Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	17th March 2021	**Level(s)**	Foundation, IMT, GP, Specialty
Type of visit	Re-visit (Virtual)	**Hospital**	St John's Hospital
Specialty(s)	General Internal Medicine	**Board**	NHS Lothian

Visit panel	
Dr Geraldine Brennan	Visit Chair – Associate Postgraduate Dean (Quality)
Dr Shilpi Pal	Training Programme Director
Dr Yatin Patel	Foundation Consortium Lead
Dr Gary Rodgers	Trainee Associate
Mrs Jennifer Duncan	Quality Improvement Manager
Mr Robert Kemp Mrs Sarah Summers	Lay Representative Shadowing Lay Representative
In attendance	
Mrs Gaynor Macfarlane	Quality Improvement Administrator

Specialty Group Information											
Specialty Group		Foundation									
Lead Dean/Director		Professor Clare McKenzie									
Quality Lead(s)		Dr Geraldine Brennan & Dr Marie Mathers									
Quality Improvement Manager(s)		Mrs Jennifer Duncan									
Unit/Site Information											
Trainers in attendance		8									
Trainees in attendance		F1 – 11, F2 – 2, IMT – 2, GPST – 1, ST - 7									
Feedback session: Managers in attendance	Chief Executive	0	DME	1	ADME	0	Medical Director	0	Other	7	

Date report approved by Lead Visitor	21/06/2021 Dr Geraldine Brennan	30/06/2021 Professor Clare McKenzie (Lead Dean)

1. Principal issues arising from pre-visit review:

Following a Deanery triggered visit in May 2018, a number of concerns were raised regarding Foundation training within the medical unit at St John's Hospital. The department was revisited in September 2019 and it was evident that the department were focused on making improvements. Whilst the visit team were impressed with the improvements made there were still some recommendations that had not been addressed. It was therefore agreed that a further re-visit was required. This decision was upheld at the Quality Review Panel which took place in August 2020.

Recommendations from 2019 visit:

- Allegations of undermining behaviour must be investigated, and if upheld, put in place an appropriate action plan must be instigated to address them.
- The scope of cover and the associated workload of the DVT Clinic requires urgent review. (See 2.12).
- The scope of cover and the associated workload for both the MAU/PAA between 5 and 7pm and the observation ward between 4 and 5pm must be reviewed as the work within these areas does not feel manageable and safe for trainees or patients. (See 2.12).
- Induction to all ward areas, including the DVT clinic, must be provided in a timely manner and prepare the trainees for their roles. This should include practical information on protocols and ways of working on the wards.
- All trainees must be assigned to a ward/unit for a minimum of a 4-week continuous period. The discontinuity of ward placements for all trainees 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. *(This 2018 requirement is particularly relevant for FY1 trainees who reported to be struggling to feel part of the wider team with the current arrangements).*
- The department must review and reduce the volume of non-educational tasks undertaken by trainees to allow them better access to educational opportunities). *(This 2018 requirement now mainly applies to FY1 trainees within the DVT Clinic and to CMT trainees when working on call within the MAU).*
- Trainees must have equitable access to clinics and be able to attend sufficient numbers to achieve their curriculum competencies. *(This 2018 requirement is now noted to be applicable to all trainees who are required to attend clinic as part of their curriculum).*

- A formal structured handover with input from senior team members must be established for the Foundation trainees. *This 2018 requirement must be sustained, and the handover must be scheduled within the rostered hours of work of the trainees.*
- Handover for the on call medical registrar must be formalised and structured to ensure safe handover and continuity of care. (See 2.12).
- There must be a process that ensures trainees understand, and are able to articulate, arrangements regarding Educational Governance at both site and board level.

STS Data 2020
White Flags – Clinical Supervision, Educational Environment, Handover, Induction, Teaching, Team Culture and Workload.

At the pre-visit teleconference the visit panel agreed that the focus of the visit should be around the areas highlighted in the previous visit report recommendations.

A summary of the discussions has been compiled under the headings in section 2 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.

Department Presentation:

The visit commenced with Dr Karen Adamson, Clinical Director delivering an informative presentation to the panel which provided an update regarding the progress against the previous visit requirements and the impact of COVID-19 on working arrangements within the unit.

2.1 Induction (R1.13):

Not covered. No concerns raised in pre-visit information.

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

Trainers: Trainers commented that due to Covid-19 there have been challenges in providing a safe teaching environment in line with social distancing requirements. Trainees had disengaged slightly with weekly Tuesday lunch time teaching as this had been a difficult to move to an online platform. A hybrid teaching model has now been adopted which allows a number of trainees to attend face to face and all others have the ability to log in to the live sessions. Trainees present at these sessions and are provided with feedback for their training portfolio. This has been very well received by all. Sessions are not recorded but this is something that could be considered in the future.

Trainers commented that formal foundation teaching has moved to an online platform. This has offered a degree of flexibility which has been very well received by all. Trainees who are unable to attend a live session, now have the option to join remotely to same session running in a different region or can view the recorded session at their leisure.

F1 Trainees: Trainees reported no concerns in attending formal teaching which is available virtually or face to face and is also recorded should they be unable to attend a session. Local weekly Tuesday lunch time teaching is held for an hour and there are also the occasional adhoc teaching sessions to which F1s are invited to attend. Simulation is arranged via the TUBs system however this has not been running due to Covid-19.

F2, IMT and GPST Trainees: Not covered due to insufficient time available.

ST Trainees: Trainees reported no concerns in attending teaching and found this of good quality and relevant to the curriculum. Currently there is 1 hour of general internal medicine teaching offered locally and attendance at this can be variable.

2.3 Study Leave (R3.12)

Not covered. No concerns raised in pre-visit information.

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

Not covered. No concerns raised in pre-visit information.

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 commented that coloured lanyards are used to differentiate between the training grades of doctors. They reported that a good level of supervision was available and described a friendly, supportive and approachable consultant team who are easily contactable and have a good ward presence. They described a clear and transparent consultant rota which is available on the shared drive and provides details for each ward along with cross cover arrangements. The “front door” has been redesigned and is now a consultant led emergency medical admissions unit (EMA). Out of hours, the consultant on call is on site until 8pm and can then be contacted overnight for support. Support is also available from the intensive care unit for a rapidly deteriorating patient or there is a direct line to the cardiology registrar based in Edinburgh. Trainers are confident that trainees are not expected to work beyond their level of competence.

F1 Trainees: Trainees reported they are aware of who to contact if they require support during the day and out of hours. They stated that they have not had to work beyond their competence in this post and have no concerns in seeking appropriate support. They commented that the team are very friendly and approachable.

F2, IMT and GPST Trainees: Trainees commented on good levels of supervision with approachable and easily contactable registrars and consultants. Trainees described a WhatsApp group used as a general discussion forum and to support handover. This is generally trainee led where they provide updates on cases and seek advice from colleagues. Consultants monitor and contribute to discussions. No patient identifiable information is recorded in the group chats.

ST Trainees: Trainees agreed that they had no concerns with supervision which is of good quality. They find the consultant team are approachable in and out of hours and are extremely supportive.

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

Trainers: Trainers commented that they are confident that all trainee grades can achieve their learning outcomes and the balance between development and non-educational tasks is about right. There is now a greater consultant presence on all wards and trainers pro-actively prompt trainees with regards to learning opportunities. Trainees also have more opportunity to present cases to the consultant team and receive feedback. Trainers commented that providing remote supervision for virtual outpatient clinics at the onset of Covid-19 has been difficult however the team are adapting well to this. It is hoped in the near future that clinics will move to a blended model of face to face and virtual.

F1 Trainees: Trainees reported they had no concerns in gaining core and non-core procedures in post and have no major concerns in achieving their minimum assessment requirements. They commented on undertaking a wide range of tasks, however due to rotating wards frequently it can be difficult to chase up sign off, of an assessment undertaken in another ward. It can also be difficult to obtain a complete set of team assessment of behaviours (TAB). Trainees agreed that the post develops their skills in managing the acutely unwell patient however commented that at least half of their time is spent carrying out tasks with little or no educational benefit. They describe a lot of time spent completing discharge letters and other administrative tasks which can often be for patients that they have never seen. A large amount of time is spent carrying out tasks such as taking bloods and undertaking ECGs as nursing staff are unable to do these tasks. Trainees also commented that they are often overwhelmed by the volume of these tasks and that they do not hand these over as they do not want to burden other colleagues.

F2, IMT and GPST Trainees: Trainees reported no concerns in achieving learning outcomes and described the consultant team as being very proactive and supportive. Access to clinics has been an issue for IMT trainees as priority appears to be given to higher trainees and these opportunities do not always appear on the rotas. This is causing some concern with regards to post sign off for IMT trainees. These concerns have voiced with consultants and at a local teaching meeting. Trainees agreed that the post allows for development of skills and competence in managing the acutely unwell patient. They also find a good balance between education and non-educational tasks.

ST Trainees: Trainees commented that obtaining some supervised learning events (SLEs) such as pleural aspirations have been somewhat limited due to the recent Covid-19 surge. Trainees spend a lot of time on the wards for prolonged periods doing ward rounds and covering gaps. They report having to assist in taking bloods and doing ECGs because there may only be one F1 covering a large ward. This limits their learning opportunities if the workload is heavy. They believe a more structured model could be considered which would allow them to have specialty sessions and admin time built in. This would enhance their learning experience and reduce the repetitive nature of doing the same daily ward tasks.

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

Trainers: Trainers reported they were not aware of any issues with trainees achieving portfolio assessments or receiving feedback. The team are very supportive and approachable and with a heavier consultant presence on the ward's they are proactively seeking out trainees and prompting learning opportunities.

F1 Trainees: Not asked. Covered in section 2.6.

F2, IMT and GPST Trainees: Not covered due to insufficient time available.

ST Trainees: Trainees described their trainers as being proactive, supportive and approachable. They have no concerns in obtaining work-place based assessments in general internal medicine. When assessments are requested consultants respond swiftly. There can be difficulties in obtaining an ACAT assessment when trainees are working with 2 consultants and reviewing different patients with each.

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

Not covered. No concerns raised in pre-visit information.

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

Not covered. No concerns raised in pre-visit information.

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: Not covered.

F1 Trainees: Trainees commented that feedback is provided when asked although some consultants offer it more openly. They confirmed feedback is constructive and meaningful however there is very little continuity to work with the same teams due to the structure of the rota.

F2, IMT and GPST Trainees: Not covered due to insufficient time available.

ST Trainees: Trainees reported consultants are proactive in providing feedback and are very good at prompting learning opportunities.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: Trainers advised that trainees are invited to attend regular junior doctors' meetings, these meetings are for trainees only and have no consultant presence. Minutes and actions are reviewed regularly, and any matters are taken forward by the clinical director. The clinical teaching fellow also offers drop in sessions should a trainee wish to discuss anything.

F1 Trainees: Trainees were unsure of any formal process for providing feedback to trainers. Although they find the team very approachable, trainees reported that they would not feel comfortable providing face to face feedback to their trainers and would prefer to do so anonymously. Should they have any concerns, they are aware that they can discuss these with their clinical supervisor.

F2, IMT and GPST Trainees: Not covered due to insufficient time available.

ST Trainees: Trainees noted a meeting which took place in December 2020 where they were able to take any thoughts or concerns to a specific registrar to take forward. One trainee described being invited to attend senior management team meetings to discuss red and amber admissions in the second wave of Covid-19 which they found of great benefit as they were actively included in discussions.

2.12 Culture & undermining (R3.3)

Trainers: Trainers reported a zero-tolerance approach to bullying and undermining behaviours. This is covered within induction and trainees are advised if they have any concerns, they should contact the clinical director for a confidential discussion. The team supports a flat hierarchy and are very team focused which ensures all members are included. Some tensions relating to wearing of headscarves and masks had been raised at the start of the pandemic however these were resolved swiftly within the team.

F1 Trainees: Trainees reported that the consultant team are very supportive and find the department a pleasant environment to work in. They have not witnessed or experienced any bullying or undermining behaviour and would raise any concerns through the standard escalation policy which they would be comfortable using.

F2, IMT and GPST Trainees: Trainees commented on a very supportive working environment. They described excellent communication systems and find consultant involvement in the WhatsApp discussion forum useful. Trainees confirmed they had not experienced or witnessed bullying or undermining behaviour and are aware of how to raise concerns if needed.

ST Trainees: Trainees confirmed a supportive and approachable senior team. They have not witnessed or experienced bullying or undermining behaviour and commented on very good working relationships with supervisors who they would feel comfortable in discussing any concerns.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Trainers confirmed that there were still challenges with regards to the duration that any one F1 trainee is attached to a ward, due to overall F1 numbers and the issue is still under review. Currently F1s are attached to the same ward for a maximum of 2 weeks. F2s and middle grade trainees spend a minimum of 4 weeks attached to one ward and all higher trainees spend a minimum of 8 weeks attached to one ward. Trainers stated that continuity has been extremely challenging during Covid-19 due to gaps caused by absences and a significant increase in the footprint of the medical unit without availability of additional manpower. However, they report that they have been creative and flexible to ensure a safe service is delivered and the quality of training does not suffer.

F1 Trainees: Trainees reported no F1 rota gaps. Concerns were raised with having only one day off on a 7 day stretch. Concerns were also perceived around patient safety when the F1 is the only staff member on the ward with no senior cover alongside. They confirmed that either a registrar or consultant is available in the hospital should they need to escalate a problem, however there is sometimes no consultant or senior presence at board rounds or when they were doing a daily patient review. F1 trainees commented that this situation arises due to an imbalance in the middle grade rota and causes them much concern. They have informally suggested to registrars and consultants' ways of adjusting the rota to allow wards with greater staffing to be spread more evenly to ensure an F1 is not working alone.
Trainees commented that there is no handover of patients from the previous week which can waste a lot of time as trainees familiarise themselves with the patients. The lack of continuity can affect patient care as things can be missed or time is wasted repeating tasks that have already been done. This is a particular problem in the general wards. Trainees commented that the shortest period they have spent in one ward is one day and the longest period is between 7 and 14 days.

F2, IMT and GPST Trainees: Trainees noted that there are gaps in the current rotas which have mainly been filled by non-training grade doctors. They described the rota as sometimes accommodating learning and curriculum requirements, however that comes at the expense of continuity. They do not believe there are any patient safety concerns however commented that a lot of time is spent learning about new patients. This takes time and makes for a heavier workload as it can also mean that it takes longer to see a patient. Trainees confirmed that the minimum time spent on any one ward is one day and the maximum time was 2 weeks, although this can vary across the

trainee grades. Trainees tend to work independently due to moving wards so frequently and work with new junior doctors most days.

ST Trainees: Trainees confirmed there are gaps in the higher rota and a long-term locum has been appointed, however there are still a lot of on call shifts for those remaining to cover. They believe there are also gaps in lower grade rotas and are aware of locum appointments into them, however locum doctors may opt to only work on certain days or may request not to contribute to out of hours, meaning that existing trainees need to take on additional shifts to cover gaps. Trainees commented on recent rota redesign which has been well received as it now allows for variation and more structure around specialty specific sessions. Clinics were difficult to manage at the beginning of the pandemic however these are now running well remotely. Trainees are generally attached to a ward for 7 to 14 days, however may cover other wards out of hours. Trainees are aware that on the rota it would appear they spend up to 2 months in one area, however this does not transpire in practice. Trainee agreed that ward continuity is a big issue due to the amount of movement between wards. They believe rotas are compliant and do not believe they compromise trainee wellbeing.

2.14 Handover (R1.14)

Trainers: Trainers advised of a robust handover system which provides safe continuity of care for new admissions and for those in downstream wards. Consultants attend morning handovers which are seen as a good learning opportunity. They also described a WhatsApp group which is used to support handover. Hospital at night (H@N) handover takes place at 9am and 9pm. Hospital at weekend (H@W) handover takes place in the morning and all tasks are allocated through the workbench to ensure nothing is missed. Foundation handover post-take is provided by the foundation trainee who has been on nights. The group noted that on occasions patients have been moved without a ward being informed.

F1 Trainees: Trainees commented that they are often working alone and that the period between 5pm and 9pm when the F1 is covering all downstream medical wards is extremely busy and tasks quickly become unmanageable. Trainees stated that this situation causes them anxiety. As a result, the bulk of the tasks must be moved to the night team. Trainees also commented that there is no cross over or time in the rota for handover between the evening shift which should finish at 9pm and the night shift. F1s, therefore trainees on the evening shift must stay late to provide this handover.

F2, IMT and GPST Trainees: Not covered due to insufficient time available.

ST Trainees: Trainees reported a robust handover for new admissions however were unable to comment on handover to the downstream wards.

2.15 Educational Resources (R1.19)

Trainers: Trainers commented that lack of space can be an issue for trainees when trying to find a safe space to undertake online learning. Laptops with cameras and speakers are available in the department if required.

F1 Trainees: Trainees reported that resources and facilities are very good although are underutilised.

F2, IMT and GPST Trainees: Not covered due to insufficient time available.

ST Trainees: Trainees reported that the department have a few computers however it can be difficult to access a computer off the ward and at present the library is closed due to Covid restrictions.

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

Not covered. No concerns raised in pre-visit information.

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: Trainers reported that there is no on site back up to the department of medical education team. Currently the assistant director of medical education role is unfilled for St John's. The deanery system is robust with regular specialty training committee meetings taking place. The foundation team are particularly well represented in St John's with members of the postgraduate team based in the hospital along with TPD for IMT and APGD for medicine in east based in the unit. Finally, all educational and clinical supervisors have been through the recognition of trainer's process and regular meetings are arranged to discuss trainees and provide feedback.

F1 Trainees: Trainees reported they were unaware of the formal process for raising concerns regarding the quality of training in post, however they stated they would take any concerns to their educational supervisor. They are also aware of the local trainee management forum.

F2, IMT and GPST Trainees: Not covered due to insufficient time available.

ST Trainees: Trainees reported they would raise any concerns with regards to the quality of training in post with their educational supervisors or the training programme director. Trainees are aware of a training meeting that any issues can be raised through and commented on the use of the registrar WhatsApp group as a discussion forum.

2.18 Raising concerns (R1.1, 2.7)

Trainers: Trainers reported that all trainees are encouraged to use the datix system to report any concerns with regards to patient safety and discuss with their educational supervisors or another member of the consultant team. Regular morbidity and mortality meetings (M&M meetings) take place and any challenging cases or near misses can form part of the Tuesday lunchtime teaching session. Trainees can also discuss any issues via the junior doctors' group or at drop-in sessions offered by the clinical teaching fellow.

F1 Trainees: Trainees reported they would raise any concerns with regards to patient safety with their educational supervisor however are unaware how these would be addressed.

F2, IMT and GPST Trainees: Not covered due to insufficient time available.

ST Trainees: Trainees confirmed they would approach their educational supervisors if they had any concerns with regards to patient safety. One trainee described a situation where they had raised a concern this was addressed promptly, and additional supervision put in place for a short period.

2.19 Patient safety (R1.2)

Trainers: Trainers consider the department to be a positive and safe environment for trainees and patients. The EMA unit has been a positive development for all and the increased presence of the

consultant team allows for a heavier involvement in the patient journey. The medical unit has lost its specialty focus in adapting to meet the needs of the extra workload due to the pandemic, however as part of the continued redesign of the department this will be addressed.

F1 Trainees: Trainees commented that they would be comfortable with a friend or relative being admitted to most of the wards in the department, however not those wards where there is infrequent senior review delivered. Trainees commented that normally one or two doctors would look after one ward, however if they were struggling, they would seek appropriate senior support. Trainees made frequent reference to the terms SHO, F3 and F4.

F2, IMT and GPST Trainees: Not covered due to insufficient time available.

ST Trainees: Trainees reported they would have no concerns if a relative or friend were admitted to the department. Trainees raised some concerns about patients who are boarded over a weekend often with no effective communication to inform the parent team whether they were moved from a boarding ward or to a boarding ward. Trainee are aware of the boarding policy however decisions on suitability or not are often over written. In this instance a grading system is used to determine how suitable a patient is for boarding. The boarding system over the weekend is a concern as patients can be moved with no communications to the receiving ward.

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

Trainers: Trainers commented that educational supervisors provided feedback to trainees on adverse incidents. If directly involved a trainee would be debriefed away from the ward environment and encouraged to reflect on the event. If something was to go wrong with a patient's care, the trainee would be very well supported by their educational supervisor who would talk through the incident and any remedial action required and assist with communications to the patient. Trainees would also be highly encouraged to complete a datix on the event.

F1 Trainees: Trainees are aware of the datix reporting system however have had no experience in using this.

F2, IMT and GPST Trainees: Not covered due to insufficient time available.

ST Trainees: Trainees agreed they would be very well supported if involved in an adverse incident. Feedback is received via e-mail and can be discussed directly with the responsible consultant.

2.21 Other

Overall satisfaction score:
F1 Trainees: 7.7
F2, IMT and GPST Trainees: 9
ST Trainees: 8.4

3. Summary

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

Overall the virtual visit was very positive, there were a few technical difficulties on-site which resulted in question sets having to be reduced due to time constraints. This was a particular issue with the F2/IMT/GP trainee session. The panel however, found an approachable, engaged and supportive team who are keen to improve the training environment. The visit panel are extremely grateful for the work put into progressing previous visit report requirements and recognise the challenges that the team have faced due to the impact of Covid-19 within the current working environment. However not all requirements from previous visits have been able to be progressed fully and the panel note ongoing concerns in the following areas: adequate experience (opportunities), workload, rotas, handover and patient safety. The panel were particularly impressed with the excellent support offered to shielding trainees, the proactive approach of consultants in providing feedback and assessments, the redesign of front door services and the move to hybrid teaching models.

Positive aspects of the visit:

- The panel commend the honesty of trainers regarding the challenges in progressing some of the previous recommendations. Although the previous visit action plan has not been fully met, the panel acknowledged the challenges faced within the working environment due to the impact of Covid-19 and recognised the significant work put in and the excellent engagement from the department in making changes.
- Excellent engagement with training of shielding trainees.
- Move to hybrid teaching models has been well received, with the F1 group in particular being able to attend almost all of the required sessions.
- Good quality educational supervision for all and good clinical supervision in most areas.
- Trainees commented on enjoying working in the department and noted an extremely approachable, friendly and supportive consultant team.
- All trainee groups highlighted the consultant teams' proactive approach to providing formal feedback and trainers actively ensuring assessment requirements are met.
- Good communication pathways between senior and junior teams.
- Redesign of the front door emergency medical admissions (EMA) unit which has excellent consultant cover and support.
- ST trainees reported good feedback and learning opportunities from clinical errors.
- High levels of satisfaction reported by all trainee grades

Less positive aspects of the visit:

- Ongoing concerns with regards to non-educational tasks undertaken by F1s. For example, completing IDLs for patients they do not know. F1s report that EGCs and blood sampling is still done by them as nursing teams on wards are often unable to do this.
- IMT reported difficulties in achieving their minimum assessment requirements for attending clinics.
- Ongoing concerns with the lack of continuity for those trainees being moved around various wards. Examples provided saw a maximum period of 2 weeks for some. However, others commented on being attached to a ward for only 1-2 days.
- Ongoing concerns with regards to F1s lone working during daytime on downstream wards with no direct senior support present.to support their ward rounds

- 5pm – 9pm was also identified as an extremely difficult period on downstream wards with F1 trainees feeling very vulnerable in terms of their ability to cover multiple areas with a heavy workload. They are aware they can approach colleagues for help with workload however they often do not feel comfortable in doing so.
- No crossover in working hours with evening to night team, therefore F1s have to stay late to provide a handover to the night team.
- Lack of handover across the day when patients move to a downstream ward from a receiving ward, with a lack of understanding around what patient management is needed, which causes anxiety with trainees.
- Unease from panel around the use of WhatsApp by middle/senior grade trainees as a handover mechanism. Although the panel heard that patient identifiable information is not shared by this route, this raises concerns about the quality of handover information shared and potential for breaches of confidentiality. Wellbeing of trainees should also be considered as there is potential for all to receive handover messages when not in work.
- Trainees recognised that there is a boarding policy but reported that this was at times over-ridden, which had consequences on downstream wards as flags for patient review were missed. This is not helped by a lack of tracking in place for medical boarders, especially if patients are moved directly from receiving areas to a boarding ward
- Wards 8 and 9 were highlighted as particular areas of concern for patient safety due to infrequent Consultant ward rounds, although no examples of harm were reported.
- Use of SHO/F3/F4 terminology.

Requirements from previous visit (15/05/2018)

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

Ref	Issue	Progress noted – 24/09/2019	Progress noted – 17/03/2021
1	There must be a clear pathway for who is responsible for the day to day review of patients boarding out with their usual ward including an expectation of frequency of consultant review.	Addressed	n/a
2	There must be clear lines of supervision within the MAU at all times with easy access to Consultant support when required.	Addressed	n/a
3	Clarity of consultant cross-cover arrangements for management of patients is required when their usual consultant is on leave.	Addressed	n/a
4	All trainees must be assigned to a ward/unit for a minimum of a 4-week continuous period. The discontinuity of ward placements for all trainees 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.	No progress	Little progress
5	The department must review and reduce the volume of non-educational tasks the FY1 trainees undertake in order to maximise their potential to attend educational opportunities including wards rounds.	Some progress	Some progress
6	General Practice trainees must have equitable access to clinics and be able to attend sufficient numbers to achieve their curriculum competencies.	Some progress	Some progress – but new issues arising around IMT trainees.

7	A formal structured handover with input from senior team members must be established for the Foundation trainees.	Initial progress – not sustained	Some progress
8	Induction to the unit must be provided in a timely manner and prepare the trainees for their role in the unit. This should include practical information on protocols and ways of working in the department	Some progress	Addressed
9	The department must review and reduce the volume and intensity of daytime work for Specialty trainees when working in acute admissions.	Addressed (improvement made with the appointment of 5 Clinical Fellows)	n/a
10	Opportunities to feedback to all trainees in the ward setting must be created.	Some progress – F1 still perceive little to no feedback	Addressed
11	There must be review of the arrangements for attendance at H@N handover to ensure that patient care and trainee workload within MAU is not compromised.	Addressed	n/a

Requirements from previous visit (24/09/2019)

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

Ref	Item	Progress noted – 17/03/2021
5.1	NHS Lothian should investigate whether the Hospital@Night team and weekend staffing arrangements are sufficient (see 2.12 and 2.18).	Addressed
5.2	Clarity needs to be provided to ST trainees about pathways to support discharge of patients within acute areas including referral to DVT clinic and ambulatory care facilities in order to improve patient flow.	Addressed
5.3	Information regarding shift patterns should be updated in the medicine department handbook and the health board should consider circulating this to FY1s earlier during shadowing week in advance of their formal induction.	Addressed
5.4	Review the role of middle grade junior staff on ward rounds to shift focus from the current scribing activities towards involvement in decision making.	Addressed
5.5	Formalise time for the junior doctor forum within the rota as a vehicle for formal trainee feedback.	Addressed
5.6	Improve the communication around changes occurring in the medical receiving rota that affect the MoE trainees.	Addressed
5.7	Review start times for trainees to attend clinics when there is a timetable clash with local teaching.	Addressed
5.8	Facilitate attendance at learning opportunities for example knee aspiration and pleural clinics by timetabling these activities into the rota.	Addressed

4. Areas of Good Practice

Ref	Item	Action
4.1	Move to hybrid teaching models has been well received, with the F1 group in particular being able to attend almost all of the required sessions.	n/a
4.2	Excellent engagement with training of shielding trainees.	n/a
4.3	All trainee groups highlighted the consultant teams' proactive approach to providing formal feedback and trainers actively ensuring assessment requirements are met.	n/a

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	2.19	Frequency of Consultant led ward rounds in some units, notably Wards 8 and 9, should be reviewed to ensure that there is sufficient support to junior staff to provide safe and effective patient care and feedback opportunities for trainees.
5.2	2.2	Consideration should be given towards recording of local teaching sessions to allow greater flexibility in attendance of all trainee grades.
5.3	2.6	Ensure that there is upskilling of non-medical staff on wards to support trainees with completing non-educational tasks.

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	All trainees must be assigned to a ward/unit for a minimum of a 4-week continuous period. The discontinuity of ward placements for all training grades 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.	17th December 2021	All training grades
6.2	There must be provision on the rota to ensure IMT trainees can attend clinics relevant to their training needs.	17th December 2021	IMT
6.3	The department must review and reduce the volume of non-educational tasks the FY1 trainees undertake in order to maximise their potential to attend educational opportunities including wards rounds.	17th December 2021	F1
6.4	The scope of the ward cover and the associated workload for F1 trainees between 5pm – 9pm must be reviewed and reduced as currently they are not manageable.	17th December 2021	F1
6.5	Medical staffing must be reviewed across downstream wards to ensure there is appropriate coverage for junior medical staff to safely manage the workload, with consideration of employing more non-training medical staff.	17th December 2021	F1
6.6	The evening to night handover must be scheduled within the rostered hours of work of the trainees.	17th December 2021	F1
6.7	Handover processes must be improved between receiving wards and downstream wards to ensure there is a safe, robust handover of patient care with adequate documentation of patient issues, senior leadership and involvement of all trainee groups who would be managing each case.	17th December 2021	All grades

6.8	The use of WhatsApp by middle/senior grade trainees as a handover mechanism must be reviewed and consideration given to alternative methods of providing secure, confidential information that is of sufficient quality to support patient care and trainee wellbeing.	17th December 2021	IMT, GPST and ST
6.9	There must be robust arrangements in place to ensure the tracking of all boarded patients. In addition, for boarded patients, there needs to be clarity around which Consultant and clinical care team are responsible, how often patients are reviewed and what the escalation policy is.	17th December 2021	All grades
6.10	All references to “SHOs” “F3”, “F4” and “SHO Rotas” must cease.	17th December 2021	All grades
6.11	General Practice trainees must have equitable access to clinics and be able to attend sufficient numbers to achieve their curriculum competencies.	17th December 2021	GP

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.