Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	26th November 2018	**Level(s)**	FY; GPST; CMT; ST3+
Type of visit	Triggered	**Hospital**	Royal Alexandra Hospital
Specialty(s)	Medicine	**Board**	Greater Glasgow & Clyde

Visit panel	
Alastair McLellan	Visit Chair - Postgraduate Dean
Surinder Panpher	Foundation Programme Director
Name Redacted	Lay Representative
Fiona Ewing	Associate Postgraduate Dean – Quality
Lesley Metcalf	Senior Quality Improvement Manager
In attendance	
Patriche McGuire	Quality Improvement Administrator

Specialty Group Information		
Specialty Group	Medicine	
Lead Dean/Director	Prof Alastair McLellan	
Associate Postgraduate Dean(s) - Quality	Dr Alan McKenzie Dr Stephen Glen Dr Reem Al Soufi	
Quality Improvement Manager(s)	Mr Alex McCulloch Mrs. Heather Stronach	
Unit/Site Information		
Non-medical staff in attendance	1x senior nurse; 1 x rota coordinator; 3 x senior managers	
Trainers in attendance	10	
Trainees in attendance	11 x FY; 3 x GPST; 5 x CMT; 3 x ST3+	

Feedback session: Managers in attendance	1 x DME; 1 x ADME; 1 x Clinical Director; 1 x DME Business Manager; 3 x senior managers;

Date report approved by Lead Visitor	 7th January 2019

1. Principal issues arising from pre-visit review

The site was last visited in November 2014. An action plan from this visit was received and the issues were confirmed to have been addressed by the West of Scotland Quality Management Group in June 2015. This visit was triggered by concerns arising from the 2018 National Trainee Survey and Scottish Trainee Survey where the quality review panel noted there to be potential concerns across all grades. The following flags were noted:

Post level outcomes (responses from all levels of trainee)

NTS data

Red flags: Clinical supervision, clinical supervision out-of-hours, supportive environment, workload, feedback, study leave, teamwork & educational governance.

Foundation trainees

NTS Data

FY1 - Red flags for adequate experience, clinical supervision, overall satisfaction, supportive environment, teamwork, curriculum coverage and educational governance.

Pink flag for clinical supervision out-of-hours.

FY2 - Red flag for workload

Pink flags for clinical supervision, clinical supervision out-of-hours and induction.

STS Data

Red flags for teaching & workload

Pink flags for clinical supervision & team culture.

GP trainees

NTS Data

Red flags for handover, induction, overall satisfaction, study leave & teamwork

Pink flags for adequate experience, regional teaching, reporting systems, curriculum coverage & educational governance.

Core Medical Trainees

NTS data

Red flags for handover and workload

Pink flag for clinical supervision
STS Data
Pink flags for teaching & workload

There were 3 patient safety comments received in the NTS relating to workload and staffing in the department. In the STS there were 7 negative free text comments at FY level, 1 at GP level, 3 at core level and 2 at ST level.

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 below includes numeric reference to specific requirements listed within the standards.

The panel met with the following trainee groups:

Foundation Trainees
GP trainees
Core Trainees
Specialty Trainees

The visit team also took 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.

3.1 Induction (R1.13)

Trainers: Trainers advised that the main hospital induction takes place on the Wednesday when trainees changeover. There are also departmental inductions on this day with a full medicine induction meeting taking place on the Friday of changeover week. The full medicine induction covers more detailed information on rotas, on-call and supervision arrangements. Trainers advised they are considering running this medicine induction meeting twice in future to maximise attendance. Trainees receive a handbook in advance of taking up post and, at

departmental induction, there are checklists to follow which trainees then sign to confirm they have received all relevant information. Trainers did note that the induction to the night team could be improved. They also advised that they are updating information in the handbook regarding working out-of-hours based on feedback from trainees in post.

Foundation trainees: Trainees had little recollection of receiving a hospital induction. They noted they were not shown around the site or given a map so had little understanding of where different working environments were located. Trainees noted the medicine induction on the Friday but felt that the volume of information meant it was difficult to absorb everything and that information about out-of-hours working was difficult to understand with no 'real life' experience to relate it to. Trainees had all received the induction handbook. Many trainees felt that their induction had not adequately prepared them to begin work but trainees in Geriatric medicine praised their departmental induction as being very helpful in this regard. FY1 trainees felt that their shadowing time had too many structured events which limited the time available to actually shadow the outgoing trainees.

GP trainees: All trainees had received the induction handbook which they felt was useful. There was some concern that trainees beginning their post on-call did not receive an induction before beginning post which could be challenging. Trainees did note that anyone who missed induction was spoken to & caught up at a later stage but that this was fairly informal, and a repeated induction session may have been useful.

Core trainees: The group did not recall receiving a hospital induction on the day they started work but did receive the Friday medicine induction. Some trainees received a departmental induction, with the acute medicine induction being noted particularly positively. Trainees in Gastroenterology advised they received no departmental induction and those in Endocrinology/ Diabetes had received a guidance note from a previous trainee advising what they should do. Trainees in Haematology and Rheumatology received satisfactory inductions. Trainees did receive the handbook which they noted had some information to help those on-call, but they felt as they had not been shown around all the environments they would be working in they lacked context for this information. At the medicine induction on the Friday after beginning post trainees would have appreciated a map or tour of the hospital to orientate them to their surroundings. Trainees also noted that for those working the first weekend they would

have missed this induction and begun work without an induction if they had not come in early for the session.

ST3+ trainees: Trainees undertook online GG&C induction modules and then attended the hospital induction on their first day in post. The hospital induction consisted of a few lectures, an outline of the geography of the site and resuscitation protocol. Trainees were also emailed a handbook in advance of taking up post. Trainees found their departmental induction comprehensive and useful. It included an outline of their role, a tour of the main working areas and an introduction to staff. Trainees did suggest that a handover note from the outgoing trainee with advice about clinic attendances and key contacts would be helpful. Trainees also attended the medicine induction on their first Friday in post. Overall trainees felt well prepared to begin their post.

Non-medical staff: Managers at the session noted an awareness that trainees could find the volume of information during induction overwhelming. They noted that they were aware that trainees would appreciate hearing from someone who has worked in the department previously and can share real-life scenarios. The panel were advised that an exercise is being undertaken to ask outgoing trainees to share their helpful hints about their ward and that this information will be added to the trainee handbook.

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

Trainers: Trainers outlined a number of formal teaching opportunities across the week. This includes a formal teaching programme in Geriatric medicine where Consultants present common conditions for the first half of the programme and then trainees present improvement projects or audits for the second half. In Acute Medicine there is case based presentation on Wednesdays, where trainees also have the opportunity to present. On a Thursday lunchtime there is a discussion of interesting cases and on Thursday afternoon there is extended supervision when trainees have direct teaching and the opportunity to complete assessments. On Friday there are grand rounds attended by the whole hospital. Trainers advised that FY1 formal teaching on a Tuesday is bleep free but other teaching sessions are not. Trainers were all supportive of attendance at regional teaching, advising trainees who were on-call were welcome to arrange a swap to attend teaching. Trainers noted they would always try to support

release for regional teaching where they had sufficient notice to make alternative arrangements. All trainees at core level and above are also routinely registered to attend simulation training which focused on situational awareness and communication skills.

Foundation trainees: FY1 trainees noted they had formal teaching on a Tuesday which they could almost always attend. The topic for the Tuesday teaching is confirmed the Friday before. FY2 trainees noted they had no issues in being released for their formal teaching sessions. Trainees also noted other educational opportunities across the week, including the Thursday case discussion meeting in the acute medicine unit.

GP trainees: Trainees noted there was good access to local teaching. Although this is not bleep free trainees noted they were able to attend a good number of sessions. Teaching in Geriatric Medicine and the acute medicine unit was highlighted particularly positively. Trainees also appreciated the opportunity to develop their presentation skills. The panel heard that all trainees were accommodated to attend their GP formal teaching days.

Core trainees: Trainees advised that it can be difficult to attend regional teaching due to their workload. All trainees had attended at least one session and they all felt the quality of regional teaching was good. Trainees did highlight that their regional teaching takes place on a Friday which can make attending more challenging. Trainees also advised they would find it helpful if there was the opportunity to attend by video link as travelling to the deanery offices makes attendance more difficult.

ST3+ trainees: Trainees outlined a range of local teaching meetings. They could attend the Thursday lunchtime teaching in acute medicine which is mapped to the curriculum. There is also a weekly case-based discussion meeting. On Thursday afternoon some trainees had extended supervision with a consultant which allowed them to complete assessments and receive helpful feedback. Trainees were also aware of a Friday meeting which covered case-based discussions and morbidity & mortality, but they found this difficult to attend.

Attendance at regional teaching was felt to be generally supported but trainees highlighted that general medicine teaching at the deanery took place on a Friday and they felt this made it more difficult to attend.

Non-medical staff: The panel were advised that nursing staff are aware of when trainees should be at formal teaching and they encourage them to attend. Nursing staff advised they try not to contact trainees when they know teaching is taking place.

3.3 Study Leave (R3.12)

Trainers: Trainers advised they are always happy to support requests for study leave so long as they receive sufficient notice of the request.

Foundation trainees: As noted above, FY2 trainees, who use their study leave to attend their formal teaching programme, had found no issues in being released.

GP trainees: trainees were able to access study leave to attend their GP formal teaching/ study days.

Core trainees: All trainees felt the department was supportive and accommodating of requests for study leave.

ST3+ trainees: On the whole trainees reported no issues in obtaining study leave if sufficient notice was given. A specific example where a trainee had struggled to gain approval was shared but this appeared to have been satisfactorily resolved.

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

Trainers: The panel were advised that educational and clinical supervisors are allocated to trainees a minimum of one week prior to them taking up post. Where possible, supervisors with experience of certain trainee cohorts will be allocated this grade of trainee again to aid familiarity with the curriculum and portfolio. Core trainees have the same educational supervisor for a year so are not allocated a separate clinical supervisor during their first post as the same individual covers both roles.

Trainers did not always feel confident they would receive information in advance if there were known concerns about a trainee but offered examples of where this had previously worked well and not so well. Trainers noted that the transfer of information for foundation trainees did not always work as well as it could. Trainers felt that since the introduction of E-job planning the time for their educational role was more adequately recognised. Trainers had all undertaken some form of training for their role (often through their Royal College) and had evidenced this as part of their revalidation.

Foundation trainees: All trainees had a named educational supervisor, and most had met with their supervisor once to date. Trainees found these meetings helpful. The panel did note an instance where a trainee supervisor was leaving and so allocation of a new supervisor had delayed the initial meeting.

GP trainees: Trainees noted that they had met with their educational supervisor in their GP post. Being released to attend such meetings can be challenging but all trainees felt it was possible. Trainees had also met with their clinical supervisor in the department and noted they were individuals who they worked with closely and communicated with regularly.

Core trainees: All trainees had an allocated educational supervisor who also acted as their clinical supervisor. Trainees had met with their supervisor which they found helpful. Trainees advised they were not told in advance who their supervisor was but were aware consultants had been given this information; they perceived this caused some confusion initially. For ACCS trainees there was a lack of familiarity with the life-long learning platform, but workarounds had been found.

ST3+ trainees: Trainees all had appropriate supervision and had met with their supervisors to agree a learning plan. Trainees noted their supervisors were very helpful & supportive, particularly in helping them prepare for their penultimate year assessment.

Non-medical staff: The group were all confident that trainees would always know how to access senior support. They noted that consultants are on-site until 9pm and are always approachable & contactable. Out-of-hours there is a clear pathway for trainees to follow to access senior support and consultants are happy to be phoned.

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

Trainers: Trainers noted several tools which aided their understanding of curriculum requirements for their trainees. This included a summary sheet for foundation trainees distributed by the postgraduate administrator and a decision aid for other trainee grades. Trainers discuss trainee learning and curriculum requirements at their initial meeting with trainees. Trainers were not aware of there being local champions for each grade of trainee.

Trainers advised that clinic lists are made available to trainees and that, in general, they felt there were good opportunities to attend clinics. Geriatric medicine did note this could be more challenging due to the number of patients allocated to each trainee in that department. Trainers also highlighted that the rota coordinator sends a summary of cover for each department each week which highlights where there may be capacity to release trainees for clinic/ other educational activities. Trainers had no concerns regarding the ability of core trainees to meet their mandatory number of clinic sessions and meet curriculum requirements.

Foundation trainees: Trainees noted they liked working at the site as the size allowed them to get to know people and feel like part of a team. Trainees also liked the different experiences offered by working part of their placement in a ward and part in the acute medicine unit. Trainees generally felt unable to attend clinics due to their workload. Trainees all felt they would meet their curriculum requirements.

Trainee experience of ability to attend ward rounds, and whether they were educational, varied by department. Trainees in Respiratory Medicine & Endocrinology/ Diabetes were particularly positive about ward rounds in their department and the opportunity they provided to receive feedback. Trainees all noted feeling that the majority of their time was focused on service provision and there was limited opportunity for teaching and development.

GP trainees: Trainees felt that they would be able to meet their curriculum competencies in the post. They appreciated the support from senior staff but felt that on-the-job teaching was lacking in some areas. Teaching in the stroke/ geriatric ward was highlighted as positive and relevant. Trainees felt that the experience they gained in the acute medicine unit was less relevant to their development. Trainees had experienced very limited access to clinics which

they noted as being difficult due to their workload on the ward. In general, trainees felt their post was heavily weighted towards service provision and did not perceive their training & development to be a priority in the department. They reported that 'no-one looks out for the needs of GPSTs in the department'.

Core trainees: Trainees all noted that they appreciated the supportive consultants in the department and felt they could always contact them, especially if they were acting-up, and help would be provided. Attendance at the post-take ward round was noted as being difficult as trainees were often still caring for sick patients from the overnight workload when the post-take ward rounds were happening. We heard also their perception that a disincentive to attending the post-take ward round is that one consultant (name shared with NHS GGC) tends to give feedback in what is perceived to be an unnecessarily critical manner, in this public forum.

Trainees advised that they are allocated a base ward and are generally supported to remain there. Ability to attend clinics was noted as variable depending on trainees' base wards. Respiratory was noted as being particularly supportive of clinic attendance. In other departments trainees noted there were clinics at the Vale of Leven Hospital which they could not attend. All trainees felt that over the year they would meet their required number of clinics.

Trainees working in general medicine perceived that their post largely consisted of service provision with little of educational value. They perceived that this was partly due to locum consultants who they found pleasant to work with but felt they received less training from. In Haematology trainees noted that they often received good training and feedback on the ward rounds.

Promptly after this visit, the management team took decisive action to address the significant concerns around the performance of a locum that were raised by the doctors in training.

ST3+ trainees: Trainees noted that they work in a busy department with good exposure to a range of conditions. They advised they feel well supported by approachable consultants and they commended the process of calling the consultant prior to admitting a patient to HDU. Trainees in acute medicine appreciated the opportunity to spend time in HDU and found this a positive environment in which to gain procedural experience. Trainees also noted that in acute

medicine, consultants actively directed them to educational cases. Trainees noted that they can attend more clinics than had been their experience at other sites. They also felt the department was more focused on their education and they had less service provision in their role than in other sites they had worked. Trainees did note that experience in Gastroenterology was fine at the present time but felt if there were further consultant vacancies then training could be compromised.

Non-medical staff: The group felt that nursing/ AHP staff acted as a support and source of advice to trainees and that they all worked well together, bringing complimentary skills to the team.

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

Trainers: The panel heard that for core and specialty trainees, trainers would follow a decision aid document which outlined the assessments and activity a trainee would need to complete for a successful ARCP outcome. Trainers noted that they discuss trainee performance with each other but had not undertaken any formal benchmarking of assessments. Trainers felt that all trainees should be able to complete their required assessments in medicine posts at the site.

Foundation trainees: All trainees felt they had good support in completing assessments, particularly from more senior trainees. The acute medicine unit was highlighted as being particularly good for obtaining experience and assessments in procedures.

GP trainees: Trainees expressed some concern regarding completing assessments since they are most often supervised/ observed by more senior trainees who are not able to complete their assessments. Trainees did note, however, that where assessments such as case-based discussion had been completed these were done to a good standard.

Core trainees: The group noted that completing ACATs could be challenging. They noted this was not due to lack of support from Consultants but was as a result of the fragmented nature of their on-call work which meant that they would be unlikely to have 5 patients being reviewed by the same consultant to complete the assessment. Trainees highlighted that their week in

CCU offered good opportunities to complete assessments. Some members of the group found it challenging to evidence completion of their curriculum whilst acting up. Trainees also highlighted some concern regarding their lack of training in central line insertion. Whilst they appreciated this was not a curriculum competence they felt that when acting up out-of-hours there could be confusion regarding who is responsible for central lines and this could compromise patient care.

ST3+ trainees: All trainees reported they had no difficulties completing their assessments and that consultants were very supportive in that regard. Trainees felt that their assessments were completed in a fair and consistent manner.

Non-medical staff: The group advised that they are involved in completing multi-source feedback for trainees and that they felt their perspective in these exercises was valuable. The panel were also advised that due to the size of the department it supported informal information sharing to ensure trainees were always supported.

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

Trainers: In Geriatric medicine trainers noted that ward rounds are conducted as educational opportunities and include nurses and advanced nurse practitioners (ANPs). Trainers also highlighted the simulation training mentioned earlier as being multi-professional in addition to a motor teaching session regarding Parkinson disease.

Foundation trainees: FY1 trainees did not have any formal opportunities for multi-professional learning. FY2 trainees highlighted taking part in simulation training which had been multi-professional. They appreciated the opportunity to learn about the perspectives of other staff groups.

GP Trainees: The panel noted trainees participation in multi-professional simulation training. This was considered a worthwhile activity. Trainees did highlight that they were automatically enrolled on this training and there was an associated cost which training programme directors were not always happy to fund due to the lack of direct relevance to the GP curriculum. The Deanery team noted this and agreed to take it back for consideration.

Core trainees: not discussed.

ST3+ trainees: Trainees advised that advanced nurse practitioners attend the Thursday lunchtime teaching and the teaching on a Friday. They had also undertaken the simulation training which was multi-professional, and trainees found this a positive experience.

Non-medical staff: The group advised that board rounds and simulation training both offer opportunities for multi-professional learning.

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

Trainers: Trainers advised that a formal teaching session early in trainee placements is dedicated to audit and quality improvement. Trainees are then encouraged to undertake an audit or quality improvement project. There are quality improvement advisers in the department and formal sessions on quality improvement methodology have been run. Trainees are also assigned a project mentor.

Foundation trainees: Trainees all felt supported to undertake a quality improvement project or audit. Geriatric medicine was noted as being particularly helpful & supportive in this regard. Although not all trainees had chosen to undertake such a piece of work all felt they would be supported and have access to appropriate expertise if they wished to do so.

GP trainees: All trainees advised they had been given the opportunity to be involved in audit or quality improvement projects and the department provided good support in regard to these activities.

Core trainees: not discussed.

ST3+ trainees: Trainees advised they had been very much encouraged to undertake audit or quality improvement projects. In the acute medicine unit trainees were encouraged to use quality improvement in regard to issues they had identified. Trainees noted they were aware of individuals in the department with qualifications in quality improvement methodology who are available to support them.

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 advised that staff differentiate between trainee grades using a colour coded name badge system, with each trainee cohort having a unique colour. There is also an escalation board which highlights the severity of the patient issue and who should be contacted. Trainers did acknowledge that if foundation and GP trainees are on the same tier of the rota other staff may not fully recognise the difference in their level of competence. Trainers felt that although trainees may be challenged at times none are working beyond their competence and all trainees are encouraged to contact Consultants if they need to. There have previously been instances when trainees have raised concerns regarding their confidence working out-of-hours and when this has occurred additional training and support has been made available.

Foundation trainees: Trainees all had a named educational & clinical supervisor (combined roles). Depending on their place on the rota some trainees (those in a post, split evenly between 2 departments) felt like part of the team and felt well supported whilst others (undertaking 6-week placements) felt less like part of a team.

Out of hours in AMU Foundation trainees perceived they had to cope beyond their level of competence. They highlighted concerns in relation to patient safety and cited an example. Trainees all knew who to contact for support out-of-hours but highlighted that because of the workload pressures in the ED and HDU their overnight senior colleague was not, in practice, available to provide practical support to them because they were fully engaged elsewhere in the hospital, although they could be available on the phone. They reported these nightshifts to be ‘very challenging’.

Trainees also highlighted that in the AMU there was confusion amongst other staff as to their role. Some perceive they are there to do ‘medicines reconciliation’ and write up the drug Kardex while in practice they are more involved in reviewing patients who have been transferred from the ED without management plans (because of 4hr wait pressures); again, this was an issue because of lack of access to more senior support.

All trainees were, in general, happy to contact Consultants and found them to be generally supportive. One comment around a negative comment to being contacted overnight has been shared with the service to allow further investigation.

GP trainees: All trainees felt they had good access to senior support and were confident that consultants were always happy to be contacted. They highlighted that out-of-hours, if the team is more junior, the on-call physician is happy to offer advice and support.

Core trainees: Trainees advised they always know who to contact for senior support and that they could always reach someone by telephone. Trainees appreciated the arrangement where consultants had to be contacted prior to admitting a patient to HDU and felt that this supported more open communication in other circumstances as they knew consultants were happy to be contacted. Trainees did note that covering HDU out-of-hours only could be concerning as they received no in-hours training/ supervision, so they felt they 'taught themselves'. The panel also noted that trainees were unaware of how decisions to ask them to act-up had been reached or how the department knew they were sufficiently competent to do so.

ST3+ trainees: Trainees advised that they always know who is providing their clinical supervision and can contact them. Trainees did highlight that they are unable to access cardiology advice out-of-hours and instead must route their query via the on-call medic who can then contact the NHS Greater Glasgow & Clyde on-call consultant. They felt this was a barrier to receiving prompt assistance. Trainees felt that all consultants were approachable & accessible and noted that if a referral was received then there is prompt review by a consultant or senior trainee.

Non-medical staff: Nursing staff advised they can differentiate different levels of trainee using the colour coded badge system which had been in operation in the department for around 12 months. The group did note that more junior nursing staff may not be as familiar with the different trainee levels and their associated competence but that all nursing staff at band 6 & above are fully aware. Nursing staff also advised that working closely with the trainees gives them a good sense of individual ability levels.

3.10. Feedback to trainees (R1.15, 3.13)

Trainers: Trainers highlighted that the post-take ward round in the morning is scheduled for when trainees are still on shift and they are encouraged to attend and review patients they have seen overnight with a Consultant. Trainers did note that it could be difficult to discuss all cases at the post-take ward round as trainees will have worked across multiple environments during their nightshift. There is also a morning huddle in acute medicine where complex cases are discussed, and feedback can be given. On the wards trainers and trainees work closely together and informal feedback is offered on an ongoing basis.

Foundation trainees: Trainees again noted that they are encouraged to attend the post-take ward round following a nightshift but that they are only able to receive feedback on a limited number of cases. They also noted that they receive feedback at the morning huddle in the acute medicine unit but that this can be negative and highlight things that have not gone well. Trainees all felt they would receive feedback if they requested an assessment, but informal feedback was less frequent. Ward rounds in Geriatric Medicine and Cardiology were highlighted as being particularly positive forums in which to receive feedback.

GP trainees: Trainees noted that they sometimes receive informal feedback from more senior trainees when working overnight. They also highlighted that in the stroke ward good feedback is provided. Trainees did note that they never felt feedback they received was particularly positive or negative. The panel noted that trainees could attend the post-take ward round to receive feedback, but they did not highlight this as being a priority at the end of their nightshift.

Core trainees: Trainees in Cardiology, Gastroenterology, Haematology & Diabetes/ Endocrinology all noted receiving helpful feedback during ward rounds. Trainees also felt that their CCU week offered a good opportunity to receive feedback. Trainees working in the acute medicine unit advised that they receive feedback on an ongoing basis due to close working with seniors. Trainees who had attended clinic also noted they received feedback at the end of their session. Out-of-hours trainees felt it was more difficult to receive feedback on the care they had provided to inpatients in downstream wards and often went back and reviewed patient notes as an alternative to in-person feedback.

Core trainees highlighted concerns about an approach to feedback on some post-take ward rounds (see section 3.5).

ST3+ trainees: Trainees in acute medicine highlighted again the extended supervision they received on a Thursday afternoon as a good opportunity to receive feedback. Trainees have also been encouraged to undertake the post-take ward round and were shadowed by a consultant who then provided feedback. The panel also heard that at the end of clinics patients are discussed with the consultant and feedback is provided. Trainees noted that they sometimes receive feedback on areas they could improve but this is always delivered in a constructive manner.

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

Trainers: The panel were advised that at the beginning of each block of training a trainee representative is identified for each cohort of trainees and these representatives are given a slot at the Consultant meeting where they can provide feedback or raise concerns. There is also a trainee forum and a Chief Resident has recently been appointed. Trainers also advised that they ask trainees for feedback during their educational supervision meetings.

Foundation trainees: Trainees generally did not offer feedback. Some trainees had an awareness of representatives attending the Consultant meeting and some were aware of who the Chief Resident was. Trainees also noted there had been one meeting of a trainee forum which they welcomed.

GP trainees: Trainees were unaware of any opportunities to provide feedback on their experience.

Core trainees: Although the group were unaware of any formal mechanism to share feedback regarding their experience they noted that informally consultants seemed keen to hear their opinions and often asked how they were finding their post.

ST3+ trainees: Trainees felt that this would be largely provided through their responses to surveys but did note that they are sometimes asked for feedback on teaching sessions or their general experience.

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

Trainers: Trainers advised the panel that the senior tier of the rota had been altered in previous years following feedback from trainees. This rota now includes a week in CCU for all trainees on the senior rota which is purely educational. A Consultant is available on-site until 9pm and additional cover has been put in place at weekends to ensure trainees are supported. There is also a buddying system in place to ensure trainees have more senior support.

Trainers noted that at present the rota is fully staffed and should be more stable for trainees. They did, however, acknowledge that at the time of the last GMC survey there were gaps in the rota and significant sickness absence which compromised trainee experience. Trainers were aware that with trainee plans to go out-of-programme later in the training year the rota may face pressure again and were trying to make plans to mitigate the impact on trainees in post at that time.

Foundation trainees: On the whole trainees did not raise concerns regarding their rota or workload in-hours. The exception to this was in relation to the Gastroenterology ward (ward 27) and the Haematology/ Rheumatology ward (ward18) where trainees felt that it was unpredictable who would be around each day and they sometimes had to see 30 patients on their own.

Out-of-hours all trainees expressed concern regarding workload. FY1 trainees were particularly concerned at being in the acute medicine unit alone (as other trainees were in HDU or the emergency department) and felt they were required to work beyond their competence at times. All trainees felt that an additional person at weekends to share the workload would alleviate this. Trainees also felt that an additional FY2 trainee was required on the nightshift.

GP trainees: Trainees were happy with their rota and noted they are not expected to undertake too many on-call shifts. Trainees did highlight that only having one night off following

a nightshift does concern them as they feel exhausted. Again, trainees noted that they do not generally attend the post-take ward round following a nightshift as they are finishing tasks and are exhausted. Trainees did note that workload overnight is particularly busy with only 3 trainees covering the department.

Core trainees: Trainees were all happy with their rota in-hours and although they are busy during the day they felt their workload was manageable at the present time. Trainees noted that they were happy with the number of out-of-hours shifts they were scheduled to work but felt that the workload during these shifts was too busy.

Trainees noted that out-of-hours they were concerned by the configuration of the trainees working as they were split over A&E, HDU and the acute medicine unit. Core trainees advised that this often left a foundation trainee working alone in the acute medicine unit for several hours and they were aware the foundation trainees found this unsettling. Support is available by telephone, but the core trainees were unable to attend in person to assist the FY1 as the working areas are geographically distant in the hospital. Trainees advised they would prefer GP referrals to come to the acute medicine unit so that trainees could be collocated out-of-hours.

ST3+ trainees: The group were generally satisfied with their rota. The noted that they are not required to work many weekends but do cover a significant amount of on-call work which is largely focused on service provision. Trainees felt that the arrangement of them being third on whilst more junior trainees were first on was not the best use of their skills. There were no patient safety concerns noted by trainees in regard to the rota as they felt that the department was good at obtaining locum cover to ensure adequate staffing levels.

Non-medical staff: The group felt that the rota generally worked well and allowed reasonable breaks between trainees' on-call commitments. The group did note that things were working well presently due to having a fully staffed rota.

3.13. Handover (R1.14)

Trainers: not discussed

Foundation trainees: All trainees noted that the 9pm handover at night is good and works well. They noted that a handover at 4.45pm is being trialled but this is not yet working well and had limited attendance. Trainees praised the morning handover in the acute medicine unit where they were confident that patient information was shared, and they could highlight any concerns. In the other wards trainees described a mixed experience of handover with some concern that handover from the night team was via nursing staff and then to doctors (as rostering of overnight ANPs and daytime medical staff did not overlap). Trainees did not feel information about patients who had been unwell during the night was always shared and that this resulted in patients not being prioritised for review. Endocrinology/ Diabetes, Geriatric Medicine & Cardiology were all highlighted as positive examples of handover where a board round took place every morning. Gastroenterology and Haematology/ Rheumatology were noted as areas where no morning handover/ board round took place.

GP Trainees: The group commended the 9pm handover to the Hospital at Night team as working well and being comprehensive. Trainees perceived there to be no morning handover as the hospital at night team handover to nursing staff and information is not always then shared with doctors. Trainees noted there is a weekend handover in the acute medicine unit. The group also noted poor attendance at the 4.45pm handover. They felt this has the potential to be an educational experience but noted that, at present, this opportunity is not realised.

Core trainees: Trainees praised the day to night handover at 9pm where the whole team attended; this was structured, documented and effective. They felt this provided them with the information they needed when working overnight. The 4.45pm handover was noted as being poorly attended and often involved passing on jobs with little clinical context. Trainees also felt that holding this in the GP assessment unit was not ideal and it would be better to have a dedicated room somewhere less busy. In the morning trainees felt that the handover in the acute medicine unit was comprehensive and allowed clear highlighting of sick patients. The group perceived there to be no effective morning handover in downstream wards.

ST3+ trainees: Trainees highlighted the handover in the acute medicine unit as being comprehensive and structured. They noted that this handover covers patients across the receiving unit and HDU and is effective at highlighting issues with sick patients. In downstream

wards trainees noted that information on patients and boarders should be shared with them at a board round but they did not perceive this was happening routinely. Trainees also highlighted the handover at 4.45pm which they advised had variable attendance at present. Trainees would like to see the 4.45pm handover improved and they noted awareness that the chief resident is undertaking a quality improvement project on handover generally across the department. Trainees were aware of the 9pm handover.

Non-medical staff: The group articulated a range of handover meetings in the morning, afternoon and evening and before and after weekends. They acknowledged the issues mentioned by trainees with the attendance at the 4.45pm handover. The group also noted awareness of the potential tension between trainees and the hospital at night team during the night time handover. The panel were advised that an audit was underway in regard to this issue to look at the kind of jobs being passed over in order to determine when these would be best done & by whom. The group felt that handovers were an educational opportunity.

3.14. Educational Resources (R1.19)

Trainers: not discussed

Foundation, GP and ST3+ Trainees: Trainees reported no concerns regarding the educational resources available to them.

Core trainees: not discussed

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

Trainers: not discussed

Trainees: We heard from more than one cohort, that the department was perceived to be very supportive of doctors in less than full time training and on their return to work after prolonged absences.

Foundation trainees: Trainees expressed some concerns in regard to support. Trainees highlighted a previous example when their perceived need for an additional FY1 trainee in the acute medicine unit was addressed by offering anxiety management training. Trainees also highlighted a recent traumatic event for a trainee not in attendance where they understood Consultants had advised the trainee to take time off following the incident, but the trainee was then discouraged from doing so by managers.

GP trainees: Trainees advised they had no cause to have sought support and would be unsure how to go about it if they did.

Core trainees: The group all felt well supported and able to meet their supervisor to discuss issues they might have. The trainees were also aware of a recent incident involving a foundation trainee in a traumatic scenario; they perceived this was handled well and counselling for the individual made available.

ST3+ trainees: Trainees advised they had not had cause to seek additional support and would be unsure how to go about it, but all would be happy to speak to their supervisor in the first instance for advice. Trainees noted that the department was supportive of less than full time working.

Non-medical staff: When asked how a concern about a trainee in regard to their ability to provide safe patient care would be handled the group noted it would depend slightly on how it was raised and who by but, in general, they would refer the matter to the educational supervisor. It was also noted that if there was a situation where there was an immediate danger to a patient staff would step in and prevent this. The group all noted a willingness in the department to be supportive of trainees and use processes such as return to work interviews to discuss such matters. The group also mentioned that all in the department have an open-door policy where trainees are welcome to come and seek help or advice at any time.

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 advised that there is an educational governance group covering the sites in the Clyde sector. At this meeting there are representatives from various departments, the

hospital at night team, and the postgraduate administrator and each trainee cohort is discussed in turn. The group is generally positive, and trainers were confident it had the right people sitting on it to identify issues and take appropriate action. The chair of the group shares discussions and concerns with the NHS Greater Glasgow & Clyde Director of Medical Education.

Foundation trainees: Trainees were unaware of local arrangements for managing the quality of education and training. Trainees did note their perception, however, that many problems were known about by staff at all levels, but they saw no evidence that any action was being taken to address these concerns.

GP trainees: Trainees were unable to articulate awareness of any local committees or how the quality of education and training was managed locally. Trainees perceived there was little importance attached to whether they were adequately trained or not.

Core trainees: Trainees were aware of the role of the Chief Resident and felt that this individual may act as conduit to raise any issues relating to the quality of education. Other than that, they were unaware of any committees or structures to manage the quality of education and training at the site.

ST3+ trainees: Trainees were largely unaware of how the quality of education and training was managed locally. They noted awareness of one trainee forum meeting which had taken place to date but were unsure if there would be more of these. They also praised the local postgraduate administrator and were unsure if he had a role in this regard. Trainees advised that if they wished to raise anything regarding the quality of their training they would contact the deanery.

3.17 Raising concerns (R1.1, 2.7)

Trainers: Trainers advised that trainees are told how to raise patient safety concerns during their induction and at the morning handover in the acute medicine unit the team are specifically asked if they have any concerns. If any patient safety concerns are noted they are acted upon

immediately. Trainees are also encouraged to use the Datix system to report concerns or adverse incidents.

Foundation trainees: During the day trainees feel able to raise concerns with senior staff on their ward and have confidence issues will be addressed. There was less confidence about concerns being taken seriously if they happened out-of-hours, such as a patient having an extended wait time to be clerked in.

GP trainees: Trainees in certain wards noted they would be happy to raise any concerns with senior staff and were confident issues would be acted upon. Other trainees were less certain that their concerns would result in action being taken. Trainees noted that if they had concerns regarding their education and training they would be more inclined to discuss them with their GP educational supervisor as they have a more established relationship with that person.

Core trainees: Trainees felt that the handover in the acute medicine unit in the morning provided a good forum to raise concerns regarding patients. Trainees who had raised concerns advised that they were followed up by a consultant, although the trainee did not then receive feedback on the outcome. There was awareness of Datix and at least one example of a case being submitted and then closed off quickly which trainees perceived to be positive and responsive.

ST3+ trainees: Trainees all advised that they would be happy to raise any concerns with a consultant in the unit who they felt would all be responsive. Trainees also felt that the morning handover in the acute medicine unit was an appropriate forum to raise any concerns regarding patients. Trainees also noted that ward managers were very supportive.

Non-medical staff: The group highlighted a number of ways in which staff could raise patient safety concerns. These included using Datix, raising at any forums or meetings or by direct report to someone like a service manager or raising the issue at the weekly board round. The group were confident that any such concerns would be taken seriously and acted upon.

3.18 Patient safety (R1.2)

Trainers: Trainers acknowledged that they often have a high number of boarded patients which can make providing care more challenging. Trainers felt there was a better mechanism for managing boarders than had previously been in place and there are plans to have a dedicated service doctor covering the boarders. At the time of the visit trainers also advised that the acute receiving unit was being used as a ward due to the department being at 115% capacity and that this could impact on trainee experience.

Foundation trainees: Concerns were expressed about the performance of a senior locum and action has been taken – see section 3.5.

Trainees did not feel boarded patients received the same standard of care as patients in their ward, but they did feel all patients would be seen in a day and were confident boarded patients were tracked appropriately to ensure there was awareness of them.

GP trainees: Like the foundation trainees, GP trainees did not feel that boarded patients received the same standard of care as patients on their wards, largely due to waiting longer for review and prescriptions. Trainees felt that, overall, boarded patients were adequately tracked and they had confidence nursing staff would contact them if there were concerns regarding a boarded patient who required review.

Core trainees: In the context of the concerns raised by doctors in training in section 3.5 (that have been acted upon by the management team) the doctors in training raised additional concerns about the implications for role modelling of the individual in this training environment.

As with other groups of trainees, core trainees did not feel that boarded patients received the same standard of care as those on their ward. Trainees felt that if they hard a large number of patients on the ward and then a number of boarders across various other wards it could make reviewing them all challenging. Trainees also noted that they do not receive the boarders list directly as it is sent to consultants. It was felt that this could lead to a scenario where trainees thought they had no boarded patients as the list was not passed on. Trainees were aware of a

specialty doctor who was meant to cover boarded patients but highlighted they were unsure if/ when this person would be working.

Trainees also highlighted that they are asked to make decisions regarding which patients to board when working overnight. Trainees were uncomfortable with this as they reported there was no agreed criteria for boarding patients and that this could lead to them making decisions beyond their competence. All trainees advised they would feel some level of discomfort if a friend or relative was admitted to the department.

ST3+ trainees: The group advised the panel that they would be happy for a friend or relative to be treated in the department. Like other trainee groups, ST3+ trainees did not feel that boarded patients were likely to receive the same standard of care as patients on their ward. They highlighted that their concerns predominantly related to the additional workload when they are already busy with ward rounds and clinics. Trainees were aware of there being intermittent cover for boarded patients but noted they were unsure when this would be in place. Trainees also highlighted a sense that priority was given to newly admitted patients which made it challenging for them to move boarded patients back to the base ward when they had concerns about their condition.

Non-medical staff: The group had no concerns regarding patient safety and praised the open culture in the department which encourages talking about adverse incidents and learning from them. The group noted that in regard to boarded patients there was criteria to follow and key questions to answer when deciding if a patient was suitable to be boarded. The group had no concerns regarding patient safety in regard to boarding but understood the frustrations from medical staff in regard to workload and the potential impact on quality of care.

3.19 Adverse incidents (R1.3)

Trainers: Trainers noted that if a trainee was involved in an adverse incident they would always provide feedback. If this feedback was negative they would meet the trainee in person and if it was positive they may share it by email. Where there is generalised learning from adverse incidents or Datix cases this will be shared with the whole team.

Foundation trainees: All trainees knew they could report adverse incidents through Datix but none of them had used the system and they advised they would be likely to ask a nurse to log something for them. Trainees were not confident there would be feedback or learning from Datix cases, but they were aware of an email which was circulated with learning points. Some trainees had been able to attend morbidity & mortality meetings and they highlighted that Datix cases were reviewed at these meetings in the Respiratory & Endocrinology/ Diabetes wards. Trainees also highlighted Thursday lunchtime teaching in the acute medicine unit where critical incidents were sometimes reviewed to learn from them.

GP trainees: The group all had awareness of Datix and one trainee had submitted a Datix report but had not, to date, received any feedback following submission. Trainees also noted they would be happy to report an adverse event to the relevant Consultant. Trainees were not aware of any learning from other Datix cases.

Core trainees: not discussed.

ST3+ trainees: If an adverse incident occurred trainees advised they would report it through Datix and discuss it with the ward manager and consultant. None of the group had submitted any Datix cases but they did note they occasionally received learning points from other cases at the morning handover or at the morbidity & mortality meeting.

Non-medical staff: The group all noted that incidents would be reported through Datix and that the submitter of the Datix would receive feedback. Where the submitter would like face-to-face feedback, they are asked to include this request in their submission. The group noted there was also general learning from Datix cases which was shared as learning points for the whole team.

3.20 Duty of candour (R1.4)

Trainers: Trainers noted that they have a local duty of candour meeting. If a trainee was involved in an incident where something went wrong, they would meet with them and discuss the matter. Trainers offered an example of a recent incident involving a trainee who found the incident to be upsetting, they outlined a full package of support which had been put in place to

support the trainee. Although there is no formal process to follow trainers were confident that trainees would find someone to speak to if there was an issue. Trainers also felt that nursing staff would alert them to any such concerns in order that they could offer support.

Foundation trainees: Trainees generally lacked awareness regarding duty of candour and what it was. They felt they would be supported if something went wrong but also felt it could be dependent on the circumstances and the Consultant involved.

GP trainees: Trainees all noted they had never had an incident where something had gone wrong, but they were all confident that in such circumstances they would be supported and felt all senior staff would be approachable in such circumstances.

Core trainees: not discussed.

ST3+ trainees: Trainees advised they would feel well supported if they were involved in an incident where something went wrong and would have no hesitation in speaking to any of their trainers. The panel heard that trainees felt they would be supported by their consultant and the complaints manager. Trainees also advised that in the acute medicine teaching trainees are invited to give presentations on duty of candour issues/ events.

3.21 Culture & undermining (R3.3)

Trainers: not discussed.

Foundation trainees: Overall trainees noted that the trainers and more senior trainees in the department were all supportive and approachable. The issue referred to in 3.5 included allegations of undermining. As indicated – prompt action has since been taken

Trainees also highlighted some concerns regarding negative interactions with nursing staff on the hospital at night team when they had to handover multiple jobs which they had not been able to complete because of pressure of work during their 5-9pm shift. Trainees noted that they felt pressured to stay beyond their rostered hours as a result of this interaction in order to complete more jobs.

GP trainees: Trainees noted the issue highlighted by foundation trainees at the 9pm handover and confirmed they had witnessed some difficult interactions at this meeting. They felt this was due to the volume of jobs being passed on to the night team but perceived this was often unavoidable for the foundation trainee on the backshift due to the volume of work.

Trainees described the relationship between senior nursing staff in accident and emergency and the on-call registrar as 'very strained at times'. They noted that trainees did not like going to accident and emergency as they felt they would be spoken to disrespectfully and pressured to make decisions regarding moving patients prior to having all available information (such as blood test results).

Trainees also noted that when the post-take ward round was led be a certain consultant feedback was perceived to be unduly critical.

Core trainees: Core trainees reported largely the same points as those highlighted by GP trainees. The group noted that Consultants in accident & emergency are supportive but that relationships with senior nursing staff are perceived to be strained.

ST3+ trainees: Trainees had no concerns in regard to bullying or undermining behaviours and felt that the medical teams worked well together. If they witnessed anything that did concern them they would speak to the trainee's supervisor (if a trainee was showing negative behaviours) or their own supervisor or Clinical Director (if the negative behaviour was from a consultant).

Non-medical staff: All members of the group felt that a positive team culture was created in the department by senior people leading by example. They emphasised the need for all members of the team to be polite and respectful to each other and to create an atmosphere of approachability in order that any concerns can be raised and resolved. The group felt there was a zero-tolerance policy within the department of negative behaviours and they all confirmed that if they witnessed such behaviour they would challenge it. The group noted that although policies such as Dignity at Work were available on the intranet they were unsure how aware trainees were of such policies.

Regarding the issues between foundation trainees and the hospital at night team, the group reported that they had listened to the Foundation trainees' concerns had committed to address these. The panel was told of plans to include the Chief Resident in upcoming meetings on this matter to ensure more junior trainees felt supported.

4. Summary

The panel appreciated the engagement from the department in regard to this visit. The panel recognised that this is a busy department which offers a good range of experience for trainees. The following were noted:

Positive aspects of the visit:

- Trainees are exposed to good range of acute general medicine
- Consultants are approachable, supportive and accessible
- Handover at 9pm is consistent, robust & effective
- Handover in acute receiving in the morning promotes raising of concerns regarding safety of patients and processes (although it is less clear what happens as a result of raising these concerns)
- There is access to a good range of formal local teaching opportunities and also good access to regional teaching
- There is good promotion and support for QI projects in acute medicine
- Acute physicians' provision of extended shadowing of trainees - for a few hours provides direct supervision & opportunities for WBPA
- A number of departments provide excellent opportunities to learn, including Cardiology, Respiratory, Endocrinology & Diabetes, and Care of the Elderly

Less positive aspects of the visit:

- Induction to hospital & some departments (e.g. gastroenterology) is inconsistent & sometimes absent
- Handovers - there is a lack of robust handover for all downstream wards. This results in a feeling of 'Chinese whispers' as the ANPs overnight finish before doctors begin their shift. The 4.45pm handover lacks structure, has inconsistent engagement and is not felt to be effective at the moment.
- The significant concerns around the performance of a senior locum that were raised by the doctors in training were addressed promptly by the management team after the visit.
- Safety of AMU OOH currently with on-site FY1 who, in practice, does not have access to direct supervision for the intensity and acuity of the workload (because more senior colleagues are fully engaged elsewhere)
- There were reports of difficult 'interactions' between senior nurses in another department and the medical receiving team
- There were reports of limited opportunity to attend the post receiving ward round for feedback because trainees are fully engaged in managing the tail end of the nightshift workload.
- The feedback style of one Consultant (as per 3.5) on post-receiving ward rounds is perceived to be 'challenging'.
- Overnight the involvement of doctors in training in selecting patients for boarding added to their workload. There was lack of awareness as to whether there was a policy with agreed criteria in place to support the identification of patients who could board.

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

5. Areas of Good Practice

Ref	Item	Action
5.1	Extended period of supervision specifically for Acute Medicine trainees on Thursday afternoons offer excellent opportunities for feedback and completion of assessments.	

6. Areas for Improvement

Ref	Item	Action
6.1	Decisions around identification of patients who are potentially suitable to board should be made by clinical teams looking after patients and not by doctors in training working overnight, who are unfamiliar with the patients and who are making decisions without access to a policy that defines suitability for boarding.	Boarding criteria reviewed relaxed and recirculated following discussion at MAC. Boarding felt to be an undesirable practice, but undue stress on team lead out of hours by deferring decisions in-hours acknowledged and we will try to prevent this happening.
6.2	The hospital should have a policy for central line insertion out of hours to ensure that patients who need this should have access, when the doctors in training leading acute medical receiving have not attained this competence.	Training opportunities for practical procedures, in particular a dedicated central line insertion course, are circulated by Directorate of Medical Education – Clyde Office and acute team consultants via email. There has been mixed uptake for this.

7. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
7.1	There must be induction of all doctors in training to the hospital and to the department/s they will work covering all roles and responsibilities.	26th August 2019	ALL
7.2	The 4.45pm handover must become more structured and organised, with engagement of all relevant individuals.	26th August 2019	ALL
7.3	Ward handovers in the morning must be formalised and happen consistently in all ward areas to ensure safe handover and continuity of care following nightshift.	26th August 2019	ALL
7.4	Foundation Trainees in the acute medicine unit out-of-hours must have access to senior supervision and support.	26th August 2019	FY
7.5	Work must be undertaken to ensure that trainees are supported to attend clinics and other scheduled learning opportunities without compromise because of service needs.	26th August 2019	GPST, CMT
7.6	Trainees must be able to attend the post receiving ward round in the acute medicine unit and when they do, the feedback they receive must be delivered in a constructive manner.	26th August 2019	ALL
7.7	At the nighttime handover the interactions between the hospital at night team and foundation doctors must be respectful and professional (it is our understanding this is being addressed). Also the alleged recurring negative interactions between senior nursing staff and the medical receiving team must be addressed.	26th August 2019	FY, GPST, CMT

7.8	In response to a requirement to address the allegations of significant concerns around the performance of a senior locum that were raised by the doctors in training the management team took decisive action to address this concern.	Immediately	ALL