Scotland Deanery
Quality Management Visit Report

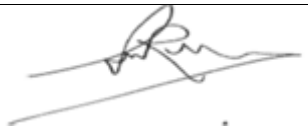
NHS Education for Scotland

Date of visit	25 & 26 November 2021	**Level(s)**	FY1, FY2, GPST, IMT, ST
Type of visit	Enhanced Monitoring Revisit	**Hospital**	Inverclyde Royal Hospital
Specialty(s)	General Internal Medicine and Geriatric Medicine	**Board**	Greater Glasgow & Clyde

Visit Panel	
Professor Alastair McLellan	Visit Chair – Postgraduate Dean for Medicine, Lead Dean Director for Quality, Medicine
Dr Clive Goddard	Associate Postgraduate Dean for Medicine, South East Scotland
Dr Nick Dunn	Deputy Director for General Practice Training, Scotland
Dr Marie Mathers	Associate Postgraduate Dean, Quality – Foundation
Ms Kate Bowden	GMC Quality Assurance Manager
Ms Cathy Fallon	Lay Representative
Mrs Hazel Stewart	Quality Improvement Manager
In Attendance	
Ms Alison Ruddock	Quality Improvement Administrator
Miss Emma Stewart	Quality Improvement Administrator

Specialty Group Information	
Specialty Group	Medicine
Lead Dean/Director	Professor Alastair McLellan
Quality Lead(s)	Dr Reem AlSoufi, Dr Greg Jones, Dr Alan McKenzie
Quality Improvement Manager(s)	Mr Alex McCulloch, Mrs Hazel Stewart
Unit/Site Information	
Non-medical staff in attendance	10

Trainers in attendance	14									
Trainees in attendance	9 x FY1, 3 x FY2, 2 x GP, 5 x IMT, 1 x ST									
Feedback session: Managers in attendance	Chief Executive		DME	✓	ADME	✓	Medical Director	✓	Other	✓

Date report approved by Lead Visitor	 Professor Alastair McLellan, 9 December 2021

1. Principal issues arising from pre-visit review:

A triggered visit was undertaken on 19/11/2018, with a subsequent revisit 13/11/2019. The site was escalated to enhanced monitoring (EM) following this visit due to clinical supervision, working beyond competence, undermining behaviour, feedback, curriculum requirements, balance between service needs & educational and training opportunities. An EM Revisit was held virtually via Microsoft Teams on 19th & 20th November 2020.

At this visit, it was noted that significant improvements had been made by the departments at improving the trainees experience, but a lot of work was still required to fully address the requirements made. The requirements related to the following indicator areas:

- Supportive Environment
- Clinical Supervision
- Adequate Experience & Opportunities
- Feedback
- Patient Safety
- Induction

On review of the 2021 GMC National Training Survey, it is evident that the trainee experience has significantly improved in both Geriatric and General Internal Medicine. All trainee data for geriatric medicine only showed 2 negative outliers with red flags for rota design and study leave, compared with 15 in 2019. Unfortunately, these are triple red flags (red flag for 3 consecutive years) which result in the department remaining on the triage list (bottom 2% of across the UK). Whilst in General Internal Medicine, there are 4 negative outliers (2 pink and 2 red compared with 1 pink and 2 red in 2019), there has been a significant improvement in a number of indicator areas.

This revisit is being undertaken to review progress against previous visit requirements, identify good practice and to identify any current trainee concerns**.** 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 Drs Abigail Gunn & Janice Murtagh (Lead Trainers) who delivered a very detailed and informative presentation to the panel, which provided an update regarding progress against the previous visit's requirements, along with supporting evidence/documentation.

2.1 Induction (R1.13):

Trainers: Trainers reported that there is an effective induction in place, which covers the key aspects needed for trainees to safely undertake their role. This includes:

- How the unit works
- Who to contact for support.
- The day to day running of the hospital
- Induction packs, including information about the area to enable trainees to familiarise themselves with Inverclyde
- Induction handbook sent out ahead of time and includes how to use the systems, such as TRAKcare and who is providing clinical and educational supervision to each trainee.

Trainers report that the induction is recorded to ensure that any trainee unable to attend, or needs a reminder, can watch the recording at a more convenient time. Dr Gunn also provided an induction to those who started their post on nightshift or after day one.

Trainers reported that those working in geriatric medicine attend the general medicine induction in addition to both a face to face and written induction in geriatric medicine.

FY1: All of the trainees confirmed that they received both a departmental and hospital induction. Some felt that having more time on the wards and less time on LearnPro (online information system), during their hospital induction, would have been more beneficial, to enable trainees to be more familiar with the wards and their protocols. University of Glasgow (UoG) graduates had a five-week shadowing period ('preparation for practice'). Those who were not UoG graduates struggled to understand how the IRH medicine worked and were uncertain about things such as protocols and how to make specialty referrals. However, they reported that there was always an FY1, who had undertaken the shadowing period, whom they could ask for advice.

FY2/GPST: All trainees received both their hospital and departmental induction. FY2 trainees reported that they were provided a useful induction to the Larkfield unit (geriatric medicine department) by the educational lead for geriatric medicine, Dr Janice Murtagh; this included introductions to medical and nursing staff. As all trainees had worked within this hospital during FY1, they felt they had a thorough knowledge of the hospital. GP trainees also received a useful departmental induction, which ensured trainees understand their roles and responsibilities.

Additional support through induction was provided to an IMG, new to working in the UK. This induction spanned 2-4 weeks. This was augmented by a 'buddying' arrangement with another IMG who was working in the department.

One of the trainees did report that at the time of the visit they still, after 3 months, did not have access to one of the IT systems despite multiple communications with the administrative team to try to resolve the issue.

IMT/ST: Trainees reported that they received both a hospital and departmental induction. They acknowledged that the consultant team clearly try hard to provide a general induction, but that descriptions of certain pathways were not accurate reflections of what happens in practice. It was suggested that being provided some of the induction information from a previous trainee would be more beneficial in understanding how certain aspects work in practice. Trainees did report that their departmental inductions were of good quality and covered what trainees needed to know about how the wards and clinics work on a day-to-day basis.

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

Trainers:

Geriatric medicine: Trainers reported that they advise trainees to submit their study leave requests in as early as possible to enable rota planning for trainees to attend their regional teaching sessions. They advised that a room is booked for the FY2 deanery led teaching, which is away from the ward environment, to help prevent any disruption to the trainee's teaching. Weekly teaching is also discussed at Monday meetings to ensure staff are aware and minimise barriers to trainees attending the sessions.

General Medicine: Trainers reported that there is weekly department teaching via MSTeams, which is often trainee-led and runs on the back of the Greater Glasgow & Clyde Grand Rounds. Teaching sessions are recorded on MSTeams to enable trainees, who are unable to attend the session, to watch this at a later time. Other departments, such as rheumatology and respiratory reported that they take the trainee's interests into account when providing teaching opportunities and provide regular on ward teaching mapped to the trainees' curriculum. Trainers also described some GP specific learning opportunities, such as the referral symposium, which would be helpful for trainees during the career as a GP.

Trainers also felt that due to the close relationship they all have within the hospital, they would be aware if a trainee was not getting to teaching sessions. It was suggested that the department are looking into a quality improvement project around online teaching and may look to include how to effectively track trainee attendance.

Reference was made to a new initiative called 'iTeach' that had started in JNorth. The principle is that each day someone takes on ownership of a commitment to leading on opportunistic teaching of others in the department. This is signalled by the wearing of a badge identifying that person to others. Trainees themselves contribute to this teaching faculty.

FY1: Trainees reported that there is 1 hour of locally delivered teaching provided every week. Most trainees found it easy to attend teaching with the exception of those in acute receiving and HDU. Trainees were not aware of having access to any particular room from which they could access teaching.

FY2/GP: Trainees reported that there had been regular local weekly teaching in geriatric medicine, but this had recently dropped off. Trainees thought this may be due to difficulties in getting presenters for the sessions. Trainees in medicine (FY2s & GPSTs) reported that there is weekly teaching on a Wednesday, but they were unable to attend due to the busy-ness in the wards and having no dedicated place to watch the teaching. Foundation trainees also reported that the Wednesday teaching sessions clashed with the GG&C Grand Round that was live streamed. Foundation trainees suggested that on average they can in practice access just over 30mins per week of the teaching sessions.

FY2 trainees reported that they have not attended any regional teaching sessions live. GPSTs similarly reported no access to regional or national teaching (as the schedule had been interrupted by COVID-19).

IMT/ST: Trainees reported that they attend the weekly lunchtime teaching session, but are often late as it begins towards the end of the wardround. It was felt that there was clear effort being made by the consultant team to provide regular teaching.

Trainees reported that whilst there is a room available to them from which they can access teaching, it is a 5 – 10 minute walk away in the education centre which they felt, due to the busy-ness of the department, amounts to an excessive amount of time away from the wards. They also reported that the dictation room was being used by the rota co-ordinator for some time, and was therefore not accessible for watching the teaching sessions. Trainees reported that the department did try to provide them with webcams and microphones to aid attendance at teaching sessions, but that these had gone missing. Trainees also indicated that other teaching opportunities are offered, but that this was only a proportion of consultants, who trainees felt were very proactive is offering teaching.

IMT trainees reported that they are generally unable to attend their national IMT teaching live, often due to being on-call, but they are given the time back to watch these sessions at a suitable time through study leave.

They reported that ‘non-essential’ study leave had been cancelled for a time by NHS GG&C in response to COVID-19 pressures.

A few were aware of ‘iTeach’ that they thought was a good idea in principle – but was challenging to deliver in practice due to the busy-ness of their roles.

2.3 Study Leave (R3.12)

Trainers: Trainers reported that as long as there is sufficient notice, there are not any barriers to supporting study leave. It was acknowledged that for a period of time, GG&C health board had cancelled all ‘non-essential study leave’ due to COVID-19 and staffing pressures. However, trainees

were informed to contact Dr Gunn for advice, if they were unsure if their leave could be approved. Trainers were not aware of any instances of a trainee being refused leave.

FY1: Not applicable.

FY2/GP: The FY2 trainees that had applied for study leave had no issues doing so.

IMT/ST: Whilst trainees generally did not have an issue accessing study leave, there were a couple of occasions reported where a trainee did face some issues. Examples were given by the trainees when their leave was not approved by the rota co-ordinator, (despite being submitted with sufficient notice) or there was felt to be a lack of support from the rota co-ordinator.

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

All trainees reported that they had met with their supervisor, discussed their educational needs and that their supervisor had a good understanding of their learning requirements.

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 reported that there is a clear escalation policy for who to contact for support provided during induction. Trainees are also provided with the consultants' mobile numbers, which are also listed on boards within the wards.

Geriatric medicine reported that as consultants work in multiple sites, they highlight to trainees which consultants are on site and when during the Monday handover to provide support. There is also a consultant buddy system for covering each other's work when someone is on leave. Trainers also acknowledged that due to COVID restrictions, it is challenging to enable trainees to attend as the patient often has a relative or guardian with them.

Trainers reported that it can be daunting for some more junior trainees when acting up as first on-call, but support is always available from the on-call consultant. They reported that trainee competency and progression is assessed before a trainee acts-up on the senior rota. In addition, a skills and procedure matrix was created this year to identify what trainee is suitable for what shift and shared

with the rota checked over by the clinical services and rota managers. Where it is felt that a trainee is not at the required level, consultants will act down to cover gaps on the rota.

FY1: Trainees reported that they know who to contact for support. The FY1 placement in HDU was challenging due to lack of on-the-ward access to more senior support and the variable presence and engagement of consultants. It was challenging to escalate concerns in relation to patients transferred to HDU from medicine. This exposed the trainee to working beyond competence, and certainly beyond confidence. There is access to consultants by phone, and most were said to be approachable, but they can be engaged in clinical activities elsewhere. Some consultants are more difficult to engage. It was reported that, whilst there were no concerns for patient safety, and no patients have come to harm, there were delays in receiving the support needed within HDU.

Trainees reported that they know who to contact for support within geriatric medicine as they are provided with a set list of consultants.

FY2/GP: Trainees reported that there is always support available within the Larkfield unit. However, some felt that due to the number of consultants and ward rounds present, there was little opportunity for decision-making. Trainees reported that within the medical wards, whilst they always know who to contact for support, there is variability around the willingness to provide support with an example given when there was lack of support when high workload and shortages of more senior trainees were escalated as concerns to the consultant.

IMT/ST: Trainees reported that they know who to contact for support, but there is variability in the level of support given. Not all trainees had been allocated a clinical supervisor. Trainees felt that when a more junior trainee, for example IMT1, is the 1st on, it can be challenging for them if the on-call consultant is less supportive as they have much less experience. However, trainees acknowledged that every consultant would answer their phone and provide advice.

Trainees felt that FY1 trainees were very stretched within the HDU as the clinical fellow who had been placed in HDU to support them often ends up filling a second on registrar gap and therefore is often not available due to provide cover somewhere else. Therefore, they felt this was particularly challenging when the on-call consultant was one that was less approachable and supportive and felt that there would be benefit from a more senior trainee being available for support when advice is

sought for more minor queries. Trainees reported that consultants do review their own patients within HDU, but less so when a patient is admitted from a downstream medical ward, resulting in the F1 trainee seeking advice from the on-call senior trainee instead. Trainees did acknowledge that other consultants are extremely supportive and will listen to their concerns and provide advice.

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

Trainers: Trainers reported that there was a non-negotiable need to ensure trainees of all levels get access to outpatient clinics. Allocated clinics are tailored on a monthly basis by one of the consultants and shared with the senior charge nurse so that they are aware that a trainee is due to attend a clinic and should not be disturbed unless there is an emergency. Trainers reported that feedback from trainees suggests that they are generally able to attend their clinics. They confirmed that when attending specialised clinics, such as neurology clinics, trainees would sit in and observe, but at other clinics such and endocrinology and diabetes trainees would assess patients themselves and run their management plans past the consultants. Trainers also described the availability of other opportunities, such as pleural procedures training following the appointment of 2 new respiratory consultants.

It was felt that the only competency that trainees may struggle to achieve would be related to gastroenterology, as there is currently no on-site gastroenterology consultant. However, trainers reported that they are looking at ways to organise for a trainee with a gastroenterology interest to attend the RAH or QEUH.

Trainers felt there was a good educational balance to the work undertaken by trainees, although they acknowledged that trainees would likely report that workload prevents attendance at educational activities, at times. Dr Gunn recently piloted a new initiative called iTEACH, in an attempt to turn what would be seen as basic tasks into teaching opportunities.

Trainers reported that as they are all qualified supervisors, they would know if a trainee was missing any curriculum needs through review of eportfolio and their regular communications with trainees.

FY1: Trainees reported that they could achieve their competencies. They are able to clerk-in and review patients out of hours. Trainees felt this provided lots of opportunities to develop their skills in

managing acutely unwell patients. They also felt that as the hospital is relatively small, it is easier for them to get to know the team and vice versa, which helps to ensure staff are aware of the level of competency. However, overall trainees felt that more than 50% of their time in post was spent undertaking tasks of little to no educational benefit.

FY2/GP: Foundation trainees felt that they are making good progress in achieving their curriculum requirements. They reported that the workload within the Larkfield unit was reasonable and enables them to easily meet their educational requirements to develop as a doctor. There was good support including from the team of stroke consultants who share input to the ward on a rotational basis. When working in the receiving unit, trainees reported that they have the opportunity to clerk-in patients. FY2s can access occasional clinics too.

GP trainees reported that they have been able to attend a limited number (4 – 6 clinics since commencing their post ~4months ago). This included the opportunity to review patients and be provided with feedback from the consultant. However, trainees felt that their educational experience overall was hindered due to working predominantly long shifts and out of hours, with ward duties limiting their ability to attend formal learning opportunities. Trainees reported that they have lots of exposure to managing acutely unwell patients, but feedback is rarely provided, except for one consultant who arrived early to commence the ward round to ensure provision of feedback.

GP trainees felt that there was a lot of service provision, worsened by staff shortages, impacting on their development as a doctor.

Whilst trainees reported that they could, at times, move around departments frequently, this was not an issue as the hospital is small and there is familiarity with staff in the medical and geriatric medicine departments.

IMT/ST: Trainees reported that they have more than enough exposure to develop their procedural skills and to manage acutely unwell patients. A monthly schedule of clinic opportunities is compiled by one of the consultants. However, IMTs reported that staffing issues are the main barrier to their ability to attend outpatient clinics; a recent sample of data from the last month had shown that while there were more than 40 clinics available only 5 – 7 clinics had a trainee in attendance. Since August, IMT2s had accessed 6-7 clinics and IMY3s had accessed 7-10 clinics (that is over about 4months).

Trainees highlighted that their experience when at clinics is very positive, with consultants visibly keen to have trainees participate at the clinics. However, trainees also highlighted that outpatient clinics do create administrative work and there is no time within their rota to undertake this. ST3 trainees can and do access sufficient clinic opportunities.

It was felt that there is a wide variability in the level of work they undertake, as at times they are acting-up as a 'medical registrar', and at other times they are undertaking basic non-educational tasks on the wards.

They also felt some anxiety about leaving a ward to access a training opportunity when the wards were very busy or when there were unwell patients on the ward.

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

Trainers: Trainers reported that there are plenty of educational opportunities to achieve their assessments and were therefore unaware of any issues.

FY1: Trainees reported that more senior trainees are a great help in completing their assessments, which they felt were easily completed in this post.

F2/GP: GP Trainees reported that they find it challenging to have their assessments completed as there are no trainees at ST4 level or above. This has resulted in trainees having to send repeated reminders to consultants to complete their required assessments. One of the trainees reported that they have not yet had a single assessment completed. GP Trainees also find it challenging to complete their mini-CEX assessment as they are rarely able to go on a consultant ward round.

IMT/ST: Trainees reported it was challenging to get assessments completed – particularly ACATs with their requirement to include 5 cases, noting that a lot bend the rules to complete these. They noted that the ease of assessment completion is consultant dependent. Dr Simmonds was highlighted as one of the consultants who actively seeks out cases for trainees of particular education benefit to have assessments completed on. Some trainees also felt, due to the lack of senior level trainees, there was high demand on consultants to complete assessments, noting that that IRH has a small cohort of hard-working consultants. Trainees reported that it is easier to have assessments

completed when working in a clinic as there is sufficient time to discuss cases or to ask someone to observe.

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

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

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: Trainers described various opportunities in which they can provide feedback to trainees:

- Almost immediate feedback during acute receiving as there is always a consultant on the ward
- Board and ward rounds
- Asking trainees to provide a summary of cases they've managed during OOH to discuss at a later date and provide ACAT assessment
- Presentations at morbidity and mortality meetings

FY1: Trainees reported that they often receive feedback from middle grade trainees, who are very approachable, and they can run things past them on the wards. The provision of feedback from consultants was variable and dependent upon individual consultants; all felt that the feedback they had received on their decisions was very supportive (and never aggressive).

F2/GP: Trainees felt that as the consultants know them well, they receive good, informal feedback. GP Trainees reported that they actively seek feedback on their decision making which is readily provided and found to be constructive and meaningful. However, trainees found that the provision of feedback was consultant dependent when working in acute receiving or on-call. Trainees reported that they rarely receiving feedback after a nightshift, except for occasions when a particular consultant arrives early to start the ward round. Trainees noted that they can seek feedback, at a later date, following an out of hours shift, but they have to seek this from a consultant rather than it be readily given.

IMT/ST: Opportunities to get feedback on trainees' management of acute medical cases were limited after overnight receiving shifts. Exceptionally, one consultant starts the post-receiving ward round at 0800h to incorporate feedback to trainees on their case-management. Another consultant after a

Board round-handover has offered opportunities to review particular cases with trainees involved in their management. There are some, if limited, opportunities to get feedback from a consultant after day shifts in medical receiving.

Feedback is also provided to trainees during or following working at an outpatient clinic.

Trainees did report that, on occasion, some had received non-constructive feedback, but did receive an apology soon after the event.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: Trainers reported that there had been for a time a fortnightly forum to discuss any rota issues. Drs Gunn and Murtagh also emphasised there was an open-door policy if trainees wish to discuss any issues they are facing. Surveys have also been undertaken to help the consultant team determine the best methods of providing feedback to trainees. Trainers noted that there would normally be a chief resident, to feedback trainee issues or concerns to the consultant team, however, they have been unable to appoint one for the current training year.

FY1: Trainees reported that there are meetings on Friday afternoons, attended by the middle grade trainees and its focus was on rota issues. They tend to contact the more senior trainees with any issues they may have. They were not aware of a junior doctor forum in the IRH at which they could raise concerns about training.

FY2/GP: Trainees were unaware of any opportunities to provide feedback on their training experience except at their end of year reviews. They reported that there was a meeting a few months ago to discuss staffing issues and have regular informal meetings about rota and workload, but they were not aware of any forum in which they could raise issues or concerns about their training experience.

IMT/ST: Trainees reported that Dr Gunn regularly asks then to feedback on how their training is going. There is no opportunity to provide anonymised or feedback as a group on their experience of training. Trainees suggested that they would not want to offer negative feedback as it is evident that the consultant team are working very hard to give the trainees a positive experience and do not want to demoralise the team. They also indicated that there is no chief resident in post to take forward

concerns, but acknowledged that none would seek this role as they believed the burden of rota issues would be passed to the chief resident to manage.

2.12 Culture & undermining (R3.3)

Trainers: Trainers described various activities to help create a positive team culture, including:

- Payday pizza
- Basketball team
- COVID compliant team walks to help breakdown any perceived hierarchical barriers
- The mess facility
- FRAPPS

It was acknowledged that there had been an issue and trainees were encouraged to escalate any issues or concerns they may have in this regard. Trainers confirmed that any undermining behaviours are appropriately addressed through formal processes. Trainers reported that an open door policy is emphasised to trainees should they have any experiences they want to report.

FY1: Trainees reported that they work within a very supportive team. None of the trainees had witnessed or experienced any undermining or bullying behaviours but would be comfortable in raising any concerns with a consultant.

FY2/GP: Trainees felt that the majority of consultants were very supportive. However, they did describe examples of situations where a particular consultant's response had been otherwise.

IMT/ST: Trainees had witnessed and some had experienced being at the receiving end of negative consultant behaviours. However, they felt that the person involved had also done a lot of good work too. An occasion was mentioned when the consultant had later apologised. Trainees would be comfortable to raise any concerns they have with Dr Gunn but also emphasised that most of the consultant team are very approachable.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Trainers reported that there are gaps within the rota, particularly at IMT level (50% gap rate for IMT3). There had been proactive planning of known gaps and whilst a number of clinical fellows were appointed, some permanent staff ended up on long term sick leave and so the benefit of the newly appointed staff was not so evident. Trainers also confirmed that COVID had also impacted on sickness absence. Trainers also felt that due to being a smaller hospital, any gaps in staffing numbers are felt more acutely. When needed, consultant staff will act down to medical registrar level to help cover some of the gaps. There are weekly rota meetings at the start of each week to determine where there are gaps and move staff to different wards if needed.

Trainees: All trainees reported concerns about the staffing levels. They reported there are gaps in the 'middle-grade rotas' and whilst clinical fellows have been appointed, this has not fully addressed the issues. Trainees reported that rota issues and staffing-workload pressures are a barrier to accessing learning opportunities. The recruitment and appointment of a middle-grade with responsibility for the care of boarders was regarded as a very positive initiative.

FY1 trainees, on occasion, have been sent home as they have been required to take on the cover of a night shift that night with very little advance notice.

There were also potential concerns around patient safety due to the lack of staff but all confirmed that no patients had come to harm.

At least one IMT trainee suggested that the department required more senior level trainees to ease workload pressure for both themselves and the consultant staff.

2.14 Handover (R1.14)

Trainers: Trainers reported that safe and effective handover arrangements were in place.

FY1: Trainees reported that there is an excellent, robust handover in place. Trainees also found it helpful that time for handover is built into their rota and allows for time to discuss any patients of concern. During the weekend, handover is done through the computer system Trakcare. They also felt that having the handover in a dedicated room, away from patients helped to reduce the possibility of being disturbed. What is handed over is not formally recorded or archived.

FY2/GP/IMT/ST: Trainees reported that there are good, structured handovers in place in both the Larkfield unit and general medicine. Trainees noted that they are able to highlight any issues or raise any concerns about a patient during handover. The 'safe to go' initiative was noted to have benefitted the handover of the care of transfers from the receiving unit. The introduction of the Boards channel on MSTeams has supported the handover of care of 'medical boarders'.

2.15 Educational Resources (R1.19) - Not asked

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

Trainers: Trainers reported that they have established "Team IRH" to try make everyone feel included. There is a doctors' mess, which recently had a new TV and fridge-freezer installed. In addition, the department has an on-call room which provides trainees with somewhere to sleep following a night-shift or long shift. The Larkfield unit also has an area for trainees which has a kitchen area in it.

Additional support through a prolonged induction for IMGs supported by a buddying system has been established.

Trainees: Trainees reported that the mess room was a great facility. Some had used the rest room. We heard from a trainee who had experience of the enhanced IMG induction process.

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 an educational governance meeting covering education & training across Clyde within NHSGG&C. Not all attended these meetings, but the few that did indicated that these meetings consider the educational opportunities provided to all levels of trainees and in all programmes. Aspects considered included the availability of procedural training that they can signpost to trainees.

Trainees: Not asked.

2.18 Raising concerns (R1.1, 2.7)

Trainers: Trainers reported that the chief resident is a link to raise any issues, but unfortunately they had not managed to recruit one this year. They reported that any concerns can be flagged to clinical and educational supervisors.

FY1: Trainees reported that they would report serious concerns about patient safety to a consultant and lesser concerns amongst their team. Trainees gave an example of a concern they had raised and Dr Gunn had stepped in to resolve the issue.

FY2/GP: FY2 trainees are happy to escalate any patient concerns to someone more senior, although they indicate they would be apprehensive about raising minor concerns with some on-call consultants. GP trainees reported that they escalate any concerns to a consultant and they are appropriately addressed.

IMT/ST: Trainees reported that they would raise specific patient safety concerns with the consultant covering the relevant ward and provide good support to resolve the issue. However, trainees felt that more generalised concerns in relation to patient or staffing numbers are more difficult to address.

2.19 Patient safety (R1.2)

Trainers: During the presentation Dr Gunn indicated that there is always a risk when a patient has to be boarded out to a different ward. However, the department recently employed a clinical fellow to care for all boarded patients. There is also a boarders' channel set up on MSTeams which is accurately updated in real time to ensure that all staff are aware of what patients are boarded, who their named consultant is and any action required.

FY1: Trainees reported they would have no concerns if a friend or relative was admitted to the department. They are not involved with the care of medical boarders and did not feel able to answer questions relating to this.

FY2/GP: Trainees reported that the appointment of the clinical fellow to review boarded patients has been very helpful. They felt that the MSTeams channel was also a very helpful development in

ensuring continuity of care; the Teams channel plus the boarders' clinical fellow ensure earlier review and prioritisation of those who are unwell. FY2s reported that they do not have access to the boarders channel but suggested they needed access, to support the care of these patients when they are asked to see them.

IMT/ST: Trainees felt that overall, boarded patients receive poorer quality of care as their reviews often take place much later and there's been a lack of ownership of patients. However, they were confident that any major concerns would be picked up. Trainees did acknowledge that the department has been trying to improve the situation, with Dr Connell setting up the MSTeams boarders channel and the appointment of a fellow to care for patients. They felt that the Teams channel helps to mitigate the risk of a patient being missed. They were confident that the care of boarders was better supported through the availability of the dedicated Teams channel and the appointment of a fellow with a remit for care of boarders.

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

Trainers: Trainers reported that trainees are expected to attend the monthly morbidity and mortality meetings, where there is shared learning from adverse incidents or very positive incidents. Dr Gunn has also started sending out weekly "spotlight" emails to share a few learning points from a recent case or other educational opportunity.

FY1: Trainees reported that there are monthly M&M meetings where a consultant can discuss a case or request that someone else reports on an interesting case. These meetings are uploaded onto Teams for trainees to access at any time should they be unable to attend the live meeting. Trainees also receive a weekly "spotlight" email, which provides brief learning points from cases that could have been managed better, or cases that were managed particularly well. The FY1 trainees found the spotlight emails particularly helpful.

FY2/GP: Trainees report awareness of Datix as the means of recording adverse events. Feedback afterwards can be tardy and may not pick up on the actual issue that was flagged. Some had attended M&M meetings, with variable perceptions of their utility. Others reported that workload has prevented them from attending the majority of the M&Ms. They were aware of the 'spotlight emails'.

IMT/ST: Trainees reported that there are monthly M&M meetings where a consultant can discuss a case or request that someone else reports on an interesting case. These meetings are uploaded onto Teams for trainees to access at any time should they be unable to attend the live meeting.

Trainees also receive weekly a “spotlight” email, which provides brief learning points from cases that could have been managed better, or cases that were managed particularly well. Some IMT trainees had little awareness of these.

2.21 Other

Trainees were asked to rate their overall satisfaction during their current place between a score of 0 (worst) to 10 (best).

FY1: Range: 6 – 8, Average 7 out of 10
FY2 & GPST: Range: 4 – 7, Average: 6 out of 10
IMT & ST3: Range: 6 – 7, Average 6.5 out of 10

Each cohort was asked what would be the one change that could improve their score:

- All levels stated more staff: predominantly more middle grade and senior level trainees.

Additional suggestions for improvement were:

- FY1 trainees also suggested moving the teaching sessions to later in the afternoon when their workload tends to be a bit quieter, and therefore easier to attend teaching.
- GP trainees also suggested changes to the rota pattern as they find the current rota exhausting.

Trainees indicated that it is evident the department is making significant efforts to provide a good training experience to the trainees and felt that with more doctors in post, it could be a great post.

3. Summary

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

Requirements following the visit in 2020

Progress against the 2020 visit requirements is reflected in the following table – as 'not met', 'partially met' or 'met'.

Ref	**Issue**	**Trainee cohorts in scope**	Requirement met?
6.1	All staff must behave with respect towards each other and conduct themselves in a manner befitting Good Medical Practice guidelines.	FY, GPST, IMT, ST	Partially met
6.2	Trainees' responsibilities for patient care must be appropriate for their stage of education and training. Supervisors must determine a learner's level of competence, confidence and experience and provide an induction that meets their needs and appropriately graded level of clinical supervision	FY, GPST, IMT, ST	Partially met
6.3	Appropriate outpatient clinic training opportunities must be provided for Internal Medicine and General Practice Trainees. Clinic experience must be active participation (rather than merely observing) as is appropriate to the level of trainee.	IMT, GPST	Partially met
6.4	Feedback to all levels of trainees on their management of acute receiving cases must be provided to inform their learning and training.	FY, GPST, IMT, ST	Not met
6.5	There must be robust arrangements in place to ensure the tracking of all boarded patients and to support regular review by a consultant.	FY, GPST, IMT, ST	Met
6.6	Departmental induction must be provided which ensures trainees are aware of all of their roles and responsibilities and feel able to provide safe	FY, GPST, IMT, ST	Met

	patient care - including for those who miss the main changeovers.		
Requirements from November 2019, that have not yet been fully addressed			
6.7	Tasks that do not support educational and professional development and that compromise access to formal learning opportunities, including teaching, for all cohorts of doctors must be reduced.	FY, GPST, IMT, ST	Not met

There is a clear sense of significant ongoing improvement, which is particularly evident over the past 2 years, with evidence of ongoing engagement to improve the training environment and willingness from various stakeholders to get the departments to a better place.

Positive Aspects of the Visit

- Dr Gunn's leadership of the improvements in the quality of training in medicine & in geriatric medicine at IRH is to be commended. While Dr Gunn's leadership is highlighted, it is clear that Dr Gunn is supported by a team of supportive and engaged consultant colleagues. Dr Gunn was also referred to on a number of occasions in relation to her positive contribution as a trainer.
- The IRH is a supportive environment for doctors in training in medicine and geriatric medicine. This reflects generally supportive consultants but also includes, among other things, the provision of the (greatly appreciated) doctors' mess and the on-call rest facility.
- IMG induction & support.
- Handovers. Although there is no written record of the handovers, they were perceived to support the safe handover of patient care.
- Learning around incidents including the provision of M&M meetings and the 'spotlight emails' to highlight learning.
- The MSTeams channel for boarders -supporting better tracking and care for boarders; it was suggested FY2 doctors would benefit from having access to this too

Less Positive Aspects of the Visit

- Staffing for workload is an ongoing issue, particularly for those on the middle grade rota.
- Clinical supervision of FY1s in HDU in managing patients escalated from medicine.
- Access to formal learning opportunities. Whilst there is provision of locally delivered teaching, trainees do not have sufficient access to these sessions in working hours. Access to regional teaching sessions in-hours is also inadequate.
- Adequacy of outpatient clinic experience: access to clinics for IMTs and GPSTs is just about adequate currently in the context of COVID but when COVID-related curricular derogations for IMT are removed this is likely to pose a significant challenge.
- Lack of sufficient feedback to trainees on their management of acutely unwell patients following acute receiving shifts.
- The lack of a regular scheduled formal forum for trainees to feedback concerns around training as a group. There is, however, no shortage of informal opportunities to feedback individually to supervisors.
- Trainees face challenges in achieving senior sign-off of formal workplace-based assessments.

4. Areas of Good Practice

Ref	Item
4.1	Enhanced induction for international medical graduates.
4.2	Pilot scheme of iTeach to endeavour to develop learning and teaching opportunities from everyday tasks, although very much in its infancy.
4.3	Process supporting learning from incidents including the monthly M&M meetings (although workload can be a barrier to attendance) and the ‘spotlight’ emails that share learning points among medical staff including doctors in training.

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	Induction for graduates from medical schools other than from UoG	Ensure that FY1s who are graduates of all medical schools gain a similar understanding as those graduating from UoG who have undertaken 'preparation for practice', as to how the IRH and how medicine and geriatric medicine 'work'
5.2	Access to all IT systems	Ensure that all trainees have passwords and training to access all IT systems they need for their role within the first few days of starting and before their first on-call duties.
5.3	Routine, scheduled process for trainees to feedback on the quality of training	A routine, regular, scheduled forum should be established at which all cohorts of trainees can feedback about their experiences and on the quality of training to management and training leads. This should apply to all cohorts of trainees and should enable feedback within a group setting and should ensure a degree of anonymity to those raising concerns.
5.4	Chief resident	Efforts should be made to restore the role of the chief resident as a means of ensuring all trainees' voices can be heard. [There was a perception that the attractiveness of this role has been devalued as it is thought to include delegation of responsibilities around fixing rota issues].
5.5	MSTeams channel for boarders	FY2s should also have access to this channel to support delivery of care to these patients.

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	Staffing levels, in particular at middle-grade level, must be sufficient for the workload and to ensure access to learning and training opportunities.	26 August 2022	F2, GP, IMT
6.2	Those providing clinical supervision must be supportive of trainees who seek their help and must never leave trainees	26 August 2022	All Levels

	dealing with issues beyond their competence or ‘comfort zone’.		
6.3	Work must be undertaken to ensure that IMTs, ST3s and GPSTs are supported to attend sufficient numbers clinics without compromise because of service needs.	26 August 2022	GP & IMT
6.4	Feedback to all levels of trainees on their management of acute receiving cases must be provided to inform their learning and training (aiming for feedback on ~40% of cases that trainees manage during a session of acute medical receiving).	26 August 2022	GP, IMT & ST3+
6.5	The department should ensure that service needs do not prevent trainees from attending scheduled formal local and regional learning opportunities.	26 August 2022	FY2, GP, IMT ST3+
6.6	The learning environment must support the provision of the WPBAs required to support training progression.	26 August 2022	GPSTs
6.7	All staff must behave with respect towards each other and conduct themselves in a manner befitting Good Medical Practice guidelines.	26 August 2022	All Levels