effectively they are the problem. Consultants often take feedback personally and can become passive aggressive. They provided an example of this behaviour taking place at a post monitoring meeting. They also describe being told not to raise problems if they do not have direct solutions. They provided an example where attempts to provide a solution were received with a valid response from the nursing team however consultant responses made trainees feel inadequate. This discussion led to the BMA representative intervening and following up with an e-mail afterwards supporting the trainees. Trainees strongly believe that the division between F1 and all other grades is due to them being ward based and not team based like all others. They commented that they are happy to raise concerns in a safe environment and have done so with educational supervisors. They also commented on the chief resident who they highly regard.

F2 and Core Trainees: Trainees reported providing feedback on their training via the Scottish Training Survey (STS) and the National Training Survey (NTS). They have also provided feedback when requested by the colorectal consultants. They are aware of the chief resident and their role they consider her to be very present, kind and an excellent resource.

ST Trainees: Trainees reported that there is no formal process for providing feedback to trainers on the quality of training provided. They commented on having provided feedback to consultants over

the years which has always been positively received. They believe the department provide a good working environment where trainees can raise things that can lead to change.

2.12 Culture & undermining (R3.3)

Trainers: Trainers were specifically asked to comment on issues raised in the pre-visit questionnaire regarding concerns relating to undermining and bullying from nursing staff in urology. Trainers found it difficult to comment on nursing staff as they are part of the medical team. They commented that they are aware that they have a responsibility to safeguard trainees. At a recent post monitoring meeting trainees had mentioned difficulties on ward 70 however no further action was taken at that time. Trainees were encouraged to group together, discuss, and put something in writing that could be taken forward.

F1 Trainees: Trainees commented on a poor working environment where again they described being perceived as the problem when raising a concern. They find management meetings to be problem focused and not solution driven. They stated that seniors are approachable should a patient become unwell. Trainees also described incidents with nursing staff in ward 70, urology, with comments around aggressively toned conversations, questioning of management plans and being shouted at. These concerns were raised at a recent management meeting where trainees were informed that for any action to be taken these must be put into writing and formalised. Trainees confirmed that they had complied an anonymous document providing scenarios which will be sent to the consultant team.

F2 and Core Trainees: Trainees stated the department is a very supportive team. No trainees had experienced or witnessed undermining but if they did, they would know who to raise it with.

ST Trainees: Trainees stated the department is a very supportive team. No trainees have experienced or witnessed behaviours of bullying or undermining. If they were to raise concerns, they would do so through their educational supervisor or the clinical lead for surgery.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Trainers stated that the rota will be adjusted slightly in block 3. One person will move from receiving to same day admissions in a bid to help better involve F1s in day-to-day tasks such as

clerking of patients. Trainers confirmed a rota gap at ST level which has been filled with a fellow however they have had a delayed start to post. There are also 2 gaps at middle grade one of which has been appointed to and the other is currently filled by locum cover. The department also have research fellows who help contribute to filling any gaps. Trainers confirmed no issues with endoscopy numbers with trainees getting good exposure.

F1 Trainees: Trainees stated that a fully staffed rota is 3 F1s on each of the 2 wards with enough to cover sick leave. They noted unknown rota gaps where there may only be 2 on a long day also where there is only one person covering receiving instead of 3. In these scenarios often the F1s on short days stay late to help with workload. They commented on being unable to raise concerns about the rota as it is a computer system. The e-mail template for the rota states in bold constructive feedback only. They find that often gaps are advertised at short notice and on occasion F1s have received strongly worded e-mails to fill these gaps.

F2 and Core Trainees: Trainees reported rota gaps in colorectal however are aware of efforts to fill these with clinical fellow appointments. There are no gaps in UGI. The short stay assessment unit should be staffed by a middle grade or junior registrar however this has been an extra area of cover for trainees when on-call. They are happy that the rota supports learning opportunities and stated that there is enough time to get to mandatory teaching and that clinics provide an excellent environment for teaching. They do not believe that there are any aspects of the rota that compromise trainee wellbeing.

ST Trainees: Trainees reported 1 gap in the rota which has been filled and they await the person starting in post. They are no aware of any issues relating to the filling of gaps within the rota. They stated that each team has a designated rota person who provides a good balance of activity. This is adjusted weekly based on trainee level and trainee need. They do not believe there are any aspects of the rota that compromise their wellbeing.

2.14 Handover (R1.14)

Trainers: Trainers stated that handover moved to a closed Microsoft Teams channel only accessible by surgery in August 2022 where staff can view a live spreadsheet of patient details. Access via a

mobile device can be difficult due to the size of the spreadsheet however works well for accessing rotas. The updating of upstream handovers is carried out by printing and distributing copies with notes and job lists taken and updated on the spreadsheet. Downstream handover maintenance is seen as a shared responsibility between middle grades. This is a work in progress. They also described a new weekend handover sticker where a yellow ticket is placed in the patient notes. This has been audited and feedback shows that it has worked well and is a positive improvement.

F1 Trainees: Trainees stated that they understand the differences between downstream and receiving handover. Since starting in post guidance for handovers and receiving handover have improved. They find the handover sheet very useful when it is used and updated. Middle grades are tasked with maintenance of the handover sheet however this task generally falls to F1s. Downstream weekend handover could be improved. Concerns were raised with HDU which they consider to be unsafe. They described a 10-minute peer to peer handover at 8am, which is not protected. Trainees can be asked to leave to attend a ward round or patients will often be seen without the F1 present. Given how often F1s rotate it is not feasible to review each bed everyday however this would be useful once a week. There are 6 ward rounds where F1 must read notes to get jobs on occasion some registrars will provide a list of jobs. This was raised at the last management meeting and will be taken forward with the registrars.

F2 and Core Trainees: Trainees reported that handover for receiving is conducted via a Microsoft Teams channel and handovers for downstream are team based. They commented that upstream handover is very good however downstream handover has little senior contact. There is an F1-to-F1 morning handover which they believe would benefit from senior input. There is no formal structure to handover the department try to use Microsoft Teams for handover filtering by subspecialties. They would find it beneficial to have a morning handover for subspecialties for downstream to discuss patients. Workload and the need to be in theatre at another hospital location are factors that deter regular handover. They believe working in a team-based structure instead of ward based is more beneficial to their training and working experience and can see this is the main problem for the F1 cohort.

ST Trainees: Trainees stated that handovers are not effective and handovers lists are not up to date. There is no upstream to downstream handover which leads to problems tracking boarders. The upstream handover is robust and sees all patients being discussed. They find little benefit to going

over every patient of which there can be over 60 discussed which can be difficult to remember. They believe it would be more beneficial to discuss only the sick patients daily and discuss all patients once a week.

2.15 Educational Resources (R1.19)

Trainers: Not asked.

Foundation, Core & ST Trainees: 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: Not asked.

Foundation, Core and ST Trainees: 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)

Trainers: Not asked.
F1 Trainees: Trainees stated that they would report concerns regarding the quality of their training with their educational supervisor. Concerns can also be raised via the West of Scotland trainee forum.

F2 and Core Trainees: Trainees stated that they would report concerns regarding the quality of their training to either a consultant or with their educational supervisor. Concerns can also be raised with the medical education department or Training Programme Director (TPD).

ST Trainees: Trainees stated that they would raise concerns about the quality of their training at deanery visits. They are aware of and attend CG meetings and M&M meetings where training issues can be discussed. They commented on a very good training experience for ST trainees and recognise the concerns and problems at F1 level and agree this need improving.

2.18 Raising concerns (R1.1, 2.7)

Trainers: Not asked.

F1 Trainees: Trainees stated that patient safety concerns are raised through the datix system or directly with a consultant.

F2 and Core Trainees: Trainees reported that they would raise any patient safety concerns with the subspecialty team and are confident concerns would be addressed appropriately.

ST Trainees: Trainees reported that they would raise any patient safety concerns with the clinical governance lead.

2.19 Patient safety (R1.2)

Trainers: Trainers reported on a safe environment for trainees and patients. They have robust M&M meetings which promote shared learning. There have also been a few audits performed as a result. All training grades are invited and encouraged to attend these meetings.

F1 Trainees: Trainees commented they would have concerns is a friend or relative were admitted to the department. They feel the burden of raising problems they have no solution for and pressure of how these can be fixed by an F1. They again noted the lack of continuity due to the team and ward-based structure adopted by the department and how easily jobs can be missed.

F2 and Core Trainees: Trainees do not have any concerns regarding safety in the department and would be happy for a family member to be admitted to the unit. Concerns were raised around HEPMA and things being missed or over looked and also a lack of computers in the department.

ST Trainees: Trainees do not have any concerns regarding safety in the department and would be happy for a family member to be admitted to the unit. They commented concerns with number of beds available and boarders being sent to inappropriate specialty wards however note this is an NHS wide issue.

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

Trainers: Trainers stated that adverse incidents are used as shared learning experiences for the entire team.

F1 Trainees: Trainees stated that they are aware of and have used the datix reporting system. They are also aware that each team have regular M&M meetings to which F1s are not invited to attend. Trainees fear that if something was to go wrong with a patients care that they would be blamed. They believe that there is a disconnect with consultants who have no investment in their learning. They witness the differences in how F2 trainees and above are treated due to being team based.

F2 and Core Trainees: Trainees reported that adverse incidents are discussed at M&M meetings and CG meetings. There would also be a departmental wide e-mail sent. F2 trainees and above are involved in incident reporting which is well supported with shared learning.

ST Trainees: Trainees commented that they do receive feedback on adverse incidents. Consultants are accessible and incidents are discussed with learning points taken.

2.21 Other

Overall Satisfaction Scores:

F1 – average 4.5/10
F2 & Core – average 8/10
ST – average 7.5/10

3. Summary

Is a revisit required?	Yes	No	Highly Likely	Highly Unlikely

The panel commended the engagement of the site, trainers, and medical education team in supporting the visit. The panel noted a good training environment for F2, core and specialty trainees however significant concerns still remain relating to the poor educational environment and training opportunities available to the F1 trainees. The key areas for improvement noted at the visit relate to culture and undermining specifically relating to urology, discontinuity of ward placements for F1 and the ward versus team-based structure adopted, teaching, rota, handover, workload specifically relating to balance of tasks, and feedback. The next steps will be to conduct an action plan review meeting in block 2 and 3 with a focus on the F1 training grade with a revisit highly likely.

Positive aspects of the visit:

- Wide range of experiential learning opportunities for middle and higher-grade trainees including endoscopy.
- Role of the chief resident commended by all training grades.
- Teams channel provides a good repository and is accessible by all. This could do with some tightening up regarding responsibilities for updating.
- Good engagement from the department and trainers at the visit and in the pre-visit organisation.
- Positive feedback received from ST trainees who actively wish to work in the unit.
- Consistent flow of constructive and meaningful feedback provided to F2 and ST trainees.
- Positive feedback received from F2 trainees on experience within HDU.
- Good variety of teaching opportunities offered including informal opportunities within clinics and theatre.
- Positive feedback received on upstream handover however there is still room for improvement.
- F1s commented on good learning opportunities and feedback within OOH.

Less positive aspects of the visit:

- Consultants require adequate time within job plans to be actively involved in implementing and sustaining change within the department.
- F1 trainees raised concerns about interactions with nursing staff within Urology.
- Ward based versus team-based structure for F1s. Discontinuity of ward placements for F1s is still an ongoing concern. Trainees are moving wards every few days and have no consistency of working within a team.
- Although the 6 weekly engagement meetings are seen as a positive development, F1 trainees reported a reluctance to raise concerns in this environment.
- Better signposting of educational meetings and teaching sessions to ensure appropriate training grades are aware of which sessions are suitable for them to attend.
- Staffing on the F1 rota is extremely tight with no built-in flexibility for short term sick leave. The commencement of surgical nurse practitioners (SNPs) is recognised as a work in progress and the panel would encourage exploration of physician associates (PAs) to improve support.
- Teams channel is recognised as an excellent endeavour however it can be cumbersome when trying to establish who to contact for support in downstream wards.
- Concerns raised regarding downstream handover which is F1 peer-peer and is not robust. There is an unawareness of what is happening across the wards.
- It is clear that the SNP role is helping with ward-based workload however F1s spend a lot of time completing routine tasks. Work across both staffing groups could be reviewed to provide a better balance and training experience.
- F1 referrals to Radiology are taking a lot of time due to difficulty in understanding reasons for referrals.
- Feedback to F1s during the day perceived as largely negative.

4. Areas of Good Practice

Ref	Item	Action
4.1	Wide range of experiential learning opportunities for middle and higher-grade trainees including endoscopy.	n/a

5. Areas for Improvement

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

Ref	Item	Action
5.1	Although the 6 weekly engagement meetings are seen as a positive development, F1 trainees reported a reluctance to raise concerns in this environment.	
5.2	Staffing on the F1 rota is extremely tight with no built-in flexibility for short term sick leave. The commencement of surgical nurse practitioners (SNPs) is recognised as a work in progress and the panel would encourage exploration of physician associates (PAs) to improve support.	
5.3	Teams channel is recognised as an excellent endeavour however it can be cumbersome when trying to establish who to contact for support in downstream wards.	
5.4	It is clear that the SNP role is helping with ward-based workload however F1s spend a lot of time completing routine tasks. Work across both staffing groups could be reviewed to provide a better balance and training experience.	
5.5	F1 referrals to Radiology are taking a lot of time due to difficulty in understanding reasons for referrals.	
5.6	Teams channel provides a good repository and is accessible by all. This could do with some tightening up regarding responsibilities for updating.	

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	Carried forward from 21st June 2019 – Partially met All staff must behave with respect towards each other and conduct themselves in a manner befitting Good Medical Practice guidelines.	August 2023	F1
6.2	There must be a protected formal teaching programme for doctors in training. With better signposting of all educational meetings and teaching sessions.	August 2023	ALL
6.3	Medical staffing must be reviewed to ensure this is appropriate to safely manage the workload, with consideration of employing more non-training medical staff.	August 2023	FY1
6.4	FY1 Trainees must be provided with clearly identified seniors who are providing them with support for all clinical areas they cover particularly downstream wards and HDU/Critical care (In hours)	August 2023	FY1
6.5	Handovers involving FY1 trainees on the downstream wards must include senior input to ensure patient safety and learning opportunities.	August 2023	All
6.6	Tasks that do not support educational and professional development and that compromise access to formal learning opportunities for FY1 doctors should be reduced.	August 2023	FY1
6.7	A process for providing feedback to FY1 doctors on their input to the management of acute cases must be established. This should also support provision of WPBAs.	August 2023	FY1
6.8	The discontinuity of ward placements for FY1 trainees must be addressed as a matter of urgency as it is compromising quality of training, feedback, workload and the safety of the care that doctors in training can provide. The duration of	August 2023	FY1

	ward attachments of Foundation doctor must be increased to be for at least 4 weeks.		
6.9	Carried forward from 21st June 2019 – Partially met Rota/ timetabling management must be addressed to eliminate frequent, short notice, movement of trainees away from their base ward.	August 2023	
6.10	Carried forward from 21st June 2019 – Partially met Link with 6.5 Ward handover must be formalised and happen consistently in all ward areas to ensure safe handover and continuity of care.	August 2023	
6.11	All Consultants, who are trainers, must have time within their job plans for their roles to meet GMC Recognition of Trainers requirements.	August 2023	