Scotland Deanery
Quality Management Visit Report

Date of visit	10th November 2021	Level(s)	FY, Core, Specialty
Type of visit	Triggered	Hospital	Glasgow Royal Infirmary
Specialty(s)	General Surgery	Board	Greater Glasgow & Clyde

Visit panel	
Dr Marie Mathers	Visit Chair – Associate Postgraduate Dean - Quality
Mr Alastair Moses	Training Programme Director
Dr Fiona Cameron	Associate Postgraduate Dean & Foundation School Director
Guo Liang Yong	Trainee Associate
Fiona Paterson	Quality Improvement Manager
Eddie Kelly	Lay representative
In attendance	
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)	Ms Jennifer Duncan

Unit/Site Information		
Non-medical staff in attendance	4	
Trainers in attendance	8	
Trainees in attendance	17x FY1, 3x FY2/Core, 11x Specialty	

Feedback session: Managers in attendance	Chief Executive		DME	x	ADME	x	Medical Director		Other	x

Date report approved by Lead Visitor	3rd December 2021

1. Principal issues arising from pre-visit review:

Following a deanery visit in June 2019 a number of concerns were raised regarding Foundation training at Glasgow Royal Infirmary. Along with several requirements made in the visit report the panel also stated their intention to revisit. The Foundation Quality Review Panel in August 2019 agreed a revisit should take place however due to the Covid-19 pandemic this was not possible to arrange.

Below is data from the GMC National Training Survey 2021 (NTS) and the Scottish Training Survey 2021 (STS).

GMC Triage List 2021

General Surgery - STS Level Triage List, number of red flags.
F1 Surgery - NTS Programme Group Triage List, number of red flags. Persistent low scores, significantly low for specialty.
F2 Surgery – NTS Programme Group Triage List, persistent low scores.

NTS Data 2021

F1 Surgery – Red Flags, Adequate Experience, Curriculum Coverage, Feedback, Overall Satisfaction, Reporting Systems, Rota Design, Supportive Environment. Pink Flag, Educational Supervision.

F2 Surgery – Red Flags, Induction, Study Leave, Supportive Environment. Pink Flags, Clinical Supervision, Clinical Supervision Out of Hours, Educational Supervision, Facilities, Overall Satisfaction, Reporting Systems, Rota Design, Teamwork.

CST – all white flags.

ST – Red Flag, Workload. Pink Flag, Regional Teaching.

STS Data 2021

Foundation General Surgery – Red Flags, Educational Environment, Teaching, Team Culture. Pink Flag, Workload.

Core CST – Pink Flag, Handover.

Core General Surgery – all grey flags.

ST – all white flags

The visit commenced with Mr Colin MacKay delivering an informative presentation to the panel which provided an update regarding the progress against the previous visit requirements.

2.1 Induction (R1.13):

Trainers: Trainers told us that all trainees receive induction to site. FY1 trainees receive a half day induction and prior to starting the role are sent an electronic pack which details their roles and responsibilities. Included within the induction are both common and rare surgical presentations and a peer to peer presentation from an FY1 of the previous cohort. Trainees are given the opportunity to query or ask for further information. We were told that to further improve the induction trainers planned to include a talk on immediate discharge letters (IDL's) to help address a recent disconnect.

FY1 Trainees: All trainees received an induction to the site. Trainees said the induction was adequate however, highlighted that they never received their allocated 'buddy' until a few weeks in post. To further enhance the induction trainees suggested providing more ward specific information to better prepare them as the roles and responsibilities for each ward can vary.

FY2 & Core Trainees: Trainees confirmed they received a good quality face to face induction which included a tour of the department. Trainees were sent the induction pack via email prior to starting. 1 trainee did not receive a 'General Surgery' induction and instead received a specific team induction which they felt adequately prepared them for their role.

Specialty Trainees: Trainees advised that they had all received a relevant induction.

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

Trainers: Trainers described a variety of formal teaching opportunities available to trainees. Specialty trainees have monthly teaching which is well attended. To help aid attendance at teaching sessions clinics are limited and consultant led. FY1 program teaching is mostly delivered online, trainees are encouraged to attend however trainers acknowledged the challenges in providing interruption free training. Within the Urology department trainees are encouraged to attend clinics and there are plans

to incorporate clinics into trainee timetables. Weekly departmental teaching is now recorded and stored online to allow trainees to access the sessions at a more suitable time and compliment the induction process. Other opportunities include:

- A surgical skills club delivered weekly prior to morning ward rounds.
- Core and clinical fellow trainees deliver weekly peer to peer teaching for their FY1 colleagues.
- Pharmacy teaching
- Morbidity & Mortality Meetings (M&M)

FY1 Trainees: Trainees stated that they struggle to attend teaching sessions due to workload pressures. Teaching is not bleep free and tasks are not delegated to others if they attend. Some trainees stated they regularly catch up on recorded sessions in their own time. Trainees told us that there is no designated area for them to attend their regional teaching.

FY2 & Core Trainees: Trainees told us that they are able to attend their regional teaching without barriers. Departmental teaching is delivered weekly and the majority of trainees can attend. Trainees value the Surgical Skills Club however attendance is limited due to the scheduled start time of 06:30hrs.

Specialty Trainees: Trainees reported that departmental teaching is scheduled on a Friday afternoon and they can attend in person or access online. All sessions are recorded and stored in a bank for future reference. The trainees commended the department for providing teaching sessions at the beginning of the pandemic which they recorded and shared with all Surgical teams within the deanery.

2.3 Study Leave (R3.12)

Trainers: Trainers advised that due to staff shortages and workload they are unable to grant universal study leave requests for FY2 trainees. All requests are reviewed on a case by case basis and reported they had managed to permit taster weeks for some trainees. They reported no barriers in approving study leave for specialty trainees.

FY2, Core & Specialty Trainees: Trainees reported no concerns in accessing study leave. The specialty trainees commended the consultants for their commitment to ensuring trainees study leave is approved.

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

Trainers: All trainers have time in their job plan for their supervisory role. They are well supported by the Deanery and are kept up to date with curricular changes from the Royal College of Surgeons.

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: The escalation policy is detailed at induction and trainees are made aware that senior escalation is expected. All wards have an up to date contact list. When trainees are not based on the wards they can access the rota's which are stored on a central hard drive. Senior trainees are always aware who to contact and have regular consultant contact during ward rounds. A recent change to the rota providing a designated 'night' and 'on call week' consultant has improved consultant accessibility for trainees. Within the Urology department there is an agreement that if the consultant is unavailable and an emergency arises, the surgical specialty trainee will support the core trainee until the consultant can attend. Trainers also reported they were unaware of any instances where trainees have felt they have had to cope with problems that are beyond their competence.

FY1: Trainees described a lack of clarity around the escalation process whilst working in the downstream wards and HDU/Critical Care unit (within hours). They told us that accessing timeous support can be difficult at times, which has resulted in them working out with their competence level. Registrar support was described as good however on occasions FY1 trainees felt they had to persuade registrars to help. Consultant interactions are limited.

FY2 & Core Trainees: Trainees reported that there is a clear escalation policy and they have no issues accessing senior support. They have not been expected to work beyond their competence and found consultants approachable and helpful. They commented that although they work in teams, FY1 trainees are ward based with a lack of continuity which may contribute to them being unsure of who to escalate to.

Specialty Trainees: Trainees can access senior support both during the day and out of hours. Trainees do not feel they have to deal with problems beyond their competence. They told us that each patient has a named consultant and the consultants are both accessible and supportive when called. There is a separate page for the middle grade doctor and everyone is aware of this. On each ward there are a list of names and page/phone numbers for escalation.

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

Trainers: Trainers acknowledged the impact of the Covid 19 pandemic on elective surgical experience for trainees. They advised they have attended webinars and bootcamps to learn about the upcoming changes to the surgical training programme and are further supported by the training programme director.

Within the Colorectal department trainees meet with a consultant at the start and middle of their post to discuss their learning needs and the rota is tailored to support this. Overall, trainees have excellent exposure to emergency surgeries and can access some elective work (hernia, gallbladder) at Stobhill Hospital. Trainers reported that this placement is a popular choice for senior trainees due to the volume and diversity of cases available.

Trainers commented that FY1 trainees are ward based and although opportunity to get to theatre or clinics are limited, there is opportunity to clerk in patients and present on ward rounds when working on the receiving wards.

FY1 Trainees: Trainees reported limited patient interaction in their roles and commented that the majority, of their time is spent carrying out admin tasks which are of little or no benefit to their training or education. All trainees are assigned a week working on the receiving ward and while that is designed to provide opportunities to clerk patients and get feedback, trainees commented that this leaves the rest of the team short in completing their ward work and either nurse practitioners or middle grade trainees complete the clerking. Trainees can develop their skills of managing unwell patients when attending acute emergencies as first on call.

FY2 & Core Trainees: Trainees reported no concerns in achieving learning outcomes for their post. FY2 trainees spend time working in the high dependency unit (HDU) which allows them to develop their skills in managing acutely unwell patients, Core trainees are allocated a week working in the GP assessment area.

Specialty Trainees: Trainees reported that Covid has impacted learning opportunities particularly, elective procedures. Very little time is spent carrying out duties of little or no benefit to training.

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

Trainers: Not asked

FY1 Trainees: Trainees reported difficulties in obtaining workplace-based assessments. They advised that whilst working in the receiving unit during the day there is no senior to supervise assessments. Trainees commented that the junior and middle grade trainees do encourage them to complete assessments where possible.

FY2 & Core Trainees: Trainees confirmed that in general they were able to complete Workplace Based Assessments and have them signed off easily. They felt they were assessed fairly and consistently.

Specialty Trainees: Trainees reported that they have no issues completing their WPBAs.

2.9 Feedback to trainees (R1.15, 3.13)

Trainers: Trainers felt informal feedback was regularly provided to trainees during ward rounds and was delivered in a constructive manner. FY1 doctors working on the receiving wards attend the morning 8am handover with a consultant and registrar and can receive feedback at this time. Any concerns with a decision made by an FY1 overnight would be discussed with their educational supervisor. There is no formal mechanism of feeding back on decisions made that have not been escalated.

FY1 Trainees: Trainees told us that feedback can be variable and again highlighted the limited decision-making opportunities available to them. On occasions feedback has been given to an individual to disseminate amongst the FY1 cohort and they felt this would have been more beneficial in a group setting to allow discussion. Trainees were aware of the Greatix system however no trainees present had received one. When attending morning handover, they occasionally can present any patients they clerked in or patient who took seriously unwell throughout the night.

FY2 & Core Trainees: Trainees felt that they receive a reasonable amount of feedback when on call during the day as they attend twice daily ward rounds. OOH immediate feedback is provided informally by their registrar colleagues and they have the opportunity to present at morning handovers which are well attended by consultants.

Specialty Trainees: All trainees confirmed they have ample opportunity to receive feedback.

2.10 Feedback from trainees (R1.5, 2.3)

Trainers: Not asked

FY1 Trainees: Trainees were aware of a specific FY1 departmental meeting that they could raise any concerns however, highlighted the 2 meetings that had taken place during their post had not been very well attended. Trainees were not aware of the chief resident and their role in the department

FY2 & Core Trainees: All trainees would raise any concerns with their educational supervisor.

Specialty Trainees: Trainees told us that there is a weekly Oesophagus & Gastric (OG) meeting where they can discuss any educational or training needs and their rota would be amended to accommodate. The Colorectal team have a designated registrar review meeting and present their logbook, conferences attended and exams. Any actions required are discussed with the consultant and rota coordinator and similar to the OG team, the rota will be amended. Trainees were not aware of a formal way in which they could raise concerns about the quality of their training as a group.

2.12 Culture & undermining (R3.3)

Trainers: Trainers reported that from induction they welcome trainees to the department and promote a positive team culture. They ensure trainees are aware of their expectations, the value of their role and what opportunities are available to them. FY1 trainees have a 6 weekly meeting with trainers and this is an opportunity for both to feedback any areas for improvement. The department have implemented a buddy system for junior doctors and there are 2 chief residents to allow peer to peer discussion. Trainers detailed 2 instances of undermining which had been escalated and adequately addressed.

FY1 Trainees: Trainees said that they receive good support from their registrar colleagues. They described support from consultants as variable. Trainees detailed an incident where they were threatened with 'Datix' by a member of the nursing staff, should they interrupt a consultant led ward round to pass on patient information. They also shared instances of being undermined and yelled at

on ward rounds. None of these instances were escalated and trainees were unaware of a formalised process to do so.

FY2 & Core Trainees: Some trainees had witnessed undermining behaviours from the nursing staff to their FY1 colleagues. They would escalate any concerns to Mr Mansouri as the FY1 lead and Mr McKay for all other. Trainees commented that they receive good support from both the pancreatic and colorectal team.

Specialty Trainees: All trainees felt they worked in a very supportive environment where mistakes are discussed in a productive manner and used as a learning opportunity. Some trainees had witnessed undermining or bullying behaviours but, felt these had been escalated and dealt with appropriately. Due to the supportive relationship with their educational and clinical supervisors, trainees would raise any concerns directly with them.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Trainers reported that there are no gaps on the current rota. Sickness gaps are offered to trainees at bank rate pay. The current specialty rota has not been reviewed in the past 5 years, there have been discussions to review this however, they have not yet happened. Trainers were unaware of any aspects of the post that compromise trainee wellbeing.

FY1 Trainees: Trainees felt gaps on the rota were not well managed and told us they have been contacted last minute to provide cover. They described their workload as unmanageable and provided examples of working 12hour shifts with no breaks, 70+ hour weeks and a high frequency of back to back out of hour shifts. Trainees can be based in a ward for 2 days before moving to another ward and the discontinuity is affecting their learning opportunities. They highlighted that they are told by their senior colleagues to take their breaks but this results in them having to stay later to complete the tasks or passing on an unmanageable workload to the next shift. They stated the rota has been monitored on and found to be non-compliant.

FY2 & Core Trainees: Trainees confirmed there are no gaps on their rota and occasional sickness gaps are offered to them at locum rates. They commented that their rota is compliant and very different to the FY1 rota. They do not believe the rota is impacting on their wellbeing.

Specialty Trainees: Trainees reported no gaps on their rota. Providing cover throughout the pandemic had limited training opportunities however, they felt consultants we appreciative of this and they were offered an extra training list or time in lieu to cover. Trainees commended Ms Katrina Knight in ensuring both junior and senior trainees are allocated training opportunities on the rota within the colorectal team. Trainees do not feel the rota impacts their wellbeing and they reported receiving 1 day off post weekend and 2 days off post night shifts.

2.14 Handover (R1.14)

Trainers: Not asked

FY1 Trainees: Trainees advised there are daily structured written handovers in the receiving wards which are consultant led and working well. Downstream handovers are a concern as FY1 doctors are not team based and do not participate nor receive formal output from the handover. FY1 trainees do complete a peer to peer handover however this is not formalised and relies on the trainees gathering information from the ward round and sending via WhatsApp. Trainees felt handover was not used as a learning opportunity.

FY2 & Core Trainees: Trainees reported they attend written, formalised handovers for both the acute and downstream wards. They advised that FY1 trainees do not attend nor have access to the multiple team based handovers that take place. Handover on the acute wards can be used as a learning opportunity.

Specialty Trainees: Trainees advised that handover on the acute wards takes place at 8am and 8pm daily. Weekend elective handover has been improved and each patient file now has a formalised yellow sticker attached which details diagnosis, management plan and required tasks for the on-call team. Trainees felt that on call and weekend handovers were the most structured. Trainees try to provide learning opportunities at the on-call handover for FY1 trainees taking time to explain relevant 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: Not asked

FY1 Trainees: Most trainees were unaware how to raise concerns regarding the quality of their training. Some trainees commented this could be done via the department meeting. Very few trainees were aware of the chief residents within the department.

FY2 & Core Trainees: Trainees commented they would raise any concerns with the quality of the training received with their clinical supervisors. Mr Vella was noted as a point of contact for Core trainees.

Specialty Trainees: The majority of trainees choose to stay within the unit and believe that is testament to the positive training environment. Any concerns with training would be raised via the trainee representatives or directly with supervisors.

2.18 Raising concerns (R1.1, 2.7)

Trainers: Not asked

FY1 Trainees: Trainees were confident that any patient safety concerns would be heard and addressed promptly.

FY2, Core & Specialty Trainees: All trainees reported they had no patient safety concerns and if they did these would be raised initially with senior staff and then escalated as appropriate.

2.19 Patient safety (R1.2)

Trainers: Trainers said the department provides a safe environment for patients. They acknowledged challenges over the past 18 months due to isolating patients with Covid, a lack of single occupancy rooms and ensuring infection control measures are met.

FY1 Trainees: The majority of trainees reported they would not feel comfortable if a friend or relative were to be admitted to the department. This is due to perceived medical and nursing understaffing throughout the hospital and the burden of what they described as unmanageable workloads in the receiving unit.

FY2, Core & Specialty Trainees: Trainees reported that they would have no concerns about the quality and safety of care a relative or friend would receive if admitted to the department

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

Trainers: Trainers reported that adverse incidents are escalated and reviewed at Morbidity & Mortality (M&M) meetings and learning points share with the department. There is also a yearly hospital wide meeting to share learning more widely.

FY1 Trainees: Trainees reported that adverse incidents are reported through the Datix system. Trainees present who had submitted a Datix, had not received any feedback or response. Trainees are invited to attend clinical governance meetings but are unable to attend due to their workload.

FY2 & Core Trainees: Trainees advised they would report any incidents to the department lead and any learning outcomes would be disseminated if required.

Specialty Trainees: Trainees reported using the Datix system to report an adverse incident. These are discussed at M&M meetings and are very well supported within the department.

2.21 Other

Trainees were asked to rate their overall satisfaction experience of working within the department from a range of 0 (very poor) to 10 (excellent). The scores are listed below:

- FY1 – Range 1-6, Average 3.4
- FY2 & Core – Range 9, Average 9
- Specialty –Range 8-9, Average 8.75

DME Action Plan: Triggered Visit 21st June 2019 (Carry forward to new action plan not met/partially met)

Ref	Issue	Update March 2020 Action(s)	Requirement: Met, partially met, not met
8.1	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.	Inductions continue, with catch up sessions made available for anyone who can't attend. Feedback from trainees incorporated into inductions	Met
8.2	A process must be put in place to ensure that any trainee who misses their induction session is identified and provided with an induction.	Recording hasn't taken place, but catch up sessions available and copies of the presentations emailed to the group. Plan is to record the August induction	Met
8.3	Rota/ timetabling management must be addressed to eliminate frequent, short notice, movement of trainees away from their base ward.	Hybrid team/ward based rota confirmed for April 2020 and feedback will be sourced from the trainees and trainers. Movement across wards minimized, although balanced with allowing experience across all shift types	Partially met
8.4	Ward handover must be formalised and happen consistently in all ward areas to ensure safe handover and continuity of care.	Medical shared drive in place and used to store all handover documents. New structured evening handover introduced and further changes implemented following feedback from the trainees	Partially met see requirement 6.6
8.5	Ensure those undertaking the role of Educational Supervision understand their responsibility to engage with the process.	List of trainees circulated to the trainers before the block starts and trainees have an escalation process	Met
8.6	All Consultants who are trainers must have time within their job plans for their roles to meet GMC	All job plans continue to have time allocated for training	Met

	Recognition of Trainers requirements.		
8.7	All staff must be behave with respect towards each other. Specific example of undermining behaviour noted during the visit has been shared out with this report.	Processes remain in place for reporting incidents and trainees aware of policies	Partially met see new requirement 6.1

3. Summary

Is a revisit required?	Yes	No	Highly Likely	Highly unlikely

The visit panel recognised the efforts made to make improvements against the previous visit report action plan during the pandemic. Progress was noted against some of the requirements however there remain areas that require further improvement. The visit panel found serious concerns relating to the educational environment and training opportunities available to the FY1 trainees. This is reflected in their overall satisfaction scores. The visit panel are highly likely to revisit within the next year to ensure progress is achieved in a reasonable timescale.

The positive aspects of the visit were:

- Enthusiastic, supportive and approachable group of trainers committed to create a strong and positive training environment for surgical training, this has been supported by time in job plans for trainers.
- Adjustments made to ensure specialty trainees gained the required curricular requirements despite the drop in elective procedures due to the pandemic.
- Wide range of complex cases available to middle and higher trainees
- Varied programme of teaching activities available both online and face to face including the Surgical Skills Club. The online bank of recorded teaching presentations is valued in particular, by the higher trainees studying for exams. During the pandemic response the department were able to offer inhouse teaching and shared this widely within the region.
- Chief resident structure is working well however, the FY1 were not fully aware of this role and what they may deliver for them.

The less positive aspects of the visit were:

The educational experience of FY1 doctors in training:

- The burden of non-educational tasks is a barrier to their education and training particularly in the downstream wards
- They struggle to access local formal teaching opportunities because of the demands of service
- The rota is affecting trainee wellbeing.
- Lack of clarity on escalation process and difficulty in accessing support in a timely manner
- It appears this cohort are not as embedded in the positive team experience reflected by other cohorts and have witnessed or been subjected to undermining behaviours.

4. Areas of Good Practice

Ref	Item	Action
4.1	Sharing department teaching throughout the pandemic with the wider surgical teams throughout the region	

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	2.10	The department should publicise the identity and function of the chief resident to all grades of trainees
5.2	2.12	Trainees should not be threatened with the use of Datix as a performance management tool.
5.3		

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	All staff must be behave with respect towards each other and conduct themselves in a manner befitting Good Medical Practice guidelines.	6 months	All
6.2	There must be a protected formal teaching programme for doctors in training.	6 months	FY1
6.3	Medical staffing must be reviewed to ensure this is appropriate to safely manage the workload, with consideration of employing more non-training medical staff.	6 months	FY1
6.4	FY1 Trainees must be provided with clearly identified seniors who are providing them with support for all clinical areas they cover particularly downstream wards and HDU/Critical care (In hours)	6 months	FY1
6.5	Handovers involving FY1 trainees on the downstream wards must include senior input to ensure patient safety and learning opportunities.	6 months	All
6.6	Tasks that do not support educational and professional development and that compromise access to formal learning opportunities for FY1 doctors should be reduced.	6 months	FY1
6.7	A process for providing feedback to FY1 doctors on their input to the management of acute cases must be established. This should also support provision of WPBAs.	6 months	FY1
6.8	The discontinuity of ward placements for FY1 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. The duration of ward attachments of Foundation doctor must be increased to be for at least 4 weeks.	6 months	FY1