Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	18th November 2021	**Level(s)**	FY/GPST/IMT/ST
Type of visit	Enhanced Monitoring re-visit	**Hospital**	Dr Gray's Hospital
Specialty(s)	General Internal Medicine	**Board**	NHS Grampian

Visit panel	
Professor Alastair McLellan	Visit Chair - Postgraduate Dean
Professor Rona Patey	Undergraduate Dean – University of Aberdeen Medical School
Robin Benstead	Principal Education QA Programme Manager
Susan Fiddes	Lay Representative
Dr Cieran McKiernan	Associate Postgraduate Dean – Quality
Dr Karen Rose	Foundation Programme Director Representative
Dr Aravind Ponnuswamy	College Representative
Alex McCulloch	Quality Improvement Manager
In attendance	
Emma Stewart	Quality Improvement Administrator
(name redacted)	Lay Representative (shadowing)
Alison Ruddock	Quality Improvement Administrator (shadowing)

Specialty Group Information	
Specialty Group	Medicine
Lead Dean/Director	Professor Alastair McLellan
Quality Lead(s)	Dr Alan McKenzie Dr Greg Jones Dr Reem Al-Soufi

Quality Improvement Manager(s)	Alex McCulloch and Hazel Stewart			
Unit/Site Information				
Non-medical staff in attendance	0			
Trainers in attendance	6			
Trainees in attendance	FY1 x 1	GPST x 2	IMT x 2	ST x 1

Feedback session: Managers in attendance	Chief Executive		DME	✓	ADME	✓	Medical Director	✓	Other	General Managers and Trainers

Date report approved by Lead Visitor	21st January 2022 

1. Principal issues arising from pre-visit review:

Following concerns raised by a number of Quality Review Panels in August/September 2019 and due to the deterioration of survey data, the Deanery Quality team agreed to undertake a whole site visit to Dr Gray's Hospital in March 2020. Unfortunately, due to the COVID-19 pandemic this was cancelled. Further concerns were raised therefore an immediate triggered visit that was arranged virtually for general medicine/general surgery/anaesthetics and emergency medicine and took place in September 2020. Although this visit was a joint visit with an undergraduate representative no undergraduate medical students were seen on the day of the visit.

At this visit the panel found significant concerns about the training environment (particularly in relation to supervision for trainees, low staffing levels and patient safety concerns). The turnout from the trainees at the visit was very poor but the challenges facing Dr Gray's as a training environment were such that it was escalated to the GMC's Enhanced Monitoring process in September 2020 for anaesthetics, general surgery, and general internal medicine.

13 visit requirements were identified at the September 2020 visit, 12 of which were related to medicine:

- There must be sufficient substantive consultant trainers to support the supervision and training of the doctors in training in general medicine and general surgery
- Hospital and departmental induction must be provided which ensures trainees are aware of all of their roles and responsibilities and feel able to provide safe patient care.
- A process must be put in place to ensure that any trainee who misses their induction session is identified and provided with an induction.
- The morning and/or evening handover must be scheduled within the rostered hours of work of the trainees.
- All consultants, who are trainers, must have time within their job plans for their roles to meet GMC Recognition of Trainers requirements.
- All staff must behave with respect towards each other and conduct themselves in a manner befitting Good Medical Practice guidelines.
- Doctors in training must not be expected to work beyond their competence.

- The level of competence of trainees must be evident to those that they come in contact with and all references to ‘SHOs’ and to ‘SHO rotas’ must cease.
- The Board must provide sufficient IT resources to enable doctors in training to fulfil their duties at work efficiently and to support their learning needs.
- Trainees must be able to access learning opportunities to meet curricular objectives including, for example, outpatient clinics.
- Lack of continuity on wards creates a barrier to training and compromises quality of care of patients.
- Initial meetings and development of learning agreements must occur within a month of starting in post for Medicine trainees

The visit panel questions were targeted around the previous visit requirements from the September 2020 visit for medicine and were informed by recent survey outputs. This visit also included a session with the undergraduate medical students from the University of Aberdeen based in a number of specialties.

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.

The panel would like to thank Dr Louise Miller who delivered a presentation, providing an informative and helpful update on the progress the Medicine department had made since the September 2020 visit against the visit requirements. The content of Dr Miller’s presentation is included in the trainers’ responses in the report below.

2.1 Induction (R1.13):

Trainers: Dr Miller provided the following update on induction in her presentation. The department of medicine handbook was regularly updated and sent to trainees in advance of start date. Induction power-point and video presentations were sent to each new trainee in advance of start date, face to face induction was undertaken by lead clinician for each cohort as well as out of synch trainees, a tour was provided by a physician's associate, an enhanced induction was provided for a new start F2 who was unfamiliar with Dr Gray's and an enhanced induction was provided for a new trainee who was also a wheelchair user. In summary trainers felt all trainees have had face to face, written and PowerPoint/video induction regardless of when they started their post.

Trainees: All trainees present had attended induction and reported it to be good. The trainees felt however, that on-call requirements were not fully covered, and more information could have been provided in regard to specific roles whilst working on-call.

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

Trainers: Trainers confirmed that a new departmental teaching programme was currently under development which included input from the local multi-disciplinary team at Dr Gray's (including advanced nurse practitioners (ANPs and pharmacists). The trainers felt they had to be creative in filling roles for delivering teaching following a recent consultant retiring and a reduction in the number of available trainers.

Trainees: Trainees described local general medicine teaching sessions as taking place around once per week, these were described as trainee led sessions and could often be difficult for trainees to attend because of workload. Trainees felt an improvement to local teaching would be more consultant led teaching sessions. Trainees reported that regional teaching sessions took place bi-monthly and were organised by Aberdeen Royal Infirmary (ARI), which they could join virtually. Trainees felt that good informal learning opportunities were available to them whilst working on the wards on a daily basis.

2.3 Study Leave (R3.12) - Not covered.

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

Trainers: Dr Miller confirmed that only 1 substantive consultant was employed at Dr Gray's in a rota of 8. Several substantive consultant physician posts were advertised in the summer of 2021; however, recruitment was unsuccessful, and the posts remain unfilled. To mitigate the recruitment difficulties, a consultant geriatrician was relocated to Dr Gray's from Aberdeen Royal Infirmary in November 2020. In addition, a further 4 locum consultants were recruited. Dr Miller confirmed that all trainees within medicine had been allocated nominated educational and clinical supervisors. Supervision for IMTs was provided by Dr Miller and Dr Hoyle at Dr Gray's and their educational supervision was provided by trainers based at Raigmore Hospital in Inverness.
Foundation trainees were supervised by Drs Hoyle, Williams, Kumar, and Garg and GPST clinical supervision was provided by Dr Miller. The trainers advised they did have time in their job plans to provide supervision and teaching which amounted to around 0.25 p.a. per trainee, but it was acknowledged to be very challenging to take that time. Dr Miller advised that a job plan meeting had taken place in January/February 2021 and it was hoped that once more consultants were recruited, more time could be created in job plans to deliver training.

Trainees: Most of the trainees' present worked on the wards with their educational supervisor and had also met formally with them on more than one occasion to discuss and agree their learning plans.

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 confirmed that trainees should have access to clinical supervision whenever they required it both during the day, at weekends and whilst working out of hours. Consultants were available on- site from 0800-2200 and on call by phone from home in the out of hours period. Dr Miller confirmed that there was acknowledgement that new start F2s may feel concerned about starting on a generic middle grade medical rota, which also applied to one of the new IMT1 trainees and these trainees were buddied on call for the initial month in medicine by a specialty doctor, PA or ANP and they reviewed this arrangement with the trainees after a month to assess ongoing needs. An escalation policy was in place (i.e., middle grade FY/GPST/IMT to consultant) and this was reiterated to new start middle grade doctors and new start consultant locums.

Trainees: Trainees confirmed they were aware of who to contact for support both during the day and out of hours. Trainees were able to reach on-call consultants in the out of hours period for support when they required it, although the time between calling the consultant and receiving support could be variable. Some trainees felt it could take a long time to receive support. In the pre-visit information, an instance of a trainee calling an on-call consultant who declined to come to the hospital to assist with the management of a patient was reported, despite this need being identified by another consultant. More junior middle-grade trainees reported feeling they had to cope beyond their level of competence when leading medical receiving out of hours with, at times, not terribly supportive responses when contacting some consultants out of hours.

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

Trainers: Trainers confirmed that IMT and ST trainees were prioritised to attend clinics due to their curriculum requirements and ANPs would hold their pagers to allow them to attend without interruption. As a limited number of clinics were available it was difficult to provide access for GPSTs and FYs and their access to clinics was felt to be more ad hoc. Trainers felt that all trainees would be able to meet their curriculum requirements, they participated in hospital wide audits and felt that clinic experience was the most challenging to provide for trainees in the current circumstances of the COVID-19 pandemic.

Trainees: Trainees felt that obtaining clinic experience could be challenging as it was difficult to leave the wards to attend them due to a busy workload, although it was acknowledged that ANPs could occasionally hold pagers for trainees to enable clinic attendance. The numbers of clinics trainees had attended varied widely within cohorts and so far, ranged from 1 – 2 to 7 – 8; trainees felt it could be easier to attend clinics in some departments compared to others.

Trainees highlighted the post take ward rounds as good learning experiences with opportunities for feedback on their management of acute cases. They felt they were receiving good exposure to acutely ill patients. Some trainees felt that simulation training would be a valuable addition to their training. Trainees estimated they spent around 50% of their time on the wards completing tasks they considered to be non-educational.

2.7 Adequate Experience (assessment) (R1.18, 5.9, 5.10, 5.11) - Not covered

2.8 Adequate Experience (multi-professional learning) (R1.17) - Not covered.

2.9 Adequate Experience (quality improvement) (R1.22) - Not covered.

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: Trainers advised that trainees could get feedback on their training on a regular basis through ward rounds and handover where they were able to present cases and receive feedback on them. In the out of hours period, it could be more difficult to receive feedback, but trainees could receive it from a consultant the following morning at handover after a night shift.

Trainees: Trainees highlighted there were opportunities to receive feedback during post-take ward rounds or after handover to inform their learning.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: Trainers advised that trainees could attend a local trainee forum once per month where they could feedback concerns about their training. The forum was attended by the medicine management leads (Dr Hogg and Dr Pattison) who would discuss trainee concerns with them and then share the output with the trainers in order to come up with solutions.

Trainees: Trainees were aware of a local trainee forum and some had attended, they did not appear to be aware of who the current trainee lead was for medicine. Trainees felt they could also raise any concerns they had about their training with their educational or clinical supervisor.

2.12 Culture & undermining (R3.3)

Trainers: Trainers felt they were open and transparent and were not aware of any incidents of undermining taking place. They also were not aware of any feedback in surveys which suggested trainees had undermining concerns and no recent concerns had been raised through the trainee forum.

Trainees: Several trainees reported allegations of undermining behaviours that they had observed. These reports will be escalated to the local director of medical education (DME) out with this visit report.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainees: Trainees reported 2 gaps on their current rota, this increased on-call shifts for trainees and more frequent movement around the wards to provide cover for the gaps. Trainees also reported short term sickness absence which had put further pressure on the remainder of the trainee cohort who were at work to cover shifts**.** Trainees felt that staffing levels could sometimes feel unsafe. Trainees felt under pressure to take on extra shifts.

2.14 Handover (R1.14)

Trainees: Trainees confirmed that handover took place 3 times a day at 9.00 am, 5.00 pm and 9.00 pm. Trainees felt handover was structured but were not aware of any written or electronic records of handover. Due to COVID restrictions handovers were staggered to make them safer and more efficient. Trainees who had previously worked at Dr Gray's felt that handover had greatly improved since they had last worked at Dr Gray's.

2.15 Educational Resources (R1.19)

Trainees: Trainees described IT provision as generally poor, with inadequate numbers of computers, that were often old and that often struggled to support applications such as PACS. Trainees had access to a doctors' mess which they described as very good.

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

Trainees: Trainees felt help and support was available to those who were struggling with the job due to health or for other reasons. A trainee commented on how helpful and supportive the local team had been in accommodating the adjustments they had requested due to a health condition.

2.17 Educational governance (R1.6, 1.19, 2.1, 2.2, 2.4, 2.6, 2.10, 2.11, 2.12, 3.1) - Not covered.

2.18 Raising concerns (R1.1, 2.7)

Trainers: Trainers highlighted Datix as the main method for reporting concerns and that Nursing staff would often pick up on and highlight less serious concerns. Dr Miller would review the output of Datix and provide feedback to any trainees involved in Datix incidents. Work was ongoing to improve the learning and use of the output of Datix as it was not thought to be as effective as morbidity and mortality (M&M) meetings. Patient safety issues were also generally discussed on a daily basis at morning handover.

Trainees: Trainees felt they could raise concerns about patient safety through their consultant colleagues and described senior medical staff such as Dr Hogg as very approachable. Trainees repeated their concerns around the fragility of staffing and highlighted ward 6 as being understaffed and they had concerns of patients being over-looked in this ward. Trainees also described difficulties with finding beds for patients in the medical wards because of how busy the hospital was, and they could sometimes be waiting in the emergency department for lengthy periods of time before arriving in a medical ward.

While there are M&M meetings it was felt these could be developed further to realise their full potential as vehicles for reflection and learning.

2.19 Patient safety (R1.2)

Trainees: Although trainees were concerned about staffing in ward 6 and with finding patients' beds in the medical wards, as well as the fragility of staffing (particularly out of hours) they did not report any specific patient safety concerns or incidents**.**

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

Trainers: See section 2.18

Trainees: Trainees highlighted Datix as the system for reporting adverse incidents and those who had been involved in Datix incidents had received feedback on them. Most trainees could attend local

M&M meetings but described them as case presentations rather than traditional M&M to discuss learning from adverse incidents.

2.21 Other - N/A

3. Summary

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

The visit panel found the training being provided to trainees in general internal medicine had improved since the last deanery visit to Dr Gray's Hospital in 2020. The panel would like to acknowledge the significant amount of work that has gone into improving the training experience for trainees, despite significant staffing difficulties and of course the continued service pressures created by the COVID-19 pandemic. Concerns remain around the fragility of the training environment due to several long-term substantive consultant vacancies which are proving very difficult to recruit to.
Over the course of this visit, the panel asked questions which related to previous visit requirements and have highlighted in the table below where we think current progress is against each, categorised into addressed, progress noted, or little progress noted. Although improvements were found in this visit, some requirements remain in place, as well as new ones identified, and the site will remain on Enhanced Monitoring. A re-visit will take place in the 2022/2023 training year.

Requirements from 2020 deanery visit:

Req	Theme	Commentary
7.1	There must be sufficient substantive consultant trainers to support the supervision and training of the doctors in training in General Medicine (and General Surgery).	Little progress noted
7.2	Hospital and departmental induction must be provided which ensures trainees are aware of all of their roles and responsibilities and feel able to provide safe patient care.	Addressed
7.3	A process must be put in place to ensure that any trainee who misses their induction session is identified and provided with an induction.	Addressed
7.4	The morning and/or evening handover must be scheduled within the rostered hours of work of the trainees.	Addressed
7.5	All consultants, who are trainers, must have time within their job plans for their roles to meet GMC Recognition of Trainers requirements.	Progress noted
7.6	All staff must behave with respect towards each other and conduct themselves in a manner befitting Good Medical Practice guidelines.	Little progress noted
7.7	Doctors in training must not be expected to work beyond their competence.	Little progress noted
7.8	The level of competence of trainees must be evident to those that they come in contact with and all references to ‘SHOs’ and to ‘SHO rotas must cease.	Addressed

7.9	The Board must provide sufficient IT resources to enable doctors in training to fulfil their duties at work efficiently and to support their learning needs.	Little progress noted
7.10	Trainees must be able to access learning opportunities to meet curricular objectives including, for example, outpatient clinics.	Little progress noted
7.11	Lack of continuity on wards creates a barrier to training and compromises quality of care of patients.	Addressed
7.12	Initial meetings and development of learning agreements must occur within a month of starting in post for Medicine trainees.	Addressed

Overall Satisfaction:

Trainees scored their Overall Satisfaction highly and scores were between 6 – 8 out of 10, with an average score of 7.3 out of 10.

Positive aspects of the visit:

- Trajectory towards improvement in the quality of postgraduate medical training.
- Leadership around postgraduate medical education and training from Dr Miller.
- Commend additional resources made available by NHS Grampian to support medical and non-medical staffing; despite this, however, vacant consultant posts remain unfilled by substantive appointees.
- Support for doctors in training who require this.

Less positive aspects of the visit:

- Undermining concerns highlighted to DME
- Fragility to the extent of raising questions around the sustainability of training in medicine as the consultant rota that has been designed for 8 includes only 1 substantive consultant. The delivery of postgraduate medical training is critically dependent upon one individual.

- Staffing of middle grade rota and gap management.
- Formal local teaching: insufficient access to formal local teaching sessions and lack of consultant leadership of that teaching.
- Lack of effective learning from adverse incidents.
- Adequacy of IT provision.
- Variable clinical supervision support from on-call consultant for middle grade trainees (FY2/GPST/IMT) whilst working OOHs

4. Areas of Good Practice

Ref	Item	Action
4.1	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	Morbidity & Mortality meetings	Develop these to realise their potential to share learning from near-misses, adverse events, and outcomes, including among doctors in training.

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	There must be sufficient substantive consultant trainers to support the supervision and training of the doctors in training in General Medicine	18th August 2022	Service leads
6.2	All staff must behave with respect towards each other and conduct themselves in a manner befitting Good Medical Practice guidelines.	18th August 2022	FY/GPST/IMT/ST
6.3	Those providing clinical supervision must be supportive of trainees who seek their help and must never leave trainees dealing with issues beyond their competence or 'comfort zone'.	18th August 2022	FY/GPST/IMT/ST
6.4	Alternatives to doctors in training must be explored and employed to address the chronic gaps in the junior rota that are impacting on training.	18th August 2022	FY/GPST/IMT/ST
6.5	Trainees must be able to access learning opportunities to meet curricular objectives including, for example, outpatient clinics.	18th August 2022	FY/GPST/IMT/ST
6.6	The department must develop and sustain a local teaching programme relevant to curriculum requirements of all trainees, including consultant-led sessions. A system for ensuring protected time for attendance should also be implemented.	18th August 2022	FY/GPST/IMT/ST
6.7	All consultants, who are trainers, must have time within their job plans for their roles to meet GMC Recognition of Trainers requirements.	18th August 2022	Service leads
6.8	The Board must provide sufficient IT resources to enable doctors in training to fulfil their duties at work efficiently and to support their learning needs.	18th August 2022	FY/GPST/IMT/ST