Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	4th February 2020	**Level(s)**	FY1/FY2/GPST/CMT/IMT/ST
Type of visit	Enhanced Monitoring Re-visit	**Hospital**	Queen Elizabeth University Hospital
Specialty(s)	General Internal Medicine	**Board**	NHS Greater Glasgow and Clyde

Visit panel	
Professor Alastair McLellan	Visit Chair - Postgraduate Dean
Robin Benstead	GMC Visits & Monitoring Manager
[Name Redacted]	Lay Representative
Dr Nick Dunn	Associate Postgraduate Dean – Quality and Assistant GP Director
Mr John Scollay	Foundation Programme Director
Dr John Anderton	College Representative
Dr Ailie Grzybek	Trainee Associate
Alex McCulloch	Quality Improvement Manager
In attendance	
Claire Rolfe	Quality Improvement Administrator

Specialty Group Information	
Specialty Group	Medicine
Lead Dean/Director	Professor Alastair McLellan
Quality Lead(s)	Dr Reem Al-Soufi Dr Stephen Glen Dr Alan McKenzie
Quality Improvement Manager(s)	Alex McCulloch and Heather Stronach
Unit/Site Information	
Non-medical staff in attendance	12

Trainers in attendance	18									
Trainees in attendance	FY1 x 25		FY2 x 5		GPST x 6		Core/IMT x 11		ST x 15	
Feedback session: Managers in attendance	Chief Executive		DME	X	ADME	X	Medical Director	X	Other	Clinical Directors of Medicine, Clinical Service Managers

Date report approved by Lead Visitor	 2nd October 2020

1. Principal issues arising from pre-visit review:

General Internal Medicine (GIM) at the Queen Elizabeth University Hospital has been under the GMC Enhanced Monitoring process since 2016. The site has been visited on several occasions over the past 5 years, as listed below:

- 27 October 2015 (new site visit)
- 13 May 2016 (triggered revisit)
- 02 December 2016 (enhanced monitoring visit)
- 21 February 2018 (enhanced monitoring revisit)
- 22 February 2019 (enhanced monitoring revisit)

At the last visit to GIM on the 22nd February 2019, the visit panel concluded there had been some improvements made to the training experience since the previous visit in 2018. Nonetheless, the following requirements were identified:

1. Measures must be implemented to address the ongoing patient safety concerns in relation to the IAU, described in this report (see also requirement 7.14 from 2018 visit)
2. A process must be put in place to ensure that any trainee who misses their hospital induction session is provided with an induction.
3. The burden of tasks for all cohorts of doctors in training that do not support educational or professional development and that compromise access to formal learning opportunities must be significantly reduced. The provision of phlebotomy must be improved.
4. The scope of the ward cover and the associated workload overnight and at weekends must be reduced as currently they are not manageable, safely. This is generally an issue – but also 8th Floor has particular issues in this regard.
5. The medical staffing of the IAU overnight must be sufficient to ensure these staff have a safe and manageable workload that enables them to provide quality care to their patients.
6. Alternatives to doctors in training must be explored and implemented to address the chronic gaps in the rota that are impacting on training.
7. Consistent and appropriate clinical supervision of middle-grade doctors in training in HDU must be provided at all times.

8. A process for providing feedback to doctors in training on their input to the management of acute cases must be established.
9. Handover of care of patients transferred from the ED to Pods must be introduced to support safe continuity of care and to ensure unwell patients are identified and prioritized.
10. Work must be undertaken to ensure that trainees are supported to attend clinics and other scheduled learning opportunities without compromise because of service needs.
11. Trainees must know how to engage in use of the Datix system and receive feedback on Datix cases.

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.

Pre-visit presentation:

The visit panel would like to thank Dr Colin Perry (Clinical Director, Medical Services South Sector) for providing a very informative and helpful presentation provided to the panel at the beginning of the visit day, which outlined progress against some of the previously highlighted issues.

- Changes to the rota have been made, (including development of a support rota, provided usually by post CCT Clinical Fellows), increasing the level of seniority attached to ward support roles, re-arranging the stack teams cover to improve the balance of distribution of work between the stack teams and acute receiving teams, development of contingency for the senior tier of rota and weekend contingency for senior/mid-tier trainees and registrar of the week.
- Changes to improve handover (including implementation of the '5 by 5 initiative' and embedding the use of weekend electronic handover).
- Changes to departmental induction handbooks (to include information on Datix reporting and the upload of some departmental induction booklets to staff net)
- Summary of support for routine tasks (secured funding for clinical support workers but have so far been unsuccessful in recruiting them).
- Development of a Quality Improvement web page by a Core Medicine Trainee.

2.1 Induction (R1.13):

Trainers: Trainers felt a comprehensive induction was being offered to trainees, which was further supported by repeat sessions for trainees that missed the initial induction days. An induction pack was sent to trainees before they started and their Educational Supervisor was included in the distribution of the induction material, in order that if they missed the initial or follow up inductions, they would be provided with appropriate supporting documentation. Trainers confirmed that work was ongoing to further improve induction, plans included a Dr Toolbox app (which consisted of relevant contact numbers and on-call lists). Trainers felt they were continually working to improve induction and were not reaching the small numbers of trainees that missed the initial induction days.

All Trainees Cohorts: Trainees reported a mainly positive experience of hospital induction. Some concerns were raised in relation to IT logins and password not being available to some of the trainees in Core Medical Training and of the rooms being too small to accommodate the large numbers of trainees present at induction. Foundation trainees would have preferred to spend more of the time allocated to induction shadowing current FY1's and suggested extending the shadowing period for future cohorts. Trainees appreciated the comprehensive induction pack they received, which contained all the relevant information required (such as confirmation of on-call arrangements and contact lists) to allow them to start working in their posts effectively. Trainees felt splitting induction by cohort of trainee would be an improvement to induction as it would make the induction more specific and less generalised.

Trainees felt departmental induction was more variable, trainees in Respiratory Medicine described a very comprehensive induction but Core/IMT and specialty trainees in Endocrinology and Diabetes, reported not receiving departmental induction. Sporadic others missed out on inductions too. Trainees felt that a ground floor Immediate Assessment Unit induction would be beneficial to them. We heard of catch up arrangements to provide inductions to those who missed inductions through on-call arrangements. Some trainees perceived there to be a need for clarity to be provided through induction to roles at night and others thought that greater clarity around roles in in IAU would be beneficial.

Nursing and Non-Medical Staff: Staff felt that induction was comprehensive and effective in preparing trainees to work both during the day and out of hours. They described developments to induction such as a Learnpro module and attendance at induction was monitored by non-medical staff.

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

Trainers: Trainers reported various different departmental teaching sessions that took place on a weekly basis, these included:

Infectious diseases - Monday lunchtime.
Endocrinology and diabetes mellitus – Monday lunchtime.
Cardiology – Tuesday at 2.00 pm, monthly morbidity and mortality meetings (M&M) and monthly echocardiogram meetings.
Gastroenterology - Friday lunchtime, followed by handover for the weekend.

Other teaching included:

- FY1 teaching on Tuesdays and Thursdays (repeated content) all interruption free.
- Wednesday lunchtime medicine sessions.
- FY2 mandatory teaching days throughout the year
- Tuesday weekly teaching in the Immediate Assessment Unit (IAU) and morning handover in IAU.
- Friday lunchtime grand rounds.

FY1 Trainees: Trainees reported a variable experience of departmental teaching and were able to attend between 0 – 3 hours of departmental teaching per week. Respiratory Medicine and Infectious Diseases teaching were highlighted as good; trainees in Rheumatology were not aware of and had not attended any departmental teaching. Trainees felt it was difficult to get to teaching and particularly the grand rounds that took place on Fridays. Trainees were unsure if they would be able to meet their curriculum requirement of around 60 hours of teaching.

FY2 Trainees: Trainees highlighted that they got to on average <1hr of local teaching per week. They advised that Friday grand rounds could often be cancelled and were not as well organised or promoted as they could be. Trainees confirmed they were able to get to their FY2 regional teaching, which was 1 day per block of training.

General Practice Trainees: Trainees had concerns around their ability to get to departmental teaching. They felt that workload on the ward was so high, it often had an impact on their ability to get to any local teaching. They estimated they got to between 0 – 1 hour of teaching per week with some averaging no more than 15min per week. Trainees confirmed they were able to get to their regional teaching programme sessions, for which they applied for study leave.

Core and Internal Medicine Trainees: Trainees estimated they got to between 0 -3 hours of teaching per week, most accessing 0-1 hr per week and they felt workload and on-call commitments made it difficult to get to any locally delivered teaching. Of the local departmental teaching that trainees were able to get to, they highlighted Respiratory Medicine teaching as good. The Core Medicine trainees had not been to any of the new Core Medicine teaching days yet, and they explained the former Core Medicine teaching programme had been replaced with national training days, which were now 3 full day events that would take place throughout the training year. Trainees were able to access the online content of the videos of teaching, which counted towards their attendance, but their preference was to attend sessions in person, in order to gain a better learning experience and network with their peers. IMT trainees present were able to attend the 3-day bootcamp training that took place in January.

Specialty Trainees: Trainees reported variable experience of local and departmental teaching, with some departments providing more opportunities than others. Trainee estimated they got to between 30 minutes – 3 hours of teaching per week. Teaching that was highlighted as good included Respiratory Medicine and Rheumatology teaching. Trainees felt that workload often affected their ability to get to teaching. Trainees estimated they were able to attend around 60-70% of the available regional General Internal Medicine teaching sessions.

Nursing and Non-Medical Staff: Staff were aware of when teaching took place and would plan cover in advance to support the trainees and allow them to attend teaching.

2.3 Study Leave (R3.12)

Trainers: Trainers advised that although workload posed challenges in releasing trainees to go on study leave, they felt trainees would be able to access study leave.

All Trainee Cohorts: All trainee cohorts were able to request and take study leave.

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

Trainers: Trainers confirmed the allocation of trainees took place once they received an accurate list of trainees from the deanery. Information circulated about trainees who have known concerns was felt to be more variable, although in recent years this had improved for Foundation trainees and Specialty trainees. Although trainers had time allocated in their job plans for their Educational roles, it could often be difficult to provide the time due to workload pressures in some departments.

All Trainee Cohorts: Trainees present had met with their Educational Supervisors and had learning plans in place. No issues were raised in relation to Educational Supervision.

Nursing and Non-Medical Staff: Staff advised that trainees could always access senior support as and when they required it.

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

Trainers: Trainers felt trainees would know who to contact for supervision both during the day and out of hours. Some issues were raised in regard to a lack of support for FY/GPST trainees in Endocrinology and Diabetes wards, which were affected by vacancies in the specialty trainee's rota. Trainers confirmed they maintained responsibility, (where possible) for the same cohort of trainees each year, this helped maintain familiarity with the various curricula and assessments. A coloured badge system was in place, supported by posters, which ensured that all staff could differentiate between what is required of doctors at different stages of training. Role cards were available for trainees on each shift and contained relevant consultant contact details. Trainers felt it would be un-common for trainees to seek consent from patients for procedures as there was significant consultant presence across departments who would do this instead.

Foundation Trainees: Trainees felt they knew who to contact for support both during the day and out of hours and described their senior colleagues as friendly and approachable. Generally, they did not feel they had to cope with problems beyond their competence or experience aalthough nightshifts were described as very busy and overnight taking the CCU referrals was perceived to be beyond their competence (but there was access to a registrar). Overnight cover of pods could be challenging as patients were transferred from ED without handover and access to senior support was variable because the registrars were busy.

General Practice Trainees: Trainees felt they now knew who to contact for support both during the day and out of hours but advised that for the first few weeks / months in the job the cover arrangements were not as clear as they could be in some departments (for example, the arrangements relating to 5th & 8th floors). Consultant cover arrangements are, however, very clear in ID and in Respiratory.

Core and Internal Medicine Trainees: Trainees described lack of clarity around the escalation procedures for support in some wards, including in a split ward of cardiology / general internal medicine patients which resulted in the trainees contacting consultants directly as they were unsure of who the specialty trainee contacts were. Shortage of middle grade staff in the Endocrinology and Diabetes wards 5A and 5B had been an issue but they had never felt they had had to cope with problems beyond their competence.

Specialty Trainees: Most trainees were aware of who to contact for supervision both during the day and out of hours, although some concerns were raised by trainees in regard to consultant cover / clinical supervision arrangements for a shared Endocrine/General Internal Medicine ward, where no cover arrangements appeared to be in place if the consultant was covering IAU or on annual leave. Trainees described their consultant colleagues as approachable.

Nursing and Non-medical staff: Staff were able to differentiate between trainees of different grades, through a coloured badge system that was supported by posters describing the trainees' levels of competence and ability.

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

Trainers: Trainers were made aware of teaching, training and supervisory requirements through maintaining responsibility for the same cohort of trainees each year. Trainers advised they relied on the ARCP (Annual Review of Competence Progression) decision aid that was distributed by the deanery to keep them up to date with the curriculum requirements. Trainers advised that ensuring trainees were able to attend enough clinics to satisfy their curriculum requirements could be very challenging (particularly with the increase in numbers of clinics required by the new IMT curriculum). Although workload was high, trainers felt there was lots of support available to trainees through the significant consultant presence and support staff (such as Clinical Support Workers and Advanced Nurse Practitioners).

FY1 and FY2 Trainees: All described a lot of the time being spent on non-educational tasks such as taking bloods and ECGs. All described workload was high, and it could be difficult for trainees to get away from the ward duties and trainees were unsure if they would be able to meet their ARCP teaching requirements that included attending 30 additional hours of formal teaching across the training year. Trainees valued the support they received from clinical support workers especially at night but felt there was a lack of them in some of the ward areas. 60% of the FY2s had been able to access a few clinics. Trainees felt that some core procedures could be difficult to get, such as airway management (which was highlighted by trainees in Respiratory Medicine). Frequent changes of ward attachments were a barrier to learning.

General Practice Trainees: Trainees felt they would be able to meet their curriculum competences through the experience they were receiving. Clinic experience was described as variable depending on what ward the trainee was working in, trainees in Respiratory Medicine highlighted a good clinic experience. Trainees also had clinics planned into their rotas in Gastroenterology but could not leave the wards often (due to workload) to attend them. Trainees estimated they spent around 40% of their time completing what they considered to be non-educational tasks such as taking bloods and ECGs. Discontinuity of ward attachment was highlighted as a further barrier to learning opportunities.

Core and Internal Medicine Trainees: Trainees highlighted clinic experience as very good in respiratory medicine but less so in geriatric medicine and cardiology where it could be difficult to get to clinics, although cardiology were making efforts to enable this. Some departments provided ‘clinic

weeks. Trainees advised also that experience of procedures such as central line insertion and cannulation could be difficult to get. Discontinuity of ward attachment is barrier to learning also for IMTs/CMTs. Trainees reported there was limited awareness of the new internal medicine curriculum requirements.

Specialty Trainees: Trainees felt the experience they got in General Internal Medicine was good with sufficient exposure to acute unselected take. Experience of some competences or procedures in some of their specialty programmes could be more difficult (Gastroenterology was highlighted). Trainees felt they were well supported by senior colleagues but felt the ground floor (IAU and ARUs) would benefit from Clinical Support Staff, which they advised currently only worked in the main wards in the stack building.

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

Trainers: Trainers were aware of what assessments trainees were required to complete, as they maintained responsibility for the same cohort of trainees each year and were familiar with their e-portfolio and associated ARCP requirements. They also received ARCP decision aids from the deanery each year, which kept them up to date with any changes to requirements.

All Trainee Cohorts: Trainees confirmed that in general they were able to complete Workplace Based Assessments and have them signed off easily. They felt they were assessed fairly and consistently.

Nursing and Non-Medical Staff: Staff contributed to trainee assessments by completing e-portfolio tickets sent to them by trainees for Multi-Source Feedback.

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

Not covered.

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

Trainers: Trainers felt there were lots of opportunities for trainees to become involved in audits and Quality Improvement projects. A newly created Quality Improvement website had been created by a trainee which was available as a resource for trainees and they had the opportunity to present their findings at showcase events. The ‘5 before 5 initiative’ was also highlighted by trainers (which was around the importance of completing 5 key tasks each day, fluid, insulin, antibiotic and warfarin prescribing, as well as ensuring escalation plans are in place for patients before providing a handover to out of hours staff. This was being led by trainees as a Quality Improvement Project.

All Trainee Cohorts: Trainees experience of audit and Quality Improvement opportunities were described as variable. Most felt they had little time available to them to undertake projects whilst working and most had to do so in their own time. The Core/IMT trainees appeared unaware of the 5 before 5 initiative.

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: Trainers felt feedback was regularly available to trainees, in IAU trainees were working on a daily basis with consultants. The consultants in Infectious Diseases would conduct ward visits daily and would provide informal feedback to trainees on the decisions and treatments they plan for patients. Trainees who were working nightshifts in IAU and ARU would discuss the patients they had had seen overnight with consultants the following morning and receive feedback on them.

FY1 Trainees: Trainees felt that feedback was variable depending on the ward and what time of day they were working, with feedback on the wards being more feasible during the day but less so at night. Trainees felt that due to the larger number of FY1 trainees being in the wards it could be difficult for consultants to seek them out to provide feedback. Attachments to be wards were for four months with 7 weeks elsewhere. The week on haematology was reported to be greatly valued.

FY2 Trainees: Trainees described feedback as informal and was mostly when actively sought (by asking consultants when they came onto the wards). There were opportunities to get feedback on consultant ward rounds. Feedback after night shifts whilst working in IAU/ARU was felt to be very

good and lots of learning was gained from observing consultant and Specialty Trainee interactions with patients.

General Practice Trainees: Trainees felt they received feedback on a regular basis both during the day and out of hours. In ID thrice weekly consultant ward rounds enabled feedback to be given. In IAU and ARUs trainees would receive feedback in the mornings following their nightshifts on cases they had managed overnight. At weekends feedback was more variable, more often when things went wrong rather than more general provision of feedback from consultants.

Core and Internal Medicine Trainees: After overnight on-call most ARU pods conduct post-receiving ward rounds providing feedback on trainees' management of their cases. This is greatly valued and enables ACATs to be completed. In IAU where it can be more chaotic feedback is available and is enabled by consultants being present up to 11 pm. Cardiology with 2 to 3 consultant ward rounds per week provides good feedback including during the post ward- round debriefs. However more generally discontinuity of ward base is a barrier to feedback and the diabetes endocrinology wards are noteworthy because of the absence of any feedback opportunities.

Specialty Trainees: Trainees described feedback as regular and informal in most departments with feedback in Respiratory Medicine highlighted as good, including in clinic settings. Trainees felt the feedback they received was meaningful and constructive.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: Trainers highlighted the trainee forum, Chief Residents and a pastural lead in Respiratory Medicine as avenues for trainees to feedback on concerns about their training.

All Trainee Cohorts: Trainees highlighted the trainee forum as their main opportunity to provide feedback to trainers and the hospital management team on the quality of training they were receiving. Issues raised through the forum in the past included lack of junior doctors' rooms in the wards, time spent completing what they considered to be non-educational tasks and difficulties getting to teaching. Trainees felt consultants were very receptive to trainees' concerns but acknowledged that many remained unresolved. Most of the trainee cohorts were aware of who their Chief Residents were, with the exception of FY2 trainees, who seemed unaware.

2.12 Culture & undermining (R3.3)

Trainers: Trainers felt that lots of work had been done to support trainees and to create a team culture, they felt consultant presence was frequent in most departments and lots of work had been done with the rotas to ensure support was available to trainees as when they required it. Trainers were unaware of any undermining incidents.

All Trainee Cohorts: Most of the trainee cohorts felt their clinical teams and senior consultant colleagues were approachable and supportive. Trainees would raise any concerns they had in relation to undermining or bullying with their Educational or Clinical Supervisors.

GPSTs were aware of the 'civility saves lives' initiative and suggested a small number of staff including a couple of consultants had a reputation for concerning behaviours but did not provide further details.

Nursing and Non-Medical Staff: Staff felt there was a focus on wellbeing in the QEUH. They advised if they witnessed undermining or bullying behaviours, they would intervene to resolve them trainees could report or escalate any concerns they had to their Educational or Clinical Supervisors.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Trainers advised there were current gaps on their rota, some of which they had received late notification for, from the deanery. Trainers felt they were now more pro-active at recruiting locum doctors and Clinical Development Fellows to cover vacancies. Although they were now more pro-active in recruitment, it could often be difficult to recruit staff, and this was highlighted by the recent difficulties in recruiting Clinical Support staff. Trainers described the support provided to senior trainees through the contingency role, which was a 12.5 hour shift that was put in place to cover short notice absences such as sick leave, if the hospital was fully staffed then trainees were advised they could leave the hospital without remaining on-call. This arrangement allowed the cover of short notice gaps to be made without the need to ask trainees to outside their rostered hours in most circumstances. The 'contingency role' had been extended recently to cover weekend absences.

FY1 trainees: Trainees confirmed there were gaps in current rota and described fluctuations of staffing levels impacting on training. Endocrinology & Diabetes and Gastroenterology wards were described as particularly challenging which meant it could often be difficult for trainees to get to learning opportunities due to the need to provide ward cover. Trainees described frequent inexplicable movements of trainees around the wards in Medicine and this caused in-balances in ward staffing from 1 week to the next (Trainees described wards having 5 FY1 on them one week and going down to one trainee the following week).

FY2 Trainees: Trainees were aware of gaps in their rota and described most as short-term cover for sick leave. Trainees were satisfied that most rota gaps were managed pro-actively; trainees advised that there was a daily email highlighting the rota gaps that needed to be covered. Trainees did not feel there were rota issues that had implications for patient safety or their well-being and that learning opportunities were accommodated into the design of their rota.

General Practice Trainees: Trainees advised there were gaps in the rotas. Trainees reported being backfill pawns and being moved around at any moment to plug gaps. Consequently they felt they had no continuity on the wards. At weekends they reported gastroenterology cover was very tight looking after 90 patients and reviewing between 30 and 50+ patients plus any who were unwell.

Core and Internal Medicine Trainees: Frequent shortages of staff were reported. They commended the ‘contingency registrar model’, but it was noted to be a challenging role to be in, but it was perceived to be an asset to rota management. They reported that managers work hard to ensure the on-call rota is always staffed**.** Trainees highlighted gaps in Endocrinology and Diabetes for which some locum cover was provided, but often this was not felt to be enough to cover the gaps and it affected trainee’s ability to get to teaching.

Specialty Trainees: Trainees advised there were gaps in Endocrinology and Diabetes and the rota was short of 1.6 trainees, because of this, trainees felt they often worked beyond their finish times in order to provide cover for the gaps and to manage the heavy workload. In general the perception was that the rota team was good at plugging gaps. They commended the contingency rota role that was generally valued. Trainees felt there was an in-balance in the allocation of clinical support staff and Clinical Development Fellows, with some specialties/wards receiving more than others.

Nursing and Non-Medical Staff: Although workload was high, staff did not have concerns around the affect the rotas had on trainee wellbeing. They described lots of work being done to support trainees, such as the employment of Clinical Development Fellows, Clinical Support Workers and Advanced Nurse Practitioners.

2.14 Handover (R1.14)

Trainers: Not covered.

All Trainee Cohorts: Trainees advised that handover took place in the morning in the IAU/ARU daily at 9.00 am, handover for the wards in the main hospital building took place in the Clinical Decision Unit at 9.00am daily with each team sending a representative from their ward to attend. Handover to the Hospital at Night team also took place at 9.00 pm daily. Weekend handover in downstream medical wards took place at 9.00 am. Morning handover could be led by consultants or Specialty Trainees and 9.00 pm handover was generally led by Specialty Trainees. Trainees felt that morning handover and the H@N handovers were the most structured and a proforma was followed. Trakcare was used to record weekend handover. Pre-handover meetings which were post night shift at 8.50 am and took place in IAU before morning handover, were highlighted by trainees as an opportunity to receive feedback on their cases, which they valued.

Nursing and Non-Medical Staff: Staff felt handover was effective and in ensuring that information about patients is passed to the next team. No concerns were raised in relation to handover.

2.15 Educational Resources (R1.19)

Trainers: Not covered.

All Trainee Cohorts: Trainees felt that quiet spaces in the ward areas within Medicine were limited especially on 7th & 8th floors; some wards had access to pods (which contained computers) that the trainees could access to complete assessments but most did not have available space they could use and there was thought to be a lack of junior doctors' rooms in most of the ward areas. Trainees highlighted the library as good.

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

Trainers: Not covered.

All Trainee Cohorts: Trainees highlighted that excellent support was provided to them in order to return to work from sick leave, maternity leave and out of programme periods. The trainees described reasonable adjustments made to support them, which included phased return to work arrangements, 1-2-1 meetings and being taken off the on-call rota. They advised that pastoral support was also available to them through the hospital chaplain and Respiratory Medicine also had a nominated local pastoral lead.

Nursing and Non- Medical Staff: Not covered.

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

Trainers: Not covered.

All Trainee Cohorts: Most of trainees' present did not have awareness of who their Director of Medical Education was and what they were responsible for.

2.18 Raising concerns (R1.1, 2.7)

Trainers: Not covered.

All Trainee Cohorts: Trainees highlighted Datix as the system for reporting adverse incidents. They also felt they could raise concerns with their educational or clinical supervisor. Learning around Datix incidents was discussed at Morbidity and Mortality (M&M) meetings. Trainees present who had submitted Datix reports, reported that feedback to them was inconsistent. The chief resident and junior doctor forum presented further routes for raising concerns. IMT/CMTs noted that in the IAU in the morning meeting with consultants there are opportunities to flag concerns about safety during the safety brief.

Nursing and Non-Medical Staff: Not covered.

2.19 Patient safety (R1.2)

Trainers: Trainers felt that significant improvements had been made to the safety of IAU overnight for both trainees and patients, the significant changes to the rota, including the employment of a locum AIM consultant had helped manage the workload more effectively. Trainers felt that although IAU staffing had improved, capacity within the unit remained a challenge. Some trainers perceived their voice was not being heard in relation to potential opportunities to make further improvements. Workload in both the IAU and in the main hospital stack building was still considered to be high but the employment of Clinical Development Fellows and Clinical Support Workers had helped reduce the workload burden on trainees but there remained challenges in the distribution of ward cover in some areas.

All Trainee Cohorts:

Initial Assessment Unit (IAU) & ARU:

Trainees perceived there had been improvements to the safety of IAU over the last 2 years and commended the engagement of consultants and the efforts made by the consultants to improve the situation in the IAU. It was still considered to be an extremely busy unit but use of the Emergency Medical Assessment and Triage (EMAT) process between 0900 and 1800h by registrars and consultants had improved the identification of sick patients and had helped expedite their investigations and management. This isn't operational after 2000h. Trainees were still concerned about the lack of capacity in the IAU and bed availability. It was also noted that more patients were moved to ambulatory care where there is consultant cover but only for 4hr/week, and none after 6pm. It was also possible to divert patients to ARU5, but this has no medical staff and the medical registrar has to see these patients as well. While these changes have helped there remain concerns around lengthy backlogs of patients accumulating through to the evenings and the length of time these patients can wait for assessment. Trainees report that when they come in for night shifts there can be more than 35 patients waiting to be assessed with estimates of delays in that happening of up to 12 hours.

Wards in the main hospital building (stack):

Some concerns were raised by trainees working in Gastroenterology on the 8th floor of the stack building, they felt there was a lack of consultant cover for the wards at weekends and often it was one middle grade trainee who provided cover for the whole floor. Trainees highlighted further concerns around a lack of Consultant input to the split Endocrinology and Diabetes/General Internal Medicine ward at times, reporting that when the consultant was working in ARU or on leave, no consultant input would be provided for their patients for, at times, over a week, and nor would there be opportunities for oversight of their work or feedback.

FY1 trainees felt weekends across the wards were extremely busy and unmanageable and they were concerned about missing things and delays in attending to patients. They were concerned also that they may not have time to access the results for the day until 7pm – with added worries around not acting sooner on abnormal results.

Medical HDU: Although concerns were raised in previous visits in relation to senior support in Medical HDU, trainees now appeared to be satisfied with the senior cover arrangements that were in place and were aware of the escalation pathways for support.

Boarding: The QEUH has a team dedicated to caring for medical boarders; this includes a charge nurse and a registrar. Some concerns were expressed by FY2 trainees about inappropriate boarding of some patients without the knowledge of the medical team.

Nursing and Non-Medical Staff: Staff advised that mechanisms to support trainees had been put in place during busy periods and the escalation process for all staff was now clearer than it had been in previous years. They felt the environment was now much safer for patients than it had been in the past.

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

Trainers: Not covered.

All Trainee Cohorts: Most FY1 and some FY2 trainees reported being unfamiliar with how to use Datix but most other trainees highlighted that Datix was the system for reporting adverse incidents. Feedback on the outcome of Datix incidents was variable across the trainee cohorts, with some but not all receiving feedback when involved in the reporting of incidents. Learning from adverse incidents was discussed at regular Morbidity and Mortality meetings that most trainees could attend.

3. Summary

Is a revisit required? (please highlight the appropriate statement on the right)	**Yes**	**No**	**Highly Likely**	**Highly unlikely**

The visit panel noted the ongoing commitment of site leads, clinical and non-clinical managers, and consultant trainers in improving the educational environment at the QEUH. Although this visit was more positive than previous visits, the visit panel found ongoing concerns around postgraduate training and specifically in relation to the constraints around the capacity of IAU and resulting delays in assessment of GP referrals continue to pose an ongoing potential risk to safe care at the QEUH. The engagement of NHS GG&C in seeking solutions to the issues of capacity of IAU and the resulting delays in the assessment of GP referrals includes their engagement of the North East of England Commissioning Team to advise on possible solutions to manage patient flows and we noted also the ongoing involvement of this Team in overseeing the action plan. The commitment of the ground floor medical staff in supporting quality training and sustaining service delivery is commended. A number of changes have resulted that have helped – including the appointment of an additional locum AIM Consultant to the ground floor and some degree of reconfiguration, however nightshift staff still come on duty facing lengthy backlogs of patients**.**

Progress against previous visit requirements:

Progress against previous requirements recorded as ‘addressed’, ‘significant’, ‘some progress’, ‘little or no progress’.

Ref	Issue	Progress noted at 2020 visit
7.1	Measures must be implemented to address the ongoing patient safety concerns in relation to the IAU, described in this report (see also requirement 7.14 from 2018 visit)	Some progress but concerns remain
7.2	A process must be put in place to ensure that any trainee who misses their hospital induction session is provided with an induction.	Addressed
7.3	The burden of tasks for all cohorts of doctors in training that do not support educational or professional development and that compromise access to formal learning opportunities must be significantly reduced. The provision of phlebotomy must be improved.	Some progress
7.4	The scope of the ward cover and the associated workload overnight and at weekends must be reduced as currently they are not manageable, safely. This is generally an issue – but also 8th Floor has particular issues in this regard.	Some progress
7.5	The medical staffing of the IAU overnight must be sufficient to ensure these staff have a safe and manageable workload that enables them to provide quality care to their patients.	Some progress
7.7	Consistent and appropriate clinical supervision of middle-grade doctors in training in HDU must be provided at all times.	Addressed
7.8	A process for providing feedback to doctors in training on their input to the management of acute cases must be established.	Addressed
7.9	Handover of care of patients transferred from the ED to Pods must be introduced to support safe	No progress

	continuity of care and to ensure unwell patients are identified and prioritised.	
7.10	Work must be undertaken to ensure that trainees are supported to attend clinics and other scheduled learning opportunities without compromise because of service needs.	Some progress
7.11	Trainees must know how to engage in use of the Datix system and receive feedback on Datix cases.	Some progress (although trainees still appear to not be receiving feedback).

The visit panel recommends the continuation of the Enhanced Monitoring case for the Queen Elizabeth University Hospital. Further discussion will take place between the deanery and the GMC (following approval of this report) around whether escalation of this site to Enhanced Monitoring with conditions is necessary and this will be communicated to the site directly.

The positive aspects of the visit were:

- Supportive and accessible consultants (in and out of hours)
- Support for trainees returning to work after periods of absence was very good
- Pastoral support from the hospital chaplain for trainees
- Respiratory pastoral lead role
- '5 before 5' quality improvement initiative (although not all trainees aware)
- Chief Resident role and contributions (although not all junior trainees were aware of CR)
- 'Contingency trainee role' and its positive contribution to rota gap management
- IAU and ARU as a learning environment (aside from the known potential safety issue above) that ensures feedback and learning around trainees' management of the acute medical workload

Less positive aspects of the visit were:

- IAU and concerns around capacity and potential implications for patient safety (see above)
- Datix and reporting of adverse events & incidents – lack of familiarity among the Foundation trainees with the Datix system and a lack of feedback, more generally, after Datix submissions

- While some improvements have been made, there remains concern around lack of staffing for the workload of Foundation trainees at the weekend in the wards in the 'stack'
- Diabetes and Endocrinology – lack of support for junior staff, lack of mid-grade cover and consultant presence. There is also a ward shared by EDM & GIM and we heard that consultant input by the latter can be infrequent, at times with gaps of many days, due to lack of cover when that person is receiving or on leave
- Discontinuity of placements of GPST and CMT/IMT trainees on base wards compromising education and training
- Lack of a culture of education and training generally for GPST trainees (although there are exceptions e.g. Respiratory Medicine where GP training works well)
- Access to local teaching is poor generally, averaging at less than 1 hour per week for most trainees
- Burden of non-educational tasks is a barrier to education and training (although we are aware of attempts to recruit non-medical staff and the challenges this has presented)

Overall Satisfaction scores:

FY1 Trainees: Trainees scored between 4 – 8 out of 10 – with an average score of 5.8
FY2 Trainees: Trainees scored between 5 – 8 out of 10 – with an average score of 6.2
General Practice Trainees scored between 5 – 8 out of 10 – with an average score of 6.5
Core and Internal Medicine Trainees scored between 5 – 7 out of 10 – with an average score of 5.6
Specialty Trainees scored between 5 – 8 out of 10 – with an average score of 6.4.

4. Areas of Good Practice

Ref	Item	Action
4.1	Contingency trainee role' and its positive contribution to rota gap management.	
4.2	5 before 5 quality initiative (although not all trainees aware).	Raise awareness amongst trainee cohorts.
4.3	IAU and ARU as a learning environment (aside from the known potential safety issue above) that ensures feedback and learning around trainees' management of the acute medical workload.	
4.4	Support for trainees returning to work after periods of absence.	
4.5	Pastoral support from the hospital chaplain for trainees.	
4.6	Respiratory pastoral lead role.	
4.7	Quality Improvement Website.	Raise awareness amongst the trainee cohorts.

5. Areas for Improvement

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

Ref	Item	Action
5.1		

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	Measures must be implemented to build on the progress in addressing the ongoing patient safety concerns in relation to the IAU, described in this report (see also requirement 7.1 from 2019 visit)	4th December 2020.	FY/GPST/CMT/IMT/ST
6.2	The burden of tasks for all cohorts of doctors in training that do not support educational or professional development and that compromise access to formal learning opportunities must be significantly reduced. (see also 7.3 from 2019 visit).	4th December 2020.	FY/GPST
6.3	Trainees must know how to engage in use of the Datix system and receive feedback on Datix Cases (see also 7.11 from 2019 visit).	4th December 2020.	FY/GPST/CMT/IMT/ST
6.4	The scope of the ward cover and the associated workload for Foundation Trainees at weekends and overnight (in the wards in 'the stack') must be reduced as currently they are not manageable and safe.	4th December 2020.	FY
6.5	There must be robust arrangements for both ongoing senior review of patients' care and ongoing supervision of the contributions of doctors in training to the management of their patients during times of Consultant absences (including leave and when on other duties) in the ward shared by Endocrinology/Diabetes and General Internal Medicine.	4th December 2020.	FY/GPST/CMT/IMT/ST
6.6	The training opportunities provided to GPSTs must meet the needs of the curriculum.	4th December 2020.	GPST

6.7	The discontinuity of ward placements for GPST and must be addressed as a matter of urgency as it is compromising quality of training, feedback, workload and the safety of the care that doctors in training can provide. The duration of ward attachments for Foundation trainees must be increased to at least 4 weeks.	4th December 2020.	FY/GPST/CMTs/IMTs
6.8	Work must be undertaken to ensure that trainees are supported to attend clinics and other scheduled local learning opportunities without compromise because of service needs. (see also 7.10 from 2019 visit).	4th December 2020.	FY/GPST/CMT/IMT/ST
6.9	Handover of care of patients transferred from the ED to Pods must be provided to support safe continuity of care and to ensure unwell patients are identified and prioritised. (see also 7.9 from 2019 visit).	4th December 2020.	FY/GPST/CMT/IMT/ST
6.10	Alternatives to doctors in training must be explored and implemented to address the chronic gaps in the rota that are impacting on training (although we are aware of attempts to recruit non-medical staff and the challenges this has presented)	4th December 2020.	FY/GPST/CMT/IMT/ST