<table>
<thead>
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<th>Date of visit</th>
<th>16 January 2019</th>
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<tbody>
<tr>
<td>Level(s)</td>
<td>Foundation, General Practice, Core Training, Specialty Training</td>
</tr>
<tr>
<td>Type of visit</td>
<td>Revisit</td>
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<tr>
<td>Hospital</td>
<td>Borders General Hospital</td>
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<tr>
<td>Specialty(s)</td>
<td>General Internal Medicine</td>
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**Visit panel**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
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<tbody>
<tr>
<td>Kenneth Lee</td>
<td>Visit Lead, Associate Postgraduate Dean – Quality</td>
</tr>
<tr>
<td>Linsey Semple</td>
<td>GP Representative</td>
</tr>
<tr>
<td>Claire Langridge</td>
<td>Foundation Representative</td>
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<tr>
<td>Tom Drake</td>
<td>Lay Representative</td>
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<tr>
<td>Hazel Stewart</td>
<td>Quality Improvement Manager</td>
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**In attendance**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
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<tbody>
<tr>
<td>Claire Rolfe</td>
<td>Quality Improvement Administrator</td>
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</tbody>
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**Specialty Group Information**

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<thead>
<tr>
<th>Specialty Group</th>
<th>General Practice, Occupational Medicine, Public Health</th>
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<tbody>
<tr>
<td>Lead Dean/Director</td>
<td>Moya Kelly</td>
</tr>
<tr>
<td>Quality Lead(s)</td>
<td>Kenneth Lee, Nick Dunn</td>
</tr>
<tr>
<td>Quality Improvement Manager(s)</td>
<td>Hazel Stewart</td>
</tr>
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**Unit/Site Information**

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Trainers in attendance</td>
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<tr>
<td>Trainees in attendance</td>
<td>5 x ST, 4 x GP, 1 x CT, 10 x FY</td>
</tr>
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<td>Feedback session: Managers in attendance</td>
<td>Chief Executive, Director of Medical Education, Associate Medical Director, General Manager (unscheduled care), Clinical Nurse Manager (unscheduled care)</td>
</tr>
<tr>
<td>Date report approved by Lead Visitor</td>
<td>24/01/2019</td>
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1. **Principal issues arising from pre-visit review**

A revisit to this department took place on 28th March 2017 following a triggered visit the previous year. It was felt that significant improvements had been made by the department following this with the 5 requirements from the revisit having been addressed. This report and subsequent action plan responses can be found in the visit pack.

Due to low GP trainee numbers there was not enough data for the 2017 General Practice quality review panel (QRP) to determine if issues were still ongoing for GP trainees. Following the 2018 QRP for General Practice, it appears that the improvements made by the department have had little impact on improving the training experience for GP trainees and the panel felt that a further revisit was required.

**NTS Data**

The one-year post data trend does not indicate any concerns for trainees as a whole, with continuing improvement in teamwork.

**Foundation:** The NTS data for Foundation Year 1 (FY1) and Foundation Year 2 (FY2) trainees does not indicate any concerns. FY1 trainees have 3 green flags for supportive environment, teamwork and educational governance and there are 2 green flags for FY2 trainees with handover and teamwork.

**Core Training:** Aggregated data over the past 3 years indicate that trainees are happy in their post with no negative indicators and 8 positive indicators, including overall satisfaction.

**General Practice:** There are a significant number of negative indicators for GP trainees with red flags for:

- Adequate experience
- Clinical supervision
- Handover
- Induction,
- Overall satisfaction
- Curriculum coverage and
- Rota design

In addition, there are 5 pink flags for:
Clinical supervision out of hours
Educational Supervision
Study leave
Teamwork and Educational governance.

Specialty Training: Specialty trainees are dual accredited and therefore there is no NTS data which specifically relates to General Medicine. Aggregated data for respiratory and geriatric medicine trainees does not indicate any significant concerns although geriatrics trainee feedback suggests local teaching (pink flag) could be improved. Trainees in Acute Internal Medicine are less positive although aggregated data does indicate their experience is improving moving from 3 red and 2 pink flags in 2015-17, to 1 red flag for local teaching and 2 pink flags for regional teaching and reporting systems.

STS Data (RAG 2018)
The STS RAG data collates the responses from every post during the year. There are insufficient responses from core trainees but the other trainee cohorts, including GP, do not have any negative indicators.

On review of the available data, it is not clear as to the reasons behind the significantly poor NTS data for GP trainees and this will be explored in detail at the visit. Rotas were highlighted as an area of concern from all levels of trainee, but generally all other trainee cohorts appear to be satisfied with their training experience within the hospital.

The visit aims to investigate issues, both positive and negative, to advise on steps towards addressing and resolving them where required. The visit team will also take the opportunity to gain a broader picture of how training is carried out within the department and to identify any points of good practice for sharing more widely.

2. Introduction

The Borders General Hospital is a district general hospital. It is the main hospital in the Borders and is located in Melrose. The hospital provides a wide range of services to patients across the region including Accident & Emergency.
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.

Due to only one member of the non-medical team being able to attend, their input was sought but has not been included within the report to provide anonymity. No significant concerns were highlighted.

### 3.1 Induction (R1.13)

**Trainees:** Trainers reported there is an effective structured induction provided to the trainees. Foundation year 1 (FY1) trainees receive a separate hospital induction which is aligned with Lothian and Fife Health Boards. Feedback received is positive. There is a standardised ward-based induction which utilises a checklist to ensure all relevant information is provided to trainees. Trainers advised there is a virtual induction available to trainees on their education website for trainees unable to attend the standard induction and a separate ward induction is provided to trainees.

**Foundation:** Trainees reported they received a hospital induction which provided them with lots of information and a helpful booklet. They suggested that it could be improved by including within the booklet summary information on how to make internal referrals, as different departments used different methods for these. All received a departmental induction which equipped them to start work. Trainees felt the department induction could be improved by:
- Being informed of their roles & responsibilities for each ward
- An overview of protocols and how things work, particularly within the medical assessment unit.

**General Practice/Core Training:** Trainees reported that they received a hospital induction if they hadn’t previously worked in the hospital. They were aware of the virtual induction available to them online. Trainees suggested that having TRAK training from a member of IT would be beneficial as it would provide trainees with the more basic ‘how to’ information for those who had never used the system before. Trainees received an induction to the departments which they felt was sufficient to enable them to start work.
**Specialty Training:**  Most trainees reported that they received a hospital and departmental induction. Those who were unable to attend were unaware of the virtual induction. None could suggest how the induction could be improved.

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

**Trainers:** Trainers reported there are one-hour weekly teaching sessions for FY and GP trainees. Trainers encourage trainees to leave their bleep with a member of staff on the ward to ensure they are not interrupted. Trainers are aware of poor attendance at the GP teaching sessions and plans are in place to change the timing of this to improve the GP trainee’s ability to attend. There are no similar teaching sessions for core (CT) or specialty (ST) trainees but their regional teaching sessions are built into the rota to maximise attendance. All trainees are invited to attend a variety of other teaching opportunities available, such as:

- Monthly morbidity and mortality meetings
- Weekly Radiology meetings
- Grand Round.

**Foundation:** Trainees reported there is a one-hour weekly teaching session. Trainees reported that they do take their page, but they have not been bleeped out during a teaching session. They could not suggest any improvements to the local teaching provided. Trainees also reported they can join the grand round if they are not busy undertaking other tasks on the wards. One trainee was aware of the Friday X-ray teaching session, but few had attended.

**General Practice/Core Training:** Trainees reported there is weekly, consultant led local teaching for GP trainees, which is relevant to their curriculum. The timing of the weekly teaching can prevent trainees from attending as they may still be undertaking the ward round or completion follow up tasks. Trainees agreed that moving the time from 12pm to 1pm would help facilitate their attendance. There is no local teaching specific for the core trainees apart from the Grand Round. There is some simulation training, but not all trainees have been able to access the simulations specific to their curriculum. Trainees reported they can attend their regional teaching sessions.

**Specialty Training:** Trainees reported that, apart from the Grand Round, there is no formal teaching provided to them in the hospital. Trainees were not aware of the morbidity and mortality meetings and
most were not aware of the Friday afternoon x-ray meetings. All confirmed that they are able to attend their regional teaching sessions.

3.3 Study Leave (R3.12)

**Trainers:** Trainers felt the department faced no challenges in supporting study leave.

**Foundation:** Trainees did not report any issues applying for or taking study leave.

**General Practice/Core Training:** Some trainees felt it was difficult at times to take study leave. One trainee had been refused study leave due to other trainees already having had their leave, for the same day, approved.

**Specialty Training:** Trainees reported that they can easily request and take study leave.

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

**Trainers:** Trainers reported that clinical and educational supervisors are allocated based on their experience with the level and type of trainees as well as any specialist interests the trainee’s may have. There are designated FY and GP supervisors to enable a greater understanding of the curriculum requirements these trainees require. There is a system in place to enable supervisors to be aware of any known concerns regarding a trainee’s performance. The amount of time for training in the trainer’s job plans is variable but trainers agreed that the standard amount is 1 hour per trainee. Trainers reported that their educational role is reviewed annual through recognition of trainers at appraisal.

**Foundation:** Not all trainees had met with their educational supervisor at the time of the visit. Trainees felt they could easily contact the supervisor due to the small size of the hospital.

**General Practice/Core Training:** Trainees reported that they had formally met with their supervisor in the hospital up to three times during their post.
**Specialty Training:** Trainees reported that they had formally met their educational supervisor once since starting their post but often worked with their supervisor.

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

**Trainers:** Trainers are aware of the different curriculum requirements for the different levels of trainee by having designated trainers for each cohort. Trainers will discuss what specific learning experiences trainees need to meet their requirements. Trainers were aware that GP trainees are reluctant to leave the ward to attend outpatient clinics, but they continue to encourage trainees to attend. The department are currently looking into how GP trainee clinic attendance could be built into the rota. They did not feel there were any curriculum competences that are difficult to deliver to trainees. Trainers also highlight they have developed acute simulation training scenarios within the acute medical assessment unit. This involves the multidisciplinary team and are aligned to different trainee curriculums. Trainers felt that there is a good balance for trainees between educational and non-educational tasks which they are required to so.

**Foundation:** Trainees reported that the post provided them with lots of opportunities to meet their learning outcomes. They did not feel that there were any particular outcomes that would be difficult to achieve. Trainees reported that they do not get to out-patient clinics. Trainees felt that the overall balance between educational and non-educational tasks was satisfactory. However, trainees did feel that there was some variability to the balance depending upon which ward they were working in, particularly at the weekend, as there is no phlebotomist at the weekend and not all nurses undertake tasks such as cannulation and male catheter insertion. Trainees commented that the amount of routine tasks at the weekend can be overwhelming.

**General Practice/Core Training:** Trainees reported that they see a variety of patients providing them with a lot of opportunities to achieve their required competences. GP trainees felt that it was difficult to attend out-patient clinics. They felt that their workload, at times, prevented them from attending outpatient clinics. Some trainees did not want to leave the Foundation doctor on their own on the ward and would therefore choose not to attend an out-patient clinic but acknowledged that they are encouraged to attend. Out-patient clinics are included in the rota for core trainees and this would enable them to meet their training requirement.
**Specialty Training:** Trainees reported that as they see a variety of patients. The post provides them with a lot of opportunities to achieve their required competences. They felt that some procedural skills would be difficult to achieve during their post e.g. chest drains, due to how this was organised in the hospital. Attendance at out-patient clinics is built into the trainee rota.

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

**Trainers:** Trainers are aware of the assessments trainees need to complete through discussion with trainees and by being allocated to specific cohorts. They felt that overall, trainees can easily achieve their assessment requirements. Trainers reported that they will also encourage trainees to highlight any outstanding assessments or procedures that they require to complete. Trainers reported they had received training for completing assessments but had no formal opportunity to benchmark their assessments against other trainers.

**Foundation:** Trainees reported that they need to be proactive in asking colleagues to complete their assessments, but these can be achieved. Some felt that it was difficult to undertake their Team Assessment of Behaviour (TAB) assessments. This was due to trainees frequently changing wards and therefore, trainees felt it was difficult to build a rapport with various staff to enable them to complete the form.

**General Practice/Core Training:** Trainees reported that they can complete their required assessments. GP trainees will work with their allocated clinical supervisor, at times, during their post. GP trainees reported there was variability in the quality of their assessments as some lacked detail from the assessor. This meant it was difficult for the trainee to evidence that they had met some of their competences.

**Specialty Training:** Trainees reported that it is easy for them to complete their required assessments.
3.7. Adequate Experience (multi-professional learning) (R1.17)

**Trainers:** Trainers report there are a variety of opportunities for multi-professional learning, including:
- Weekly x-ray meetings.
- Morbidity and mortality meetings and
- Simulation training.

**Foundation:** Trainees reported that the multi-disciplinary team meetings provide opportunities for multi-professional learning. Trainees can also attend morbidity and mortality meetings within geriatrics, if they are working on the ward at that time.

**General Practice/Core Training:** Trainees were not aware of any opportunities for multi-professional learning in General Medicine. Those that were working within geriatrics were aware of multi-disciplinary team meetings, but none were aware of morbidity and mortality meetings.

**Specialty Training:** Trainees that were aware of the x-ray meetings reported that these provide an opportunity for multi-disciplinary learning, but trainees were unable to attend. They reported that there is ad hoc simulation training which involves the multi-disciplinary team.

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

**Trainers:** Trainers reported that they encourage trainees to undertake a quality improvement (QI) project. The department are currently looking into setting up a QI forum. They reported that FY trainees have the opportunity to present their findings at one of the teaching sessions and ST trainees can present their QI projects at the Grand Round.

**Foundation:** Trainees reported that there are quality improvement opportunities available to them. Some trainees felt that their rotation made it more difficult to undertake a QI project but indicated that they would likely undertake their project in another post.

**General Practice/Core Training:** Some trainees had commenced a quality improvement project and felt senior colleagues provided good support and encouragement.
**Specialty Training:** Trainees reported that quality improvement projects are not actively highlighted to them. They also reported that QI time is not built into their timetable and therefore require to undertake this in their own time.

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:** Trainers reported that the hospital uses the coloured badge holder system to identify the different stages of training of trainees. There is a hospital at night team leader that trainees are aware of to contact for support. Trainers reported that there is good consultant presence within the wards and systems in place for trainees to know who to contact during the day.

**Foundation:** Trainees reported that they always have access to clinical supervision and are aware of who to contact for support both during the day and out of hours. None of the trainees felt they had been left to cope with a situation beyond their competence. Trainees, however, did feel that if they are working within the MacMillan centre there was no clear escalation pathway when queries arose about patient management plans or prescriptions. Otherwise Trainees felt that their senior colleagues were accessible and approachable when they require support.

**General Practice/Core Training:** Trainees reported that they always have access to a supervising clinician and know who to contact for that supervision during the day and out of hours. Some trainees felt that working during out of hours could be challenging but support is available. None of the trainees felt they had been left to cope with a situation beyond their competence. Trainees reported that senior colleagues are accessible and approachable when they seek support.

**Specialty Training:** Trainees reported that they always have access to clinical supervision and are aware of who to contact for support both during the day and out of hours. None of the trainees felt they had been left to cope with a situation beyond their competence. Trainees felt that their senior colleagues were accessible and approachable when they require support.
3.10. Feedback to trainees (R1.15, 3.13)

Trainers: Trainers reported that they will often highlight to trainees when they are providing feedback to ensure the trainee understands that they are receiving feedback. They report a variety of feedback opportunities, these included:

- Case-based discussions on the post take shift
- Through workplace-based assessments
- After reverse wardround (trainee led ward round)
- Informally thanking staff at the end of a ward round and
- Debriefs following significant events such as a cardiac arrest.

Foundation: Trainees reported that they receive constructive feedback on their clinical decisions. They felt that this was particularly good when working in the acute assessment units.

General Practice/Core Training: Trainees reported that they receive constructive feedback on their clinical decisions, particularly when dealing with an acute patient. Trainees also felt that the feedback and learning opportunities when on the post take shift was very good.

Specialty Training: Trainees reported that they receive constructive feedback on their clinical decisions. They felt this was particularly effective when on post take shift. Trainees also reported that feedback is provided during discussion at the morning handover following a hospital at night shift.

3.11. Feedback from trainees (R1.5, 2.3)

Trainers: Trainers reported that feedback forms are completed following every teaching and simulation training session. Trainers will also seek trainee input as to what would be useful for their training. An example was given where GP trainees working within cardiology have the opportunity to review and discuss GP referrals and learn from these.

Foundation: Trainees were not aware of any opportunities to feed back on the quality of training they experience within the department. However, they felt that they could feedback to the consultant team if they wanted to. They reported that they do complete feedback forms following attendance at the local teaching sessions.
**General Practice/Core Training:** Trainees felt they could feedback about their experience in the department when meeting with their supervisor. GP trainees also complete feedback forms on the quality of teaching following each session they can attend. Not all trainees were aware of the role of the chief resident as a method for feedback.

**Specialty Training:** Trainees reported they can feedback about their experience in the unit at educational meetings and midpoint reviews with their supervisor.

**3.12. Workload/ Rota (1.7, 1.12, 2.19)**

**Trainers:** Trainers reported there is a 3-tier rolling rota in place. Trainees are allocated to a base ward but work in various medical wards. They reported that they have increased staffing levels with the appointment of Clinical Development Fellows to help enable trainees to attend relevant teaching and reduce the workload for trainees, but the rota remains a significant challenge. Trainers reported that the rota is designed to enable trainees to work on the acute medical take and then post take ward rounds. They thought this worked well. This enables trainees to discuss cases and gain constructive feedback.

**Foundation:** Trainees reported that their rota feels manageable both during the day and out of hours. They did not feel the rota had any patient safety implications, but some trainees did feel that the lack of continuity to a specific ward was challenging. They suggest that the rota could be improved by being allocated to work full weekends rather than split weekends which occurs due to the 6-day working pattern. Trainees also suggested that the workload on the wards is variable and it would be useful to review the number of trainees allocated to the busier wards.

**General Practice/Core Training:** Trainees felt that their workload was manageable during the day and the rota was very good in relation to the weekend and nightshift allocations. Trainees reported that they were concerned about the variability of the ward allocation within the rota and felt that it would be beneficial to be rostered on to the same ward for a longer period of time. Some trainees also felt that the rota was not issued with enough notice. It was suggested that being allocated float days would be useful.
**Specialty Training:** Trainees reported that their workload is manageable. They did however feel that there are potential patient safety implications with their rota. This was due to only working on a ward for about one week, however, examples of only working on a ward for one or two days at a time were given. Trainees felt the lack of continuity could impact on patient safety especially regards making decisions about inpatients for whom they had no previous responsibility. They suggested that being allocated to the same ward for a longer period of time would be beneficial.

### 3.13. Handover (R1.14)

**Trainers:** Trainers reported there is an effective, structured, hospital-wide handover twice daily. Handover is used as a learning opportunity. This is followed by individual ward handovers. There are 2 morning handovers (pre and post consultant review) within the medical assessment unit which follows the S-BAR (situation, background, assessment, recommendation). This format is used as soon as the patient is first reviewed, and an electronic record created (TRAK) which is easily accessed when a patient is moved to another ward. Trainers felt that the restructuring of ward 16, where most boarded-out patients will be placed, is viewed as an additional medical ward and included within handover.

**Foundation:** Trainees reported that there is a good handover in place. They felt that when working in the medical acute unit, it would be useful if they could start their shift earlier to enable them to participate in the handover there.

**General Practice/Core Training:** Trainees reported there is a good effective handover in place. Trainees felt that this was used as a learning opportunity at times but was dependent on the individual consultant.

**Specialty Training:** Trainees reported that there is a consistent, structured effective handover in place to ensure information about sick patients is passed to the next team.

### 3.14. Educational Resources (R1.19)

**Trainers:** Trainers reported that simulation training provides opportunities for technology enhanced learning.
Foundation: Trainees reported that the educational resources available to them are adequate. They suggested having more computers in the department would be beneficial, but they can access IT and other educational resources within the library.

General Practice/Core Training: Trainees reported that there are sufficient facilities to support learning, including:
- Education centre
- Videoconference facilities, and,
- Computer access.

Specialty Training: Trainees reported that the educational resources available to them could be improved. They felt the computers available to them are very old and slow. This impacted on the time taken to undertake educational tasks such as completing assessments on their electronic portfolio.

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 reported that trainees are encouraged to feedback concerns as a group to the chief resident and through the monthly junior doctor meetings. These meetings have input from the Director of Medical Education (DME) and Medical Director. Trainers would raise concerns about a trainee’s performance with their educational supervisor and can escalate to the relevant Training Programme Director. If further training support is required, the trainers were aware of the Deanery’s performance support unit. Where a trainee is in difficulty, the department can arrange for the trainee to be supernumerary to provide them with direct senior support on each shift.

Foundation: Trainees reported that support would be available to them if they felt they were struggling professionally or personally. None of the trainees interviewed were working less than full time. None of the trainees were able to comment on how the site may accommodate reasonable adjustments.

General Practice/Core Training: Trainees reported that there is good support available to them. Those who are less than full time had no issues with the arrangements in place.
**Specialty Training:** Trainees reported that support is available to them if they felt they were struggling professionally or personally. None of the trainees interviewed were working less than full time. None of the trainees were able to comment on how the site may accommodate reasonable adjustments.

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 reported there is a quality governance forum, but attendance is difficult due to workload demands. The department has a trainee forum where concerns are raised and have involvement from the DME and MD.

**Foundation:** Trainees were aware of who the chief resident is to highlight any issues they are experiencing. They are also aware and happy to attend the monthly trainee forum.

**General Practice/Core Training:** Trainees were not aware of the educational governance structures within the hospital.

**Specialty Training:** Trainees were not aware of the educational governance structures within the hospital.

3.17 **Raising concerns (R1.1, 2.7)**

**Trainers:** Trainers reported that they encourage trainees to raise patient safety concerns at induction and are shown how to use the datix system. They also encourage trainees to highlight concerns to consultants in addition to during the daily handovers.

**Foundation:** Trainees reported they would raise any patient safety concerns initially with a charge nurse. If required, they would submit a datix report. Trainees reported that if they had a concern about their education or training, they would raise this with their educational supervisor.

**General Practice/Core Training:** Trainees would raise any patient safety concerns with a consultant or their supervisor. Trainees reported that if they had a concern about their education or training, they would raise this with their educational supervisor and if needed, escalate to their training programme director.
**Specialty Training:** Trainees reported they would raise any patient safety concerns with the on-call consultant and ward sister. If required, they would submit a datix report. Patient safety would also be discussed during handover. If there was a concern about the training being provided, trainees can raise this with the chief resident to discuss at the monthly trainee forum.

**3.18 Patient safety (R1.2)**

**Trainers:** Trainers felt the environment in the departments had significantly improved for both patients and trainees with an increase in staffing numbers, a much improved consistent and structured handover and the introduction of a specific ward to care for most boarded-out patients. In addition to handovers and ward rounds, there is a daily safety brief. This involves management and nursing staff, but the department are looking at ways to further develop this going forward.

**Foundation:** Trainees reported that they would have no concerns about the quality or safety of care that would be provided in the department if a friend or relative was admitted. Trainees felt that quality of care of boarded out patients could be improved.

**General Practice/Core Training:** Trainees reported they would have no concerns about patient safety if a friend or relative was admitted to the department. They felt that the introduction of a dedicated patient boarding team had significantly improved the care boarded out patients received. Trainees reported that the communication about boarded patients can be poor at times, such as when a patient is going to be boarded and who is responsible for competing the immediate discharge letters. A concern was raised about patients being moved from the acute assessment unit to wards before initial investigations are complete and this not communicated to the trainees currently looking after the patient.

**Specialty Training:** Trainees felt that staff are stretched in the department. They highlighted that during out of hours, they are required to get their supervisor’s approval for some radiology requests which they felt could delay treatment. Trainees reported that the structure for boarding out patients to other wards had changed and there is now a new ward where most boarded patients are allocated. There is now an allocated consultant and trainee for boarded out patients which has improved quality of care.
3.19 Adverse incidents (R1.3)

**Trainers:** Trainers reported that adverse incidents are logged through the datix system. Datix reports are discussed at morbidity and mortality meetings where learning outcomes can be shared with the wider team.

**Foundation:** Trainees reported that adverse incidents are recorded through the datix system by nursing staff. If a trainee is involved they would have an initial informal debrief to discuss what happened. Trainees reported that adverse incidents are discussed, and any learning outcomes shared, at morbidity and mortality meetings.

**General Practice/Core Training:** Trainees reported that they would record an adverse incident through the datix reporting system. They were not aware of any meetings that would provide feedback and shared learning following an adverse incident.

**Specialty Training:** Trainees reported that they will discuss any adverse incident with the consultant on-call and senior charge nurse. If needed, trainees will submit a datix report which can be escalated to specific consultants to review. Trainees can tick a box on the datix form to request feedback. Shared learning from adverse incidents is included in the Grand Round on a monthly basis.

3.20 Duty of candour (R1.4)

**Trainers:** Trainers felt that they promote a no blame culture to support trainees to be open and honest when something goes wrong. They also felt that discussion of significant events and learning about what went wrong and what could be done differently through the M&M meetings promotes a culture of being open and honest.

**Foundation:** Trainees felt they would be supported by the consultant team if they were involved in an incident where something went wrong. They reported that there is a debrief following any such incidents and trainees can access further support from a psychiatrist.
**General Practice/Core Training:** Trainees reported that support would be available if they were involved in an incident where something went wrong. Trainees were able to provide an example of this support which included a hot (immediately after) and cold (follow-up) debrief and regular informal conversations from all levels of staff to check that a trainee was coping following an incident.

**Specialty Training:** Trainees felt they would be supported by the consultant team if they were involved in an incident where something went wrong.

### 3.21 Culture & undermining (R3.3)

**Trainees:** Trainees felt there was a good team ethos within the department. Social events are organised to further develop a positive team culture. Channels for reporting bullying or undermining concerns are highlighted at induction. Trainees were aware of staff feeling undermined by management with pressures to discharge patients. Trainees felt that by empowering charge nurses to look at bed and discharge management, the culture had improved.

**Foundation:** Trainees felt that there was a good supportive environment. Some trainees felt that there was some conflict between the medicine and emergency medicine department due to a busy and stressful environment. However, trainees did not feel there is any culture of bullying or undermining within the departments. All reported they would be happy to raise any such concerns with their supervisor.

**General Practice/Core Training:** Trainees felt the senior colleagues provided a very supportive environment. No-one had experience or witnessed any bullying or undermining behaviours in the departments. Trainees reported if they were to encounter any such behaviours they would raise this with their supervisor or another consultant.

**Specialty Training:** Trainees felt that senior colleagues provided a supportive environment. No-one had experience or witnessed any bullying or undermining behaviours in the departments. Trainees reported if they were to encounter any such behaviours they would raise this with their supervisor or another consultant.
3.22 Other

Trainees were asked to rate their experience in the post with a score range from 0 (very poor) to 10 (excellent). From those attending the overall satisfaction scores were as follows:

Foundation: Range: 7 – 9, Average: 7.3 out of 10
GP & Core: Range: 5 – 8, Average: 7 out of 10
ST: Range: 5 – 7, Average: 6.2 out of 10

4. Summary

Positive aspects of the visit

- Approachable and supportive consultant team, particularly following a recent adverse incident. This was highly valued by trainees.
- Trainees being rostered on to post-take days following acute take days was valued by all cohorts of trainees in providing them with useful feedback.
- “Reverse ward round” as an educational event
- Good clinical support provided to all levels of trainees at all times, including out of hours.
- Handover works well and is safe
- Patient boarding arrangements have improved with a designated consultant and trainee
- Cardiology GP specific teaching provided based on GP referrals.
- Local teaching provided is mapped to trainee’s curriculum
- Informative induction booklet is comprehensive and useful
- Acute simulation training, although in its infancy, appears to work well.
Less Positive aspects of the visit

- Poor trainee engagement with GP specific local teaching. The planned change of time for teaching is welcomed by trainees and the panel would encourage that this goes ahead. In addition, further review should be undertaken by the department to improve GPST engagement with the teaching opportunities provided.
- Lack of ward continuity within the rota was raised by all trainee cohorts as a patient safety concern.
- Late distribution of rotas.
- Lack of clarity of the escalation procedures for trainees working in the MacMillan Centre
- Routine tasks can be overwhelming at times for foundation doctors at weekends, including phlebotomy, cannulas and male catheterisation.
- Lack of shared team learning from adverse incidents.
- Lack of awareness of formal organised teaching activities available to trainees.
- Poor trainee awareness and understanding of the role of the chief resident.
- Variable uptake and lack of a forum to present quality improvement activities.
- An in-person induction to the acute assessment areas for all trainees is not provided resulting in some trainees feeling unprepared for working in these areas.

<table>
<thead>
<tr>
<th>Is a revisit required?</th>
<th>Yes</th>
<th>No</th>
<th>Highly Likely</th>
<th>Highly unlikely</th>
</tr>
</thead>
</table>

5. Areas of Good Practice

<table>
<thead>
<tr>
<th>Ref</th>
<th>Item</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>Rostered onto post-acute take following take day provides greater feedback and learning opportunities.</td>
<td></td>
</tr>
<tr>
<td>5.2</td>
<td>Supportive and engaged consultant team</td>
<td></td>
</tr>
<tr>
<td>5.3</td>
<td>Having a designated consultant and trainee for boarded out patients has improved patient safety.</td>
<td></td>
</tr>
<tr>
<td>5.4</td>
<td>Local teaching and simulation sessions as targeted to the different trainee’s curriculum</td>
<td></td>
</tr>
<tr>
<td>5.5</td>
<td>Designated supervisors for Foundation and GP trainees to enable a better understanding of their curriculum requirements</td>
<td></td>
</tr>
</tbody>
</table>
## 6. Areas for Improvement

<table>
<thead>
<tr>
<th>Ref</th>
<th>Item</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1</td>
<td>Formal teaching &amp; adequate experience</td>
<td>The department should review how they can improve overall GP trainee engagement with the training and teaching opportunities provided by the department such as out-patient clinics and x-ray meetings.</td>
</tr>
<tr>
<td></td>
<td>(opportunities)</td>
<td></td>
</tr>
<tr>
<td>6.2</td>
<td>Local teaching</td>
<td>The department should progress with their planned timing change for the local GP teaching sessions to improve attendance.</td>
</tr>
<tr>
<td>6.3</td>
<td>Induction</td>
<td>The department should promote the use of induction materials on the educational website.</td>
</tr>
<tr>
<td>6.4</td>
<td>Quality Improvement</td>
<td>The department should develop and promote a quality improvement project forum to support trainees to undertake QI projects.</td>
</tr>
<tr>
<td>6.5</td>
<td>Formal Teaching</td>
<td>Teaching opportunities for all levels of trainees should be signposted regularly to trainees such as x-ray meetings and M&amp;M meetings.</td>
</tr>
</tbody>
</table>
7. Requirements - Issues to be Addressed

<table>
<thead>
<tr>
<th>Ref</th>
<th>Issue</th>
<th>By when</th>
<th>Trainee cohorts in scope</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1</td>
<td>The discontinuity of ward placements for trainees must be addressed as it is compromising quality of training, feedback, workload and the safety of the care that doctors in training can provide.</td>
<td>16th October 2019</td>
<td>All cohorts</td>
</tr>
<tr>
<td>7.2</td>
<td>There must be a process that ensures trainees understand, and are able to articulate, arrangements regarding Educational Governance at both site and board level</td>
<td>16th October 2019</td>
<td>All cohorts</td>
</tr>
<tr>
<td>7.3</td>
<td>There must be a clear escalation policy in the MacMillan unit which is understood and followed by all involved.</td>
<td>16th October 2019</td>
<td>FY</td>
</tr>
<tr>
<td>7.4</td>
<td>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, particularly in the acute assessment areas.</td>
<td>16th October 2019</td>
<td>All cohorts</td>
</tr>
</tbody>
</table>