Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	9 November 2018	**Level(s)**	Undergraduate, FY, CMT, ST3+
Type of visit	Triggered Visit	**Hospital**	Aberdeen Royal Infirmary
Specialty(s)	Cardiology	**Board**	NHS Grampian

Visit panel	
Dr Stephen Glen	Visit Chair – Associate Postgraduate Dean for Quality
Dr Amjad Khan	Director of Postgraduate General Practice Education
Dr Jennifer Hanslip	Training Programme Director (Foundation)
Professor Alan Denison	Undergraduate Representative
Dr Catriona Ingram	Trainee Associate
Mr Albert Donald	Lay Representative
Heather Stronach	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 Reem Al-Soufi Dr Stephen Glen Dr Alan McKenzie

Quality Improvement Manager(s)	Heather Stronach and Alex McCulloch	
Unit/Site Information		
Non-medical staff in attendance	6 non-medical staff	
Trainers in attendance	4 consultants	
Trainees in attendance	19 trainees	9 Undergraduates, 3 FY, 1 CMT, 6 ST
Feedback session: Managers in attendance	Training Programme Director and Service Managers	

Date report approved by Lead Visitor	14/12/2018

1. Principal issues arising from pre-visit review

Following review and triangulation of available data, including the General Medical Council's (GMC's) National Training Survey (NTS), the Deanery's Scottish Trainee Survey (STS) and Undergraduate course evaluation data, a Deanery visit was arranged to cardiology at Aberdeen Royal Infirmary.

At the time of the visit, data was available for both 2017 and 2018. The following data is collected and analysed prior to the visit:

- NTS 2017= National Training Survey (2017)
- NTS 2018 = National Training Survey (2018)
- PVQ = Pre-visit Questionnaire (2018)
- STS = Scottish Training Survey (2018)
- Undergraduate evaluation data (2018).

According to trainee responses from these most recent data sources, areas that may require improvement to the cardiology unit are illustrated in the table below:

Issue	Programme data	Post data	Undergraduate data
Adequate Experience			
Clinical Supervision +OOH		NTS 2017	X
Educational Supervision	NTS 2018	NTS 2017	X
Feedback	NTS 2018		X
Handover			
Induction	NTS 2017, PVQ		X
Patient Safety			
Teaching (formal)	NTS 2018		
Workload/Working Hours		NTS 2018, PVQ	
Study Leave		NTS 2017	
Team Culture	NTS 2018, PVQ	NTS 2017, NTS 2018, STS, PVQ	
Environment/Undermining	PVQ	PVQ	
Learning from adverse incidents	NTS 2017	PVQ	
Educational Governance		PVQ	
Overall Satisfaction		NTS 2017	

2. Introduction

A summary of the discussions has been compiled under the headings in section 3 below. This report is compiled with direct reference to the GMC's Promoting Excellence - Standards for Medical Education and Training. Each section heading includes numeric reference to specific requirements listed within the standards.

The panel met with trainers and non-medical staff as well as the following groups: Year 4 and 5 medical students, a physician associate student, foundation trainees (FY), core medicine trainees (CMT) and specialty training registrars (STs) in cardiology.

3.1 Induction (R1.13)

Trainers

Trainers advised there is a structured induction programme. An NHS Grampian wide induction that takes place once a year and a cardiology induction runs every time there are new starters in the unit.

FY1 trainees have a shadowing period prior to starting in post. Foundation and core trainees are inducted to clinical work together by a ST. Induction materials are made available online.

If trainees are unable to attend their normal inductions, trainers advised that they can catch up using the materials available on the intranet.

Trainers stated that trainees appear to be satisfied with induction and have not raised any specific areas for improvement to induction with them. No formal feedback is sought on the quality of induction from a trainee perspective.

Undergraduate/Physician Associate ("students")

Students confirmed having received both a site and department induction. One student had missed the site induction and no catch-up induction was offered. Two students missed the department induction as their responsible consultant was on annual leave. They stated they had worked out how the ward worked by the time their supervising consultant had returned

from annual leave and had met with them. Students had access to IT systems and resources to support their learning.

FY + CMT

Trainees confirmed an NHS Grampian wide hospital induction. They said that the online induction was very good with example clinical scenarios. However, some trainees did not receive their passwords in a timely fashion and were therefore unable to complete induction when they started at the hospital. One trainee did not complete the hospital induction until four weeks after starting in post.

Regarding induction to the cardiology unit specifically, trainees stated that this is delivered by their predecessor and not by consultants. They often asked nursing colleagues how the department worked and there was no specific induction about the coronary care unit (CCU).

FY and CMT trainees stated that a detailed document was circulated by email that was likely to cover these areas. However, not all trainees received this. Trainees would prefer a face-to-face meeting to cover the key points about working on the ward and to allow them the opportunity to meet with the wider team.

FY1 trainees stated they found their shadowing period useful.

ST

STs said that the hospital induction is extensive. Department induction included meeting face-to-face with the senior trainees at the time as well as a face-to-face meeting with the educational supervisor and training programme director. They were also introduced to nursing staff and the clinics.

STs felt prepared for their role including how the on-call rota works following their induction.

Non-Medical Staff

Non-medical staff confirmed that trainees receive a lot of information about the hospital. They considered that department induction could be more structured. From their perspective, they introduce trainees (especially FY and CMT trainees) to the wards.

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

Trainers

Trainers said that there is structured teaching within cardiology. Teaching for STs is a half day per month bleep free session that is delivered by consultants. Teaching is designed by trainees themselves and is a mixture of both anatomy and clinical teaching as well as non-clinical skills teaching.

There are also:

- echocardiography teaching sessions delivered by the cardiac physiologists
- electrophysiology (EP) /percutaneous coronary intervention (PCI) meetings to which specialty trainees are invited to attend, and
- weekly combined meetings with surgeons that take place on Friday mornings.

Foundation and CMT doctors follow a formal hospital wide teaching programme. Within cardiology specifically there is electrocardiogram (ECG) teaching every Thursday.

Undergraduates

Year 4 students advised that cardiology comprised a 1 week attachment within a 5 week block and that tutorials occurred. They advised that the quality of teaching was very good. Year 5 students were attached to cardiology as part of an 8 week medicine block which included a student assistantship. All students could attend Wednesday lunchtime teaching (usually 12 – 1pm).

Medical students can also access clinics, echocardiography teaching sessions and can attend the cardiac catheterisation laboratory. The amount of teaching they get per week can vary between one and two hours. Time spent in theatre can sometimes mean that they might miss teaching sessions. Medical students were happy with the content of teaching.

FY + CMT

On average trainees attend one hour a week of teaching. The formal hospital wide FY teaching is bleep free.

CMT teaching takes place on alternate weeks. Teaching is not bleep free and it is considered that there is no one to hand the bleep to. Teaching is good but attendance is affected when CMT trainees are rostered to work the night shift.

Trainees described a Wednesday cardiology teaching that lasts for one hour and is led by STs. They said that they are invited to attend this teaching and it is very good.

All trainees were able to access deanery led teaching.

ST

Regional teaching takes place every 6 weeks and is organised by STs: they send email correspondence to all registrars asking what topics would like to be covered.

The regional teaching is delivered by a consultant and can include non-cardiologists or surgeons depending on the subject matter. Topics include case based clinical presentations (for example, intervention and heart failure), as well as some of the more unusual conditions such as cardiac tumours. These sessions are bleep free.

Local teaching takes place weekly and is not bleep free. Teaching can be missed due to the on-call rota. Trainees said cardiology is a demanding specialty and the bleep goes off constantly. To reduce the number of bleeps received during teaching trainees have tried to come up with solutions and make changes to the referral system; however, it was felt that in reality, teaching is not bleep free.

Non-Medical Staff

Non-medical staff confirmed trainee attendance at teaching although were not aware of the timetabling of sessions. They said teaching was not bleep free and there was no policy to avoid bleeping trainees during teaching sessions. Trainees always confirmed that they had their phones if they are needed. Nurses considered that the phones could be left with consultant or someone else, with a referral threshold developed to assist trainees to attend bleep free teaching.

3.3 Study Leave (R3.12)

Trainers

Trainers said that NHS Grampian (service managers) are responsible for organising the FY and CMT rotas. As this rota is fixed, there are challenges for junior doctors to obtain study leave. Rotas for STs is not fixed in the same way and study leave is much easier to support.

Trainees

CMT trainees had found it difficult to access study leave. Study leave is only granted by the rota manager if there is sufficient minimal staffing on the ward. Trainees said the responsibility had fallen on them to ensure there is someone to cover they rota gap they would leave on the ward by taking study leave. The training programme director can only approve study leave if the rota manager has approved the leave.

All trainees had been granted study leave for 'Tasters' and Advanced Life Support courses.

STs had been granted the study leave they had requested.

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

Trainers

Trainers advised that supervisors are usually allocated to trainees according to their training year. There is one allocated supervisor for each of the following groups: 4th year medical students, 5th year medical students, FY1, FY2 and CMT.

STs have an educational supervisor allocated to them for a year who meets with them at the start, mid-point and end of their attachment. Senior STs (ST6 and ST7) are usually allocated an educational supervisor that matches their specialist interest.

Educational supervisors are required to meet with their allocated trainees within the first 2-3 weeks.

All educational supervisors complete the Recognition of Trainers as part of their appraisal process. There is protected time in trainers' contracts to provide educational supervision although it was felt this could be increased as the current SPA allocation also includes time for teaching.

Undergraduates

Year 5 medical students confirmed having an educational supervisor who came and found them to give them the relevant information they needed within the second week of them starting in the unit. Their educational supervisor agreed to meet with them at the end of their attachment in cardiology.

Year 4 medical students do not require a departmental educational supervisor during their attachment.

FY + CMT

All but one trainee had met with their educational supervisor at the start of their post to agree a learning plan. Trainees said that they know who their supervisor is through eportfolio. Their educational supervisor is also their clinical supervisor.

ST

Most STs reported having met with their educational supervisor at the beginning of the training year. Those who had not were expecting to meet with their educational supervisor within the next week.

STs said that they usually meet their educational supervisor at the start, mid-point and end of the training year.

Clinical supervisors for STs change according to the educational needs of trainees. For example, those requiring EP and pacing procedures are assigned to an EP consultant.

Non-Medical Staff

Non-medical staff perceived that FY and CMT doctors do not have the support they need and are left to manage inpatient ward duties on their own. Trainees often seek the support of nursing staff. Senior nursing staff reported a disengagement of senior medical staff in the management of patient flow which is delegated to the most junior medical staff who find this very challenging. A flow coordinator has just been appointed to assist with this, but it is perceived that this work falls to junior doctor/nursing staff.

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

Trainers

Trainers stated that it is the role of the educational supervisor to keep up to date with the curriculum requirements for the trainees which they are supervising. There has been no mapping of the post or teaching to the curriculum as far as trainers are aware.

Trainers concede that access to clinics is difficult for trainees – both in terms of clinic space and trainees having time within their rotas to attend clinic, which becomes more difficult when there are rota gaps. On average, STs can access one clinic a week. For more junior trainees it has been more difficult.

Trainers advised that a full complement of trainees is expected at the next training rotation. NHS Grampian has also appointed a substantive physician associate to alleviate the administrative burden on trainees that may help free up time for trainees to access clinics.

Trainers have raised the issue with the board as they are concerned about clinic access for trainees. They consider this is a particular risk with the implementation of the new Internal Medicine Training (IMT) curriculum where there will be an increased requirement for clinics. Trainers said they had raised this with the board two or three years ago at the initial discussion phase for IMT, but no progress made had been made as far as they are aware.

When asked what clinics are available, trainers said that there is just one clinic room on site for the cardiology department. Medical students wish to have access to this clinic as well as

postgraduate trainees. Most clinics take place at the Aberdeen Community Health and Care Village. Trainees must spend time travelling to these clinics and limits accessibility for junior trainees as they are unable to return quickly if they are needed on the ward.

Trainers consider that the availability for clinics for trainees has become progressively worse over the last ten years. The Emergency Care Centre (ECC) rota structure has changed and junior doctors are no longer able to attend.

One trainer felt that there are not equal opportunities in academic training for trainees at Aberdeen compared with other centres with only one day per week allocated to academic activities and was concerned that this might affect recruitment to academic training pathways.

Undergraduates

Year 5 medical students spend most of their time with the FYs to gain appropriate clinical experience. They felt they would benefit from getting one-to-one teaching on the ward and would prefer to have scheduled organised meetings for feedback with consultants.

Medical students can attend two clinics per week and receive individual timetables to ensure they obtain clinic experience. They also attend investigation sessions such as echocardiography and exercise testing.

Undergraduate students reported that they particularly appreciated their clinic experience with Dr Adelle Dawson who was widely acknowledged as providing an excellent teaching experience.

FY + CMT

FYs and CMTs confirmed that they are on the same rota and there is no differentiation in their roles: there is no allocated clinic time for CMT trainees.

FY and CMT trainees considered that their clinical skills had improved but were unsure whether their clinical knowledge had improved greatly, in that they feel that ward rounds could be used as a teaching opportunity. Trainees described a ward round pattern of daily alternating ward

sides; this pattern does not allow for regular feedback to junior doctors from STs or consultants. Consultant ward rounds are sporadic and unpredictable in timing.

FY and CMT trainees feel that their experience in the CCU is their only opportunity to receive feedback from consultants.

Trainees reported that they can get occasional access to clinics if the ward is quiet and an arrangement is made with agreeable members of staff as CCU nurses can feel unsupported if doctors are unavailable on the wards because they are attending clinic. Attendance at clinics is not protected.

ST

STs commented that they initially struggled to get echocardiography experience at the start of training due to gaps in the rota. The high volume of work combined with unfilled posts and the frequency of on-call commitments had impacted on their ability to get this experience. Changes to the curriculum requiring echocardiography competence means there is now dedicated time in echocardiography training and the situation has improved.

The allocation of specialty trainees to training opportunities from week to week is organised by a senior specialist trainee. Feedback suggests that this allocation takes place from week to week without advance planning and that there may be conflict between registrars in terms of the equity of access to specialist training opportunities, such as coronary angiography or intervention.

ST trainees were advised at induction that they could expect two angiography sessions per week at the cardiac catheterisation laboratory.

Overall, STs said that training worked well providing there is a full complement of trainees. As soon as there is just one gap in the rota, this has a huge impact on training. STs felt that they could achieve their core competencies, for example:

- there is weekly coronary CT scanning one morning per week.
- they can attend at least one clinic per week with a consultant
- as a group, they run 4 clinics per week (although this used to be 9 clinics per week)

they get good experience with subspecialty areas including intervention, devices, heart failure, electrophysiology, imaging, adult congenital heart disease and lipid clinics.

Non-Medical Staff

Non-medical staff said they are happy to impart their knowledge. Nurses support medical students during their time in cardiology.

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

Trainers

Trainers advised that they use eportfolio to guide them through the assessment process. Trainers believe that the educational opportunities, for example, cardioversions and exercise tests, are very strong within the department. Trainers had all carried out training on undertaking workplace-based assessments a few years ago but had not had an opportunity to benchmark their assessments against other trainers.

Undergraduate

Year 5 medical students said that they can easily achieve the assessments required of them. Case-based discussions (CBDs) and direct observation of procedures (DOPs) are very easy to achieve. Mini-clinical evaluations (Mini-CEX) are more difficult to achieve as they work on the ward and their consultant supervisor is usually working elsewhere, often within the cardiac catheterisation laboratory. Medical students said Mini-CEXs would be easier to achieve if there was a time scheduled for them on the wards.

Year 4 medical students said that assessments on myMBChB were easy to access and that questions were fair and pitched at an appropriate level of challenge.

FY + CMT

FY and CMT trainees said that it can be extremely difficult to get workplace-based assessments completed as they are often based on the ward and ward rounds are usually carried out with registrars. For CMT trainees, this is difficult as the CMT curriculum requires a portion of supervised learning events to be signed off by a consultant. As previously stated

within this report, trainees report that consultants are usually working elsewhere, often within the cardiac catheterisation laboratory.

Assessments completed are deemed to be fair.

ST

STs said that consultants are busy. They often had to remind consultants to carry out their assessments. When completed, trainees felt assessments were fair and consistent.

Non-Medical Staff

Non-medical staff contribute to the multi-source feedback assessment.

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

Trainers

Trainers said there are several opportunities for multi-professional learning such as: working alongside physiologists carrying out device checks, echocardiography, exercise testing, in the cardiac catheterisation laboratory for coronary angiography, intervention and electrophysiology, as well as feedback from ward pharmacists and occasional simulation training in the cardiac catheterisation laboratory.

Undergraduates

Medical students enjoy working with the nurses and particularly enjoyed their time meeting the team in the cardiac catheterisation laboratory and enjoyed this multi-professional experience.

FY + CMT

FY and CMT described working alongside nurses and pharmacists. They do not attend morbidity and mortality meetings.

ST

STs described the following examples of multi-professional learning:

- working alongside cardiac physiologists as described by the trainers above

- a nurse led meeting at 9:30am at the cardiac catheterisation laboratory that trainees are welcome to attend.
- working alongside coronary care nurses
- multi-disciplinary team meetings.

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

Trainers

Trainers advised that trainees are supported in carrying out quality improvement projects. STs carry out audits and have junior doctors supporting them in this activity. Group meetings take place weekly and trainees are invited to present their findings at multidisciplinary team meetings and some have taken this further presenting their work at national specialist meetings.

FY + CMT

Trainees confirmed that they can carry out quality improvement projects within the cardiology department if they wish to.

ST

STs confirmed that they are supported with quality improvement projects and present their work within the department.

Non-Medical Staff

Non-medical staff, particularly nurses, have a strong drive to conduct quality improvement projects and are happy to help trainees.

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

Trainers

When asked how all staff differentiate between doctors at different stages of training, trainers advised that this is identified at induction. The department works as a team and everyone is aware of each person's role and responsibilities.

The visiting panel noted that FYs and CMTs are still referred to as Senior House Officers by the trainers (SHOs).

Trainers said that trainees know who to contact for advice or support during the day and out of hours. Trainers considered that when the department was understaffed, trainees may have felt that they have had to cope with problems that were beyond their experience.

Undergraduate

When students were asked if they always have access to clinical supervision, they replied that there is someone identified to them to provide support, and they always know who they can approach for support and this tends to be the foundation trainees.

Medical students have not had to cope with problems beyond their experience. Year 5 students had also formally met with STs.

FY + CMT

Trainees confirmed that they always had access to the on-call registrar and the on-call registrar is always approachable.

ST

STs reported no concerns with respect to clinical supervision. They know who to contact both during the day and out of hours. There are twice as many consultants as registrars, so support is always available.

STs are usually scheduled to be on call at the same time as their educational supervisor. Colleagues are accessible and approachable.

Non-Medical Staff

Non-medical staff said that they can identify trainees by their name badges but sometimes these are not up to date in terms of trainee grade. It was further noted that name badges do not identify the level of training for STs.

Non-medical staff considered that junior doctors might not be able to identify consultants as consultants do not always introduce themselves at the start of their placement. Non-medical staff also commented that junior trainees may feel under pressure on the wards due to the lack of senior support on the wards.

3.10 Feedback to trainees (R1.15, 3.13)

Trainers

Trainers said that there is ongoing feedback to trainees on a day to day basis. When managing clinical cases especially during on call periods, there are discussions around the learning points and consultant assessments are completed as part of that process. They also discuss feedback received as part of the multisource feedback tool.

Undergraduate

Medical students said that no feedback is given to them on the ward. They only receive feedback at the end of the block.

FY + CMT

FY and CMT trainees perceive that they receive little formal feedback at all unless they take it upon themselves to actively seek feedback. Consultant feedback is challenging to get because of the ward round structure and lack of timetabling.

ST

STs said they receive constant informal feedback. Formal feedback is provided as part of the decision-making process for referrals and during ward rounds.

3.11 Feedback from trainees (R1.5, 2.3)

Trainers

Trainers said their feedback from trainees comes from the NTS and STS results. The board also requests formal feedback on the teaching programme it provides for junior doctors.

Undergraduate

Medical students complete the Student Course Evaluation Form (SCEF) which also asks for feedback on the facilities available to students.

Trainees

Trainees were not aware of any specific trainee forum to allow regular formal communication between them and unit management about their training.

STs said that the training programme director had met with them every six months to touch base with them and that they had found this useful. Junior trainers stated that they could provide feedback at educational supervisor meetings.

3.12 Workload/ Rota (1.7, 1.12, 2.19)

Trainers

When asked how rotas maximise training opportunities for trainees, trainers said that trainees learn on the job: learning is therefore dependent on how well staffed the rotas are. Trainers commented that the clinical development fellow (CDF) post at NHS Grampian is a flexible post - if the CDF chooses not to work in cardiology, then trainees receive no support from this post.

Trainers consider the complement of cardiology trainees to be vulnerable. In the past, training has had to be supported by filling vacancies with locum posts. Trainee rotas have failed to be compliant with the European Work Time Directive.

Trainers said they have escalated their concerns on several occasions to the board. However, they feel that no progress has been made aside from the appointment of one trainee physician associate.

FY + CMT

Junior trainees stated that their workload was busy. They feel that when there is a full complement of trainees the rota just about works. A physician associate had recently been appointed to relieve the administrative burden on trainees; however, it was noted that the physician associate does not have prescribing authority.

There had been changes to the hospital at night rota for CMTs which meant that the CCU was short of trainees during the day and the perception was that rota management had given this little regard. They feel pressured to come into work even if they are sick due to the perceived impact of the rota on their colleagues.

ST

STs said that the rota for them is manageable. Clinic workload is about right, but ward work can vary.

Non-Medical Staff

Non-medical staff described an occasion when there was no junior support on the ward for two weekends in a row. They were asked to raise this with the medical director by consultant staff.

3.13 Handover (R1.14)

Trainers

Handover takes place verbally. There is a crib sheet that is continuously updated. Trainers considered that handover could be used as a learning opportunity but are unsure whether it is or not.

Trainees

Trainees did not describe any particular concerns about handover. They described handover which takes place in the CCU, nights are shared with renal and so there is a handover at night in Ward 109 with renal colleagues. A medical registrar is present at handover but not consultants. The formal hospital at night handover works well.

Non-Medical Staff

Non-medical staff commented that doctors in training are engaged with handover. There is face-to-face handover in the CCU.

3.14 Educational Resources (R1.19)

Trainers

Trainers said there used to be a department library but this is no longer available since moving to the ECC. That said, they felt that all cardiology materials are available online. Examples were given of technology enhanced learning.

Undergraduate

Medical students were not aware of any educational resources at the hospital. They would access resources at the University of Aberdeen.

Trainees

Postgraduate trainees also describe the above and can access the library at the University of Aberdeen.

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

Trainers

Trainers said there has been a meeting held every 6 months with STs to discuss any problems or concerns they might have had about training. Trainees based at Raigmore were linked into the discussion via videoconference.

Undergraduate

Medical students said they would contact their head of year for support.

FY + CMT

FY and CMT trainees feel unsupported in terms of their lack of contact with the consultants and the lack of feedback from senior colleagues. They also described undermining incidents (detailed below).

ST

Overall, ST trainees feel supported although described undermining incidents (detailed below).

Non-medical staff

Non-medical staff felt that the FY and CMT's were unsupported by the consultants particularly around clinical decision making, patient flow and boarding decisions, and described an incident where a FY trainee was required to speak with a family of a patient who had died but clearly required more senior support than was readily available.

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

Trainers

Trainers said that they had met with the Director of Medical Education to discuss the implementation of the Internal Medicine Training (IMT) curriculum and prior to the deanery visit to discuss potential issues. Aside from these instances, there appeared to be no formal consultant link with the postgraduate education department in terms of representation at regular educational governance meetings.

Undergraduate

Medical students said that they had received a guide from the University of Aberdeen about what to expect in terms of their learning for each block. There is a course coordinator they can contact if they have any concerns.

Year 5 medical students said there is a clinical coordinator they can contact.

Trainees

All trainees would contact their training programme director if they had concerns about their training. There are not aware of any specific trainee forum to allow regular formal communication between trainees and the unit management.

3.17 Raising concerns (R1.1, 2.7)

Trainers

Trainers expect that trainees would raise concerns about patient safety with their clinical or educational supervisor. Concerns about training would be raised with their educational supervisor.

Undergraduate

Medical students would contact their head of year or a clinical supervisor if they had any concerns about patients. There is also a link available on MyMBChB by which students can also raise concerns.

FY + CMT

FY and CMT doctors would contact the on-call registrar or a consultant if they had any concerns about patient safety.

ST

STs said they would raise any patient concerns directly with their clinical supervisor and would feel comfortable doing so.

Non-Medical Staff

Non-medical staff would raise any concerns with supervisors.

3.18 Patient safety (R1.2)

Trainers

Trainers said that the environment is safe and that patients who are boarded are only those who are considered safe to be boarded. The junior trainees are responsible for the oversight of boarders and they would go round the ward to see boarders with either the registrar or consultant. Trainers advised that it can ‘depend on who is there’.

Undergraduate

Medical students did not have any concerns about patient care within the cardiology department.

FY + CMT

FY and CMT trainees raised no patient safety concerns within the cardiology department. They said they would have concerns about the care of boarders to wards where there are no foundation trainees to carry out basic medical tasks particularly the cardiothoracic ward. Trainees felt that some aspects, such as electrocardiograms, were not being carried out by the boarded ward when they could be. Trainees cited the cardiothoracic ward as such an example. Last year there was a period where there were 54 cardiology inpatients (and there are only 30 beds within the cardiology unit).

During the visit, junior trainees were phoned repeatedly by the cardiothoracic ward about a boarding patient who had chest pain and in whom the ward staff would not perform an ECG. The trainees answered the on-call phone as the “CCU SHO” and were clearly having difficulty in persuading the ward staff to perform basic clinical assessments.

Consultant ownership and review of boarded patients was unreliable and consultants did not review patients who were boarded. FY and CMT trainees were often phoned and required to identify boarders but did not have the support of their senior colleagues in making decisions and felt pressurised by patient flow.

ST

Boarding was identified as a significant safety issue and while low risk patients were supposed to be identified as potential boarders, the reality of the bed pressures was such that higher risk patients were moved, and trainees described incidents of these patients worsening after transfer and requiring further clinical input which was challenging in the non-cardiology wards.

Non-Medical Staff

Non-medical staff said they help support the environment and have no concerns about patient safety. They were aware of the pressure on junior medical trainees to make decisions about patient boarding and reported that national initiatives, such as the Daily Dynamic Discharge, were not actively supported by senior medical staff.

3.19 Adverse incidents (R1.3)

Trainers

Trainers said adverse incidents are reported using the Datix system. Morbidity and mortality meetings take place four times per year and attendance is compulsory. Clinics are cancelled when morbidity and mortality meetings take place and the emergency cardiac catheterisation laboratory is the only service that continues.

Consultants said there is always a debrief about incidents that occur and a consultant or educational supervisor would discuss any incidents involving trainees.

Undergraduate

Medical students were aware of Datix but would not know where to find it.[1] If there were any incidents medical students felt confident they would receive feedback from their supervisor.

FY + CMT

FY and CMT trainees are aware of the Datix system for raising concerns. They said that Datix incidents go to the charge nurse and there is 'by chance' feedback to them.

Trainees had received feedback from pharmacy about prescribing errors and were grateful for this feedback.

FY and CMT trainees were aware of the morbidity and mortality meetings but had not been able to attend any in their time so far.

ST

STs are aware and use Datix. They said that morbidity and mortality meetings were a useful forum from which they could learn from adverse incidents.

Non-Medical Staff

Non-medical staff said that junior doctors are not fully versed with Datix although they would be able to navigate the process. The final approver of Datix incidents is the senior charge nurse.

[1] Medical students are not expected to have involvement in the Datix system.

Non-medical staff said that not all Datix cases are discussed at the mortality and morbidity meetings in a timely manner due to time constraints. Therefore, there was difficulty reporting in a timely fashion to an Ombudsman request.

Non-medical staff did not feel that there was shared learning from incidents for junior doctors.

Nurses are part of the Divisional Safety Quality Improvement Forum.

3.20 Duty of candour (R1.4)

Trainers

Trainers said there is a blame free culture and that they lead by example.

Undergraduate

Duty of candour is not covered at induction. However, they feel that they would be well supported in raising concerns.

FY + CMT

FY and CMT trainees described one occasion where they felt unsupported breaking bad news to a family.

STs and non-medical staff feel that they would be well supported in raising concerns.

3.21 Culture & undermining (R3.3)

Trainers

Trainers said they foster a team-based approach on the ward. At induction trainees are advised to raise any issues at the time they happen and not to wait until the end of the block. Escalation procedures for raising concerns about inappropriate behaviours are made clear within the induction process.

Trainers were aware of an example of abrupt communications between senior nurses and junior trainees; however, this was raised at the time and here have been no instances since. The matter was dealt with appropriately.

Trainees and Non-Medical Staff

A senior member of staff who is alleged to exhibit undermining behaviours was highlighted at the visit and further details will be shared with the Director of Medical Education out with this report.

Overall satisfaction

All group of doctors were asked to rate their overall satisfaction with their placement and the average scores are presented below:

Undergraduate: Range = 7 - 9, Average = 7.6 out of 10
Foundation: Range = 8 - 9, Average = 8.6 out of 10
CMT: Range = 8 - 9, Average = 8.6 out of 10
ST3+: Range = 7 – 8, Average = 7.6 out of 10.

4. Summary

The visiting panel noted that the stress of rota gaps and lack of clinic space are serious concerns for both trainers and trainees alike. Junior trainees feel pressured to come into work even if they are sick due to the perceived impact of the rota on their colleagues. Some trainees also find it difficult to arrange study leave and feel unsupported by rota management.

Trainers consider that more support is needed from the board to protect education and training within the department.

Foundation and core trainees are treated as the same and there is widespread use of the term “SHO” by trainees and non-medical staff. There appears to be a disconnect between senior medical staff and junior doctors for inpatient supervision and support. Foundation and core

trainees struggle to get workplace-based assessments due to a perceived lack of consultant oversight on the wards which reflects the lack of timetabling of regular supervised ward rounds.

There is a gap between senior medical staff and senior nursing management in how Datix cases and the learning from adverse incidents are managed. A similar disengagement is evident in the management of patient flow which is delegated to the most junior medical staff without senior support. The trainee teaching programmes lack consultant oversight and should be mapped to the curriculum requirements.

There is no specific trainee forum to allow regular formal communication between trainees and the unit management. There appears to be no formal consultant link with the Postgraduate Education department in terms of representation at regular educational governance meetings.

There were concerns about the care of boarders - especially those boarded to the cardiothoracic ward where there are no foundation trainees to carry out basic medical tasks. Trainees felt that some aspects, such as ECGs, were not being carried out by the boarded ward when they could be. Consultant ownership and review of these patients was unreliable.

The panel considers that an urgent revisit will be required to determine whether there have been improvements made to the educational environment. If little progress is made, there is the potential for escalation to the GMC's enhanced monitoring process as an outcome of the next visit.

Aspects that are working well:

- Both site and department induction take place (although a face to face catch up induction should be make available to trainees who miss the first timetabled induction and department induction should be more formalised).
- Undergraduate formal teaching is good.
- Undergraduate access to clinics is good and students were keen to commend Dr Adelle Dawson for her teaching skills.
- Deanery delivered training is accessible for both foundation and core trainees.
- All trainees had allocated supervisors. The clinical and educational supervisors for foundation trainees are often the same person and this is good for continuity. Trainees

know who their supervisors are. STs are allocated educational supervisors according to their specialist interest.

- Subspecialty access is good with clear support from the staff in the cardiac catheterisation lab and cardiac physiologists involved in device follow-up and echocardiography.
- Trainees are able to undertake quality improvement projects and present their findings.
- Ward pharmacists provide feedback to trainees.
- Study leave and regional teaching for specialty trainees is accessible.

Aspects that are working less well:

- There were problems with IT access and passwords which were not available for many trainees at the time of induction.
- Teaching is not bleep free.
- Specialty teaching is organised by trainees without clear consultant oversight.
- The local and regional teaching programmes have not been mapped to the curriculum.
- Some junior trainees (FY / CMT level) had problems accessing study leave - they are required to provide cover for the days they wish to take study leave and appear to have little support from rota management.
- The rota impacts on the ability of junior doctors to attend clinics.
- There are concerns around the compliance of the rota. Trainees feel pressured to come into work even if they are sick due to the perceived impact of the rota on their colleagues.
- SHO terminology – foundation and core trainees are treated as exactly the same and there is widespread use of the term “SHO” by trainees and non-medical staff.
- Foundation and core trainees struggle to get workplace-based assessments due to lack of consultant oversight on the wards. There appears to be a disconnect between senior medical staff and junior doctors for inpatient supervision and support.
- Consultant ward rounds are sporadic and unpredictable in timing. The ward round pattern of daily alternating ward sides does not allow regular feedback to the junior doctors from specialist registrars or consultants.
- Specialty trainees also reported that workplace-based assessments can be difficult to obtain.

- There is infrequent regular formal feedback provided to trainees outwith the formal educational supervisor meetings.
- There is no specific trainee forum to allow regular formal communication between trainees and the unit management.
- There appears to be no formal consultant link with the Postgraduate Education department in terms of representation at regular educational governance meetings.
- Datix incidents are not fed back to trainees in a timely manner and there is a gap in the feedback and response to adverse incidents by senior medical staff as experienced by senior nursing management.
- A similar disengagement is evident in the management of patient flow which is delegated to the most junior medical staff without senior support.
- Morbidity and Mortality meetings should enable rotating trainees to learn from adverse incidents.
- There were concerns about the care of boarders - especially those boarded to the cardiothoracic ward where there are no foundation trainees to carry out basic medical tasks. Trainees felt that some aspects, such as ECGs, were not being carried out by the boarded ward when they could be. Consultant ownership and review of these patients was unreliable.
- Specialty trainees wish to have equal access to training opportunities within the department.

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

5. Areas of Good Practice

Ref	Item	Action
5.1	Subspecialty access is good with clear support from the staff in the cardiac catheterisation lab and cardiac physiologists involved in device follow-up and echocardiography.	none
5.2	Trainees are able to undertake quality improvement projects and present their findings.	none

6. Areas for Improvement

Ref	Item	Action
6.1	None	

7. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
7.1	There must be robust arrangements in place to ensure the tracking of all boarded patients and to support regular review by a Consultant.	Immediately	All
7.2	Those responsible for educational governance must investigate the allegations of undermining behaviours, and if upheld, put in place an appropriate action plan to address these concerns.	Immediately	All
7.3	The site must foster a culture of learning that includes doctors in training both in reporting critical incidents using channels such as the Datix reporting system but also in the consequent learning that comes from an effective system.	9 August 2019	FY, CMT
7.4	All references to “SHOs” and “SHO Rotas” must cease. The “Say No to SHO” programme must be adopted, with all staff involved	9 August 2019	All
7.5	Staffing levels and their support in wards must be reviewed to ensure that workload is appropriate and does not prevent access to learning opportunities including outpatient clinics.	9 August 2019	FY, CMT
7.6	Solutions must be found to address non-compliant trainee rota which may have non-intended consequences such as patient and trainee safety risks.	9 August 2019	All

7.7	There must be further support for regular Consultant ward rounds which review trainee decisions and care plans and offer constructive feedback & teaching.	9 August 2019	All
7.8	All trainees must have timely access to IT passwords and system training through their induction programme.	9 August 2019	All
7.9	Departmental induction must be provided which ensures trainees are aware of all of their roles and responsibilities and feel able to provide safe patient care.	9 August 2019	All
7.10	A process must be put in place to ensure that any trainee who misses their induction session is identified and provided with an induction.	9 August 2019	All
7.11	There must be access to study leave for all eligible trainees and this must not be dependent on trainees arranging their own service cover.	9 August 2019	FY, CMT
7.12	Department must develop and sustain a local teaching programme mapped to curriculum requirements of the ST3+ trainees including a system for protecting time for attendance.	9 August 2019	ST3+
7.13	There must be a process that ensures trainees understand, and are able to articulate, arrangements regarding Educational Governance at both site and board level.	9 August 2019	All
7.14	A trainee forum should be established and supported so trainees can safely raise concerns and provide feedback.	9 August 2019	All
7.15	The allocation of specialty trainees to training opportunities must be equitable and reflect the training requirements of the individual trainees.	9 August 2019	All