Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	26th February 2019	**Level(s)**	FY, Core & ST
Type of visit	Scheduled	**Hospital**	Royal Infirmary of Edinburgh
Specialty(s)	Anaesthetics	**Board**	NHS Lothian

Visit panel	
Dr Ronald MacVicar	Visit Lead, Emergency Medicine & Anaesthetics Lead Dean Director & Postgraduate Dean (North Region)
Dr Mo Al-Haddad	Associate Postgraduate Dean (Quality)
Dr Alistair McDiarmid	Training Programme Director, Anaesthetics, North Region
Dr David Miller	Trainee Associate
Ms Helen Raftopolous	Lay Representative
Miss Kelly More	Quality Improvement Manager
In attendance	
Ms Lorna McDermott	Quality Improvement Administrator

Specialty Group Information		
Specialty Group	Emergency Medicine, Anaesthetics & Intensive Care Medicine	
Lead Dean/Director	Professor Ronald MacVicar	
Quality Lead	Dr Mo Al-Haddad	
Quality Improvement Manager(s)	Miss Kelly More	
Unit/Site Information		
Non-medical staff in attendance	2 pain management nurses, clinical services manager, assistant service manager and anaesthetics secretary	
Trainers in attendance	13 including the college tutors and core TPD	
Trainees in attendance	17 trainees ranging from FY1 to ST7	
Feedback session: Managers in attendance	The associate director of medical education for RIE	

Date report approved by Lead Visitor	04/03/19

1. Principal issues arising from pre-visit review

The Deanery's scheduled visit programme aims to visit each unit/location delivering training once every five years. Accordingly, a scheduled visit is being arranged to the Anaesthetics department at the Royal Infirmary of Edinburgh. The visit team will take the opportunity to gain a broad picture of how training is carried out within the department and to identify any areas of innovation or good practice for sharing more widely. The visit provides an opportunity for trainees and staff within the unit/department to tell the Deanery what is working well in relation to training; and also to highlight any challenges or issues, the resolution of which could be supported by the Deanery.

At a previous visit in January 2015 the Visit Party recognised the supportive training environment that the Anaesthesia Training Programmes at Royal infirmary provide, and that feedback across the trainee cohort was very positive. Clinical and Educational Supervision was reported as being very good and it was also noted that trainees reported a very supportive culture from the Consultant cohort. Trainees were confident that they would be able to achieve the Educational Objectives and competences commensurate with their level of training. No Patient Safety or Undermining concerns were raised during the Visit.

The Deanery were encouraged to learn that trainers had recognised time within their Job Plans for educational Activities and that the Clinical Director also confirmed that any new trainers seeking time within their Job Plans would have such requests actioned.

At the pre-visit teleconference the panel decided that the areas of focus for the visit were workload, rota issues, the deterioration in NTS results for regional teaching and to investigate any possible undermining issues.

2. Introduction

The Royal Infirmary of Edinburgh is a relatively new building and opened in 2003. The hospital is a major acute teaching hospital and provides services for patients from across Lothian and the south-east of Scotland.

The visit team met with specialty trainees as well as trainers.

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.

3.1 Induction (R1.13)

Trainers: The induction has recently been updated to include lectures on a Thursday after starting on a Wednesday. A new trainee joins the department most months and all are given tailored inductions.

All trainees: Trainees rotate frequently to different hospitals but do not always need a full induction each time. If any trainee has been unable to attend the standard hospital or departmental induction they have met with the college tutor to run through any changes since they had worked there previously. Generally this works well, the only issue is occasionally when returning from a rotation it can take a few days to get all the necessary IT passwords and swipe card access.

Core trainees: They attended corporate and departmental inductions which were very structured. They had a tour of the hospital and department. They attended induction lectures and got their ID badges.

Non-medical staff: Staff from pain management deliver sessions.

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

Trainers: New trainees are given part A exam teaching every week. Acute Common Care Stem trainees have a specialised teaching programme. Part B exam teaching takes place on a Wednesday. Part C exam teaching based around viva and written exam practice runs 3 times a year, 6 weeks before the exam diet. There is also departmental teaching on a Friday afternoon from 1300-1400 where cases are presented and discussed. At 1400 is either the monthly morbidity and mortality (M&M) meeting or a presentation on quality improvement (QI) research.

There is a post-fellowship educational group and regional training days where various topics are presented.

Study leave is used for the exam teaching and trainees are able to attend unless they are rostered to be on an emergency list.

All Trainees: Trainees preparing for the primary exam attend regional teaching in one of the hospitals. They apply for study leave to attend this. Travel time is included. Trainees preparing for the final exam have mock viva and written exam practice on a weekly basis. They apply for study leave to attend this. Trainees who have passed the exams attend a post-fellowship group which they run around five times a year. They arrange for consultants to come and present topics to them. They also need to apply for study leave to attend.

Trainees who are not preparing for the exams do not have as much formal teaching although they attend M&M meetings on a Friday.

Non-medical staff: They are not involved in formal teaching but do deliver on the job teaching. They are aware of when the trainees have to attend teaching and ensure that they are released to attend.

3.3 Study Leave (R3.12)

Trainers: Requests for study leave are submitted and the rota is built around those. No requests have been turned down.

All Trainees: If applications are submitted on time there are no issues with leave being approved. If a course is popular it can be tricky to get a place on it as the study leave is not confirmed until the rota is issued which can sometimes be only a few weeks before a course is due to take place.

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

Trainers: The training committee allocates trainees to supervisors. All staff have been trained to carry out their roles. Regarding job planning the time allocated follows the recommendation of around 0.25 programmed activities per trainee per week.

All Trainees: They have all met with their educational supervisor particularly around the annual review of competency progression (ARCP) time.

Non-medical staff: Trainees are aware of the chain of command and who to contact when they need to.

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

Trainers: Clinical supervisors in each specialty block ensure that the trainees get the experience they need to be signed off. The department tries to roster trainees with similar consultants when they start so that they can get to know each other.

Trainees are allocated to a specialty block; the aim is to protect daytime work in that specialty as much as possible to ensure maximum learning opportunities. Trainees can take ownership of solo lists if they ask.

All Trainees: The experience is generally good although it can be difficult to obtain intermediate trauma experience. The college tutor is aware of this and investigating solutions. Trainees are matched with lists according to their specialty block although there is some time for service provision included in this such as on call work and emergency lists.

Senior trainees are very closely supervised and some feel that more experience of indirect supervision would be beneficial.

The trainees rotate frequently which can mean that there is an adaptation period each time they move as it takes time to get to know people.

Non-medical staff: They deliver on the job teaching and try to teach them during ward rounds and handovers.

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

Trainers: Trainers are aware of what assessments need to be completed as the curricula are on the college website.

All Trainees: There are no issues in getting assessments signed off.

Non-medical staff: They complete multi source feedback forms for trainees.

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

Trainers: As well as the M&M meetings there is airway management training which is attended by theatre staff, nursing staff and trainees.

Non-medical staff: Staff attend monthly M&M meetings as well as airway management training which is scenario based. There are also departmental wide sessions with external speakers.

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

Trainers: There is a national award-winning trainee led QI group in NHS Lothian called Squares. They work on a region-wide basis so if a trainee starts an audit in one hospital they can keep it going when they rotate to another hospital. There are QI fellows in the department who provide guidance and leadership.

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: Trainees can bleep the senior anaesthetist if they need to contact someone. The department is very busy and patients can arrive in high numbers but trainees are not unsupervised.

There is a resident consultant in the building who is the first point of call. Consultant obstetric, cardiac and general anesthetists are on call from home.

All trainees: Each rotation has its own clinical supervisor. Trainees have not felt that they have had to cope with any problems beyond their experience.

Non-medical staff: Staff are aware of trainees' level of experience as they wear different coloured badges depending on what stage of training they are at. There is also a board in the department that shows the name, photo, grade and educational supervisor for each trainee. This board is updated each time someone new joins the department.

Trainees are supported if something goes wrong. It can be very busy overnight but there are escalation policies in place to be used in these situations.

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

Trainers: Learning opportunities are ideally established at the start of the day and immediate feedback on these outcomes provided at the end of the day. Consultants also feedback to each other and this is then fed back to the trainee. When working in obstetrics if things have gone well or not well this is fed back to the trainee.

All Trainees: Discreet feedback is provided at the end of each block. Trainees feel that the provision of feedback could be better from both sides.

Core Trainees: They receive regular feedback which is mainly constructive. They think this may be because their training is so structured.

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

Trainers: A recent departmental trainee survey had a good response rate and the comments were positive. There is a feedback afternoon held once a year. This takes a workshop format. The next one is scheduled for May 2019. There is also a training committee.

All Trainees: The department ask the trainees at the end of their rotation. A trainee is sometimes asked out with this time. There is a trainee representative on the training committee.

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

Trainers: The rota is live on an electronic app and is issued for 10 weeks around 4-6 weeks in advance.

When working in obstetrics the trainees are encouraged to call for help. The charge midwife is also aware of the escalation policy. The consultants are aware of capacity issues when working in pre-operative assessment and these have been fed back to NHS Lothian management.

All Trainees: The workload is generally manageable. A reported pressure point is pre-assessment for morning admissions as patients can be in different wards/areas which can make seeing them all in the allotted time very tricky, availability of rooms to assess patients is limited and there is difficulty accessing the patient notes on the PCs in the area where the patients are waiting to be seen. Trainees perceived the workload in obstetrics to be very high and they described cover in the building as ‘thin’ overnight. Trainees understanding was that the 2nd on call is not in the building overnight. There was some reported confusion around when someone will come in to help when it is busy.

Non-medical staff: There is a lot of work done to look after trainees. It can be short staffed at times in obstetrics.

3.13. Handover (R1.14)

Trainers: There are handovers in pain, obstetrics and cardiac wards for 30 minutes and they feel that the handovers are effective.

All Trainees: There are handovers in pain, obstetrics and cardiac wards for 30 minutes. There are also ward rounds in cardiac and pain.

Non-medical staff: Trainees attend the handover that takes place in the pain team. At this handover cases are discussed and feedback given.

3.14. Educational Resources (R1.19)

Trainers: They are able to access patient notes from home. They recognise that IT access in the pre-assessment area is not adequate. There are mobile computers in and around theatres that are newer and faster. The department also has computers and a trainee room.

All Trainees: The computers are very slow, the Wi-Fi is poor as is the phone signal. This can lead to some difficulty carrying out essential work such as assessments and logging in when working in pre-assessment can take up to 10 minutes. As the organisation is trying to go paper light, patent notes and charts are online but are not always categorised properly which can lead to valuable time being wasted trying to find and access the notes.

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

Trainers: If there were concerns about a trainee these would be raised with the college tutor or training programme director (TPD). Any issues would recorded using a paper trail and the deanery notified where applicable.

There is a welfare mentoring programme which includes an ‘anaesthetic family’ where a buddy is allocated for the duration of a trainees’ training. There is also a return to work/ keep in touch course available for anyone who has been away for more than 3 months.

All Trainees: Some of the trainees are less than full time. The arrangements are generally good but it can be difficult to access teaching if it in consistently on an ‘off-day’.

Non-medical staff: If anyone was concerned about a trainee they would escalate this to the trainee’s educational supervisor or speak to the supervising consultant.

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: Staff are aware of the director of medical education structure. Trainee survey results are discussed with them.

All Trainees: The college tutors are responsible.

3.17 Raising concerns (R1.1, 2.7)

Trainers: Trainees are encouraged to raise any concerns they might have with any of the consultants.

Non-medical staff: All staff know who to contact should they have a concern that they wish to raise.

3.18 Patient safety (R1.2)

Trainers: The environment is safe. There is a daily safety briefing in obstetrics.

All Trainees: None of the trainees would be concerned if a friend or relative was being treated in the department.

Non-medical staff: The department is very safe for patients as it is well supervised.

3.19 Adverse incidents (R1.3)

Trainers: These are recorded on Datix and discussed at the M&M meetings. Minutes of these meetings are circulated. There are reviews of serious adverse events. Incidents are also discussed at the monthly trauma governance meetings.

All Trainees: Incidents are recorded on Datix. If a serious adverse event review takes place, feedback is given to those involved. One trainee reported that they had been involved in an incident but felt isolated and unsupported.

Non-medical staff: Incidents are reported using the Datix system and can be submitted by anyone. Feedback is provided. A consultant led debrief takes place after a major incident.

3.20 Duty of candour (R1.4)

Trainers: They lead by example and are all aware of duty of candour. They work closely with trainees when they are dealing with patients.

3.21 Culture & undermining (R3.3)

Trainers: Trainees are encouraged to raise any concerns they might have and made aware that there is always an alternative contact to raise anything with.

All Trainees: Trainees had experienced incidents in the past of undermining language being used but this was described as historic. There can be a lack of personal touch as the department is so large.

Non-medical staff: It is a large department but staff try to be as friendly as they can and encourage interaction. The consultants are supportive. There are board wide policies in place should anyone wish to raise any concerns about bullying or undermining behaviours.

3.22 Other

All Trainees: The foundation trainee had not longed joined the department but was happy and was enjoying the job so far.

4. Summary

Is a revisit required?	**Yes**	**No**	**Highly Likely**	**Highly unlikely –** we will monitor survey results & free text comments to assess whether or not a revisit is necessary

There were 2 potential patient safety issues that we wish to note:

- The morning admission arrangements hinder adequate pre-op assessment as patients can be distributed in different areas in the hospital, there are inadequate interview/ examination rooms, and there is difficulty accessing the patient notes on the PCs in the area where the patients are waiting to be seen.
- Out of hours staffing & workload issues have resulted in at least one critical incident where a trainee, having failed to intubate a patient had difficulty accessing immediate support.

Positive aspects of the visit were:

- Very positive supportive educational ethos.
- Good induction arrangements which include trainees who have joined out with the usual rotation times.
- Supportive department with very positive examples & role modelling of critical illness management & team work.
- Very protective clinical supervision. Indeed, some trainees feel over protected, and there is potential to work with senior trainees to ensure that they have adequate opportunities to run autonomous solo lists.
- The challenges of a large department are ameliorated by key individuals' commitment.
- The formal teaching programme which is well protected and includes innovative group work sessions, post fellowship sessions and regional off- site sessions.
- There is clear quality improvement leadership in the department – there are quality fellows & leaders in the team and the trainee led quality improvement group is an exemplar of good practice.
- There are a variety of mechanisms to receive and act on feedback from trainees, for example the annual feedback afternoon.
- Welfare approach, the anaesthetic family & mentoring.
- The return to work/ keeping in touch course.

Less positive aspects of the visit were:

- IT issues including access to wi-fi.
- The provision of feedback could be more systematic.
- The challenge of frequently rotating trough hospitals and departments to meet curricular needs to be balanced with having a professional home base.
- Consistent mechanisms should be in place to ensure active consultant support and learning is in place after an adverse incident.

5. Areas of Good Practice

Ref	Item	Action
5.1	Supportive department with very positive examples & role modelling of critical illness management & team work.	n/a
5.2	The formal teaching programme which is well protected and includes innovative group work sessions, post fellowship sessions and regional off- site sessions	n/a
5.3	There is clear quality improvement leadership in the department – there are quality fellows & leaders in the team and the trainee led quality improvement group is an exemplar of good practice.	n/a
5.4	There are a variety of mechanisms to receive and act on feedback from trainees, for example the annual feedback afternoon.	n/a
5.5	Welfare approach, the anaesthetic family & mentoring	n/a
5.6	The return to work/ keeping in touch course	n/a

6. Areas for Improvement

Ref	Item	Action
6.1	IT issues including access to wi-fi.	
6.2	The provision of feedback could be more systematic.	
6.3	The challenge of frequently rotating trough hospitals and departments to meet curricular needs to be balanced with having a professional home base.	
6.4	Consistent mechanisms should be in place to ensure active consultant support and learning is in place after an adverse incident.	

7. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
7.1	Measures must be implemented to address the patient safety concerns associated with the accommodation for pre-op assessment patients and the IT access issues that occur when seeing the patient.	9 months from date of the visit	all
7.2	Out of hours medical staffing must be reviewed to ensure doctors in training have a reasonable and manageable workload.	9 months from date of visit	all

Action undertaken by NHS Lothian to address requirements can be found by logging in to NHS Lothian's Medical Education Directorate website. See "Action Plan" – located at the bottom of the webpage.