Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	15th March 2022	**Level(s)**	FY1, FY2, IMT, CT, GP, ST
Type of visit	Triggered	**Hospital**	University Hospital Wishaw
Specialty(s)	Medicine	**Board**	Lanarkshire

Visit panel	
Dr Greg Jones	Visit Chair - Postgraduate Dean
Dr Marie Mathers	Associate Postgraduate Dean – Quality
Dr Claire Gordon	Foundation Programme Director
Dr Tracey Bradshaw	Training Programme Director
Dr Sarah-Jane Baldwin	GP Programme Director
Dr Duduzile Musa	College Representative
Mr Neil Logue	Lay Representative
Mrs Hazel Stewart	Quality Improvement Manager
In attendance	
Alison Ruddock	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	
Trainers in attendance	8
Trainees in attendance	FY1/FY2 – 9, GPST – 1, CT/IMT – 7, ST - 5

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

Date report approved by Lead Visitor	29/03/2022

1. Principal issues arising from pre-visit review:

General Internal Medicine at University Hospital Wishaw was last visited in 2016 when it was on enhanced monitoring. At the Medicine and Foundation 2021 Quality Review Panels a triggered visit to University Hospital Wishaw was recommended. This was due to the IMT Programme trainee experience at Wishaw as well as the Acute Internal Medicine and Geriatric Medicine posts being on the GMC Triage list, meaning that it was in the bottom 2% of all sites within the UK. The data for AIM and Geriatric Medicine relates to the training experience of all levels of trainee (Foundation, Core, GP, IMT and ST) in a specific post.

NTS Data 2021

Triage Data (Post and Programme)

NTS POST TRIAGE DATA

Trust / Board	Site	Post specialty	N	Red flags	Changes in scores	Low scores	Triple reds
Lanarkshire	University Hospital Wishaw - L308H	Acute Internal Medicine	4	98.7%		96.6%	
Lanarkshire	University Hospital Wishaw - L308H	Geriatric medicine	7	99.3%	84.4%	96.6%	95.5%

NTS PROGRAMME TRIAGE DATA

Trust / Board	Site	Programme Group	N	red flags	Significant Change	significantly low	persist low
Lanarkshire	University Hospital Wishaw - L308H	Medicine F1	12	91.5%	86.3%	92.8%	0.0%
Lanarkshire	University Hospital Wishaw - L308H	Medicine F2	3	96.2%	84.8%	95.2%	97.7%
Lanarkshire	University Hospital Wishaw - L308H	IMT Stage One	7	93.3%		98.5%	

Acute Internal Medicine (AIM) & Geriatric Medicine posts were in the bottom 2% due to the number of red flags, but also in the bottom 10% due to Low score and Triple red flags (a red flag for 3 consecutive years).

IMT Programme was in the bottom 2% due to significantly low scores, but also in the bottom 10% due to the number of red flags. In addition, the experience of Foundation Year 1 and 2 Trainees was in the bottom 10% due to the number of red flags, significantly low scores and persistently low scores.

The programme data showed negative outliers (pink or red flags) in the majority of indicator areas for 1 or more levels of trainee. These are noted within the table below.

Indicator	Negative Outlier
Adequate Experience	
Clinical Supervision	FY2, ST
Clinical Supervision out of hours	FY2, GP, ST
Curriculum Coverage	FY1, FY2, GP, IMT
Educational Governance	FY2
Educational Supervision	FY1, FY2, ST
Facilities	IMT
Feedback	ST
Handover	FY2, ST
Induction	FY1, FY2, GP, ST
Local Teaching	FY1, IMT, ST
Overall Satisfaction	FY1, IMT
Regional Teaching	
Reporting systems	GP
Rota Design	FY2, GP, IMT, ST
Study Leave	IMT, ST
Supportive environment	FY2, GP
Teamwork	FY2, IMT
Work Load	

Scottish Training Survey (STS)

The STS is completed by trainees at the end of each post rather than at one specific time in the training year (which the NTS reflects) and is comparing the experience of all other trainees in hospitals across Scotland only.

The STS indicates a marginally better experience, with no post or specific level of trainee experience in the bottom 2%. However, some specialties and posts are within the bottom 10%:

- General Internal Medicine, Foundation Level – Red Flags
- Acute Internal Medicine, All Trainees – Red Flags
- Cardiology, All Trainees – Aggregated Red Flags

- General Internal Medicine, All Trainees – Red Flags
- Geriatric Medicine, All Trainees – Red flags, change in score and low score

A pre-visit questionnaire provided the most up-to-date feedback from trainees. This indicated that there remains a number of areas of concern which are reflective of the NTS and STS data.

This visit will take the opportunity to gain a broader picture of how training is carried out, particularly within the ongoing challenges posed by COVID-19, and discuss the concerns raised through survey data. It will also provide both trainees and trainers with the opportunity to highlight any areas that they feel are working well in relation to training.

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 following training cohorts met with the visit panel:
Foundation Year 1 and 2 – FY1, FY2
General Practice – GP*
Acute Care Common Stem (ACCS) and Internal Medicine Training – ACCS/IMT
Specialty Trainees – ST
**The panel only met with one GP trainee. To provide greater anonymity and more rounded feedback, the responses from the pre-visit questionnaire (PVQ) are included within this report.*

2.1 Induction (R1.13):

Trainers: Trainers reported there are 2 opportunities to attend the medicine induction. Anyone unable to attend can access the slides online. It was acknowledged that virtual inductions may lack the same level of welcome that an in-person induction provides, but overall felt that it was well run. Departmental induction varies for each department, with acute medicine providing an induction over the initial 2-week period to ensure all trainees are able to attend. Other departments, such as geriatrics and respiratory medicine will provide small group inductions or a one to one induction for any trainees unable to attend. Trainers felt that the induction provided was comprehensive and well

run and provided information such as the roles and responsibilities of trainees in the department. Trainers were aware of a previous issue where trainees may be unclear on who to contact for support when the specialty is off site and praised the work undertaken by the trainees that developed an application to enable them to know who to contact.

FY: Trainees reported that they received a hospital induction and could not suggest any improvements to this. Not all received a departmental induction due to starting work at night. Other trainees reported that due to rotas being issued after starting in post, they had been provided with a departmental induction to the wrong department and no subsequent induction was offered to them. Foundation Year 1 trainees found the shadowing time helpful, although there was suggestion that the extended 2-week shadow period was more beneficial as this included more practical information about their roles and responsibilities in wards.

GP: Trainees reported they received a good quality hospital and departmental induction. It was suggested that it would have been helpful to have the shift patterns explained during the site induction and the departmental induction could be improved by informing trainees of their roles and responsibilities when working at the week.

ACCS/IMT: Not all received or were aware of a hospital induction. This resulted in some trainees commencing work without appropriate login information, despite highlighting concerns prior to starting in post. Other trainees felt that it was unclear if they should attend the online induction from home or not, with no clear guidance as to what would happen when continuing work in the afternoon. Trainees indicated that they received no structured departmental induction and basic information was not provided to them, such as: roles and responsibilities and how the referral system works. Others has no awareness of the open 2-week induction provided within acute receiving. Some trainees received an ad hoc tour from another trainee towards the end of their shift which they felt was the most useful information given to them.

ST: Trainees reported that some did not receive a hospital induction with no catch-up provided. Those that attended felt the induction was of a similar quality to other sites, but none were aware of the slides being available to them after the induction. Trainees reported that they received a departmental induction which covered the relevant information but felt that they required to complete

a shift to fully understand their roles. It was suggested that more signposting would be beneficial to their knowledge and understanding of new and/or changing local guidelines.

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

Trainers: Trainers reported that local teaching has just started to resume but is not bleep free. There is clinical teaching on the ground and ad hoc teaching to IMT trainees for assessments such as PACES. They reported that the Journal Club is now restarting, and Grand Rounds had recommenced the previous week. There is also a 'boot camp' course being introduced in the MEDED as part of the IMT national training programme to further equip IMT trainees and ease anxieties of working out of hours. Trainers reported that they ask trainees to try to group missed teaching sessions together and apply for a day's study leave. It was acknowledged that on-site access to online teaching is problematic due to a lack of suitable space and hardware, such as: headphones and working computers.

FY: Trainees reported that there is no departmental teaching provided. Trainees reported that there is a weekly teaching session for FY1 trainees, but it is not bleep free and attendance is dependent upon their workload. Trainees reported that there is no option for this to be done online and therefore no ability to record and catch up on the teaching at a later date. Some also suggested that recent topics were of little use to them, such as prescribing and discharge letters, as they had been in post for almost 8 months. It was felt that these topics would have been more relevant nearer the start of their training year. There is also a weekly teaching session for FY2 doctors, however, at least one trainee had only managed to attend once in 14 weeks due to lack of suitable facilities and hardware on site.

GP: At least one trainee is able to attend 1 hour of weekly departmental teaching bleep free. It was suggested that the ability to attend teaching will vary depending upon the number of staff on the ward. All other trainees reported that there is no departmental, local teaching provided to them and they would welcome a formalised timetable of local teaching sessions. Study leave is required to attend regional teaching sessions. However, some felt they were unable to apply to attend a regional teaching session due to the late issuing of the rota.

ACCS/IMT: Trainees reported that there is currently no local teaching being provided to them, but they had heard that this may be restarting. However, the trainees felt that they would be unlikely to be

able to attend local teaching due to the high workload. Trainees reported that they apply for study leave to attend their regional programme teaching sessions. If on-call, trainees reported that they cannot attend the regional teaching session and would have to watch it at a later date in their own time. Attendance at regional teaching varied from 1 – 3 out of 5 sessions.

ST: Trainees reported the Grand Round had recently restarted. However, there had been no other local teaching provided to them. Some were aware of a plan to restart the journal club and other lunchtime teaching but nothing was formalised yet. Regional teaching is online, however some felt that due to teaching now being a half day rather than a full day's teaching, it was more difficult to take the time to watch the session live. Trainees reported that they can catch up on the regional teaching sessions but this has to be done in their own time.

2.3 Study Leave (R3.12)

Trainers: Trainers reported that study leave has been introduced and is approved, if submitted with sufficient notice. It was temporarily suspended in 2021 due to the exceptionally high workload demands and staffing shortages due to COVID.

FY: FY2 trainees are able to take study leave, although it was reported to be challenging to take leave at times due to last minute covering being required due to sickness absence.

GP: Trainees reported that they can take study leave, although requesting it can be challenging if they are waiting for their rota to be issued.

ACCS/IMT: Trainees reported they are able to take study leave if there are sufficient staff in the ward.

ST: Trainees reported that their study leave requests had been approved.

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

Trainers: Trainers reported that although they have the allocated time in their job plans for supervising trainees, using this has been very challenging due to the workload intensity. Similarly,

trainers reported that plans to meet with their trainee(s) can require to be rescheduled at short notice due to workload and last-minute sickness absences.

FY: Trainees reported that they had met their educational supervisor at least once and agreed a learning plan.

GP: Trainees reported not all had had the opportunity to me with their hospital supervisor or agreed their educational objectives.

ACCS/IMT: Not all trainees had met with their educational supervisor. At least one had missed their meeting due to high workload on the ward. Another trainee reported that their originally allocated supervisor had no awareness of their curriculum needs and were therefore appointed to a different consultant to provide educational supervision.

ST: Trainees reported that they had met with their educational supervisor and agreed a personal learning plan.

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 a list of trainees and their different grades are provided in some departments to inform staff. Within acute medicine, trainers suggested that there is less differentiations of the different trainee grades, primarily due to covid and staffing pressures requiring trainees to take on more challenging work as well as more senior trainees (and consultants) having to undertake basic tasks, such as phlebotomy. Trainers reported that the consultant cover, especially at the front door, has increased and provide more support to trainees. Trainers indicated that trainees are usually aware of who is on-call for support but if, for any reason, they were not aware, then the switchboard would put them in touch with the on-call consultant. Trainers reported that they would discuss with a trainee to confirm that they are willing and capable to step up a level and are supported in doing so.

FY: Trainees reported that they know who to contact for supervision. A number of trainees reported that they felt they've had to cope with problems beyond their competence, such as being the most senior doctor on a ward or working out of hours in HDU. Trainees acknowledged that they can

contact a more senior colleague for support, but it may take some time to receive the support if the senior trainee is busy with another patient. Trainees felt that senior support was less available to them when their concern was not acute, such as breaking bad news to a patient or relative. Trainees did feel that senior colleagues were more accessible and approachable when staffing levels were better.

GP: Trainees reported that they are aware of who to contact for supervision or support both during the day and out of hours. None of the trainees felt that they required to work beyond their level of competence and senior colleagues are very approachable.

ACCS/IMT: Trainees reported that they know who to contact for supervision and support both during the day and out of hours. On occasion trainees have felt that the supervision was not appropriate, such as having to contact a senior trainee on the front door when undertaking a procedure. It was felt that it was inappropriate to contact the on-call medical registrar to supervise a procedure, such as large volume paracentesis (LVP), when there is a consultant on the ward and this has, at times, led to treatment delays... Some trainees felt they've had to work beyond their competence, particularly when carrying the bleep out of hours for HDU and CCU, as they do not have the opportunity to work there during the day. Trainees reported that they had raised concerns about this and the overwhelming volume of patients to manage out of hours but did not feel that their concerns were adequately resolved.

ST: Trainees reported that they know who to contact for supervision both during the day and out of hours. None of the trainees felt that they had had to work beyond their competence and found their senior colleagues to be very friendly and approachable.

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

Trainers: Trainers reported that it can be challenging to keep up with the changes to the curriculum, especially as there has been a lot of changes during the pandemic. The IMT Training Programme Director who works on site, reported they have tried to update trainers and will send out emails regarding curriculum changes. Trainers indicated that the trainees have a good awareness of their curriculum needs and can discuss this with their supervisor to ensure their needs are met. Trainers reported that a lot of effort has been made to providing outpatient clinic opportunities to trainees,

particularly IMT trainees. However, trainers acknowledged that they' initially had issues with appropriate accommodation to enable trainees to participate in clinics but the ward workload continues to be challenging for trainees to feel able to leave the wards to attend clinics, but they will continue to encourage trainees to attend clinics during their clinic weeks. Trainers reported that they try to provide a good balance between service delivery and training opportunities for trainees, but the ongoing workload pressures due to covid and sickness absences mean that this is not always possible.

FY: Trainees reported that they are concerned they won't meet their teaching requirements due to a lack of departmental teaching. They do not have the opportunity to attend any outpatient clinics. Trainees felt that their post provides plenty of opportunities to develop their skills in managing acutely unwell patients, but this was more out of necessity due to staff shortages. Some trainees reports that workload demands result in them having to stay on beyond their rostered hours to have the opportunity to discuss their learning outcome. Due to the high workload and lack of opportunity to discuss their learning outcomes with senior staff, trainees felt that their post was between 70% and 90%.

GP: Trainees reported they believe they can attend clinics but have not done so to date. It was suggested that it would be beneficial to have a clinic rota for GP trainees, similar to senior trainees, to better enable them the opportunity to attend outpatient clinics. Although it was felt that having more time freed up to attend clinic would aid in their training progression, trainees felt that only around 25% of their time was spent on solely service delivery work.

ACCS/IMT: Trainees reported that it is very challenging to achieve both their procedural skills and attendance at outpatient clinics. Trainees reported that whilst there are lots of opportunities to undertake the required procedures, there is a lack of available senior staff to supervise them and have these signed off. Workload also impacts attendance at outpatient clinics, with trainees reporting that workload on the wards has prevented them from attending clinics, being turned away from a clinic due to arriving late (despite informing the consultant that they were late due to ward commitments) or only being given the opportunity to observe rather than participate in clinics. Trainees reported that there are plenty of opportunities to develop their skills in managing acutely unwell patients, but this is more due to having to work outside their comfort zone due to staff shortages, rather than it being a supported learning opportunity. Trainees felt that everything within

their post could be beneficial to their development if the learning opportunity, through discussion with senior staff, was available. This resulted in trainees feeling that more than 50% of their time was spent on service delivery rather the development and education.

ST: Trainees reported that attendance at clinics is very ad hoc and they would like to be able to attend more clinics. Rheumatology trainees do not work in the general medicine rota and therefore are able to attend the majority of their clinics. However, it was felt attendance at planned clinics can cause workload issues for other trainees as they are still counted on the rota as being on the ward rather than at a clinic. Trainees reported that there is no shortage of opportunities to develop their skills in managing acutely unwell patients, but again, this was more out of necessity due to workload intensity, rather than planned learning. Trainees felt that there was a lot of service provision (60% - 80%) but felt this was due to the current high workload a lack of Foundation doctors and nursing staff, resulting in a trainee covering a consultant clinic one day, then doing phlebotomy the next.

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

Trainers: Not asked due to time constraints.

FY: Trainees reported that levels of staffing tend to determine how easily they can complete their assessments. They felt that it was more challenging when working on the wards as there is not always someone available to observe them, but they have never been refused supervision for an assessment when requested. Trainees felt that the feedback for their assessments is very thorough and appropriate to their level of training.

GP: Trainees that had undertaken a workplace-based assessment (WPBA) reported they are able to complete them easily and the feedback provided for this is supportive.

ACCS/IMT: Trainees reported that they can easily complete their WPBAs when working within HDU and at the front door. However, trainees felt unable to complete assessments when working in the downstream wards. Some trainees reported that they are only able to achieve their ACAT assessment if they stay on after their nightshift. At least one trainee reported that they have seen the clear development of some clinical development fellows, who have only worked at the front door, as they work alongside the same consultants and gain more training experience compared to trainees

who can be moved to multiple wards in the same week. The trainee found this disheartening, as they had worked hard to achieve a training post but felt they were receiving a poorer training experience.

ST: Trainees reported that it is usually easy to complete their assessments, and these are completed in a fair and consistent manner.

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: Not asked due to time constraints.

FY: Trainees reported that they do not receive informal feedback on their clinical decisions. Trainees reported that it is clear that some consultants are very keen to teach them but do not have the time to do so due to the workload intensity.

GP: Trainees reported that they have received little to no feedback, but feedback opportunities are more likely when in the post take ward.

ACCS/IMT: Trainees reported little to no feedback is offered to them, but they can easily seek feedback when working in ambulatory care. They felt too tired following a nightshift to attend the wardround and do not do post take round during the day to be able to receive feedback. It was also reported that due to a number of cardiology consultants being off work, they are reviewing a large number of cardiology patients with no feedback as to whether their plans were appropriate.

ST: Trainees reported that they do receive feedback but not a huge amount overall. It was suggested that more informal positive feedback would be welcomed as when it does occur, it gives the trainee a significant morale boost. Trainees felt that day to day informal feedback is limited, but that workload intensity is likely a reason for this.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: Not asked due to time constraints.

FY: Trainees reported that the deputy chief resident is very active in seeking feedback from trainees on their experience and concerns. Some trainees reported that they had a brief 10-minute meeting with their programme director, but felt that it offered little opportunity to discuss their concerns. However, trainees had not had any other opportunity to feedback to the management team on their experience.

GP: Trainees reported that they have either not felt the need to provide feedback on their experience in post as they're only in post since February, or that they would provide feedback through the training surveys.

ACCS/IMT: Trainees reported that they had an opportunity the previous week to feedback on their experience to a consultant near the end of a trainee forum meeting. They also complete training surveys as a means of feedback back on their experience.

ST: Trainees reported that they would complete surveys and attend the previous week's trainee forum to feedback on their experience. Trainees also reported that another meeting had been arranged for the week of the visit but had to be cancelled due to staff shortages. They felt that this encapsulated the issues as a whole, whereby initiatives are planned but are subsequently cancelled due to workload intensity and staffing shortages.

2.12 Culture & undermining (R3.3)

Trainers: Trainers reported that trainees have access to specific people to discuss any concerns. They reported that the training quality lead meet regularly with trainees where there is the opportunity for them to raise any issues they may have faced. Trainers felt that there is a lack of hierarchy within the departments which they hoped enabled trainees to approach them and provide a supportive team environment. Trainers did acknowledge that at times there could be a less positive experience due to workload and stress, but that they try to resolve any issues that may arise. Trainers also reported that

the hospital had opened a wellbeing area for trainees to go to and relax and discuss things in a psychologically safe area.

FY: Trainees reported that their clinical team and senior colleagues are very supportive. However, it was suggested that handover can be intimidating with the occasional feeling that their competence is being questioned, which was felt could be undermining of their confidence. Trainees were not aware of any formal channels should they wish to raise a concern in relation to bullying or undermining behaviours**.**

GP: Trainees reported that their senior colleagues are friendly and the ward and charge nurse are very nice. They suggested that relationships with emergency medicine staff can be challenging but staff remain helpful. None of the trainees had witnessed or experience any bullying or undermining behaviours. They would be comfortable in raising any such concerns with a consultant, but are not aware of any formal process.

ACCS/IMT: Trainees reported that senior level trainees are extremely supportive, however they felt that consultants were more variable and specialty dependent. Trainees indicated that some consultants are very supportive, but others would leave trainees to cope on their own. A concern was raised regarding a colleague, but it was felt that the concern was disregarded until others reported similar concerns. Trainees reported that they would be more likely to raise a concern with a senior level trainee, as many felt they hadn't had the opportunity to build a rapport or meet with their supervisor.

ST: Trainees reported that they work within a very supportive team. None of the trainees had experienced any bullying or undermining behaviours. If they were to, trainees stated that they would speak to their supervisor, but would also be comfortable to approach any senior colleague.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Trainers reported that there has been a huge workload over the past 18 months. Whilst the departments try to cover as much workload as possible, the combination of a significant increase in patients, shortages of locums and sickness absences remains a challenge to covering gaps in the rota. Trainers reported that the trainees have WhatsApp groups to try and arrange cover for gaps

themselves. They noted that this is not always possible and have to ask trainees directly at times (based on a rotating list) if they can cover some shifts, even if it is only part of the shift. They felt that these discussions with trainees were done so in a sensitive manner as they too understand the challenges of taking on more work.

FY: Trainees reported there are unfilled gaps in their rota. Some had had the opportunity to feedback about their rota, but indicated that attempts to change the rota had not necessarily led to any improvements. Trainees reported that they find some aspects of their rota very challenging, in particular, a run of 7 days in a row working a combination of long and night shifts. Although trainees were aware that they were being given the mandatory rest period following this, they felt that it was insufficient. Trainees also reported issues with rotas being issued late and only in 2 months blocks. They were aware that the blocks were only covering 2 months at a time due to the ongoing uncertainty of staffing levels, but this was resulting in difficulties in planning for annual and study leave. The late issue of the rota at the start of the post had also resulted in some trainees being given an induction for the wrong department with no catch-up induction. Trainees reported that they are not able to access the rota outwith the hospital. This has caused trainees to turn up at the wrong department and at times, perceived to have arrived late to work as they were unaware that they had been moved to a different ward.

GP: Trainees reported that they believe there are rota gaps and are unclear how and if these are filled. Some reported having to push the department to receive their rota. Trainees reported that the deputy chief resident would raise any issues or suggested improvements to the rota with the consultant team. They felt that the 7-day week of long and nightshifts was challenging and tiring and would possibly benefit from being broken up to reduce fatigue.

ACCS/IMT: Trainees reported that there are unfilled gaps in their rota. Some felt pressurised at times to fill the gaps and were concerned about needing to cover gaps when already feeling exhausted. Trainees suggested that a rota co-ordinator required support from a senior trainee to co-ordinate the rota as they were unaware of the grades of trainee that were working to know where to allocate trainees to provide safe cover. Trainees reported that they can be regularly assigned to be on-call without planning, as it is not allocated within their rota. This was a concern for the trainees as they felt that being on-call so frequently, without planning, could lead to exhaustion. A trainee suggested it would be helpful to see the rota even a few days in advance to see what the plan is and co-ordinate

amongst themselves where potential changes could be made if there are last minute absences but also where there could be learning opportunities.

ST: Trainees reported that they were uncertain if there were gaps in their rota, but the addition of a few less than fulltime trainees in April will result in them having slightly more than the usual trainee allocation. Trainees reported their rota can be adjusted to accommodate their curriculum requirements if they are proactive in seeking the required changes. However, it was noted that when they are allocated time to undertake a procedure, this is not recorded on the General Medicine rota, and can result in wards being short-staffed if the trainee chooses to undertake their procedural opportunity. Some trainees suggested that more junior doctors already working on a ward should be pulled to provide cover in a ward to enable their attendance at training. It was reported that when access to the rota co-ordinator was sought through the administrator, they were informed that they could not speak with the consultant. Trainees reported that they felt the rota could be improved by adjusting the trainee allocations in certain areas, such as having a more senior trainee working within HDU, rather than being on-call to take calls and clerk in patients from A&E as well as managing calls for support from the FY doctor within HDU.

2.14 Handover (R1.14)

Trainers: Trainers reported that there is a very effective nurse-led handover at 9pm which is usually attended by the on-call consultant and workload priorities are discussed. There are also afternoon handovers during the weekend which were felt to run well. Trainers acknowledged that improvements are required to the weekday morning handovers.

FY: Trainees reported that they did not feel the handover arrangements provide safe continuity of care. They felt that the evening and weekend handovers are more structured but the weekday mornings are very variable with only a verbal handover between trainees. Trainees reported that the workings of handover do not provide enable it to be used as a learning opportunity.

GP: Trainees reported there is a well organised, multidisciplinary evening handover. It was felt that the weekday morning handovers could be improved and currently risk information being missed as this is a verbal handover from nursing staff to FY1 doctors. Trainees reported that handovers were not used as learning opportunities.

ACCS/IMT: Trainees reported the morning weekday handovers are not fit for purpose and very unstructured but could easily be remedied. Trainees described having to move around the hospital to try and locate whomever they require to handover the page to. They also felt the lack of a boardround added more risk to something being missed.

ST: Trainees reported that have no major issues with the handover, but it feels erratic and they would welcome a structured handover. They felt that there is too much information to get through at handover for it to be used as a learning opportunity.

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: Not asked due to time constraints

Trainees: No concerns were flagged up in this area from the pre-visit questionnaire and no additional comments provided from trainees.

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 due to time constraints

FY: Trainees reported that a trainee forum meeting had just taken place the previous week but workload demands prevented attendance. Trainees were uncertain who they could raise concerns about their training to but acknowledged they may speak to the chief or deputy chief resident.

GP: Trainees reported that they would be likely to raise concerns about their training with their supervisor. Most were aware of the trainee forum and chief resident but the trainee in attendance at the visit was not aware if any GP specific issues were raised the meeting the previous week.

ACCS/IMT: Trainees reported that the chief and deputy chief residents are proactive and very approachable to raise concerns about training with and discuss at trainee meetings. However, trainees felt that although there are good systems in place to discuss concerns about their post, they

receive no feedback on actions being taken or are informed that nothing can be done. One trainee felt that the most helpful way to have their concerns addressed is through their training programme director.

ST: Trainees reported that there is a trainee forum, however a follow-up meeting had to be cancelled due to staff shortages. Trainees felt that was the recurrent theme, whereby concerns may be raised but staffing and workload issues result in a perceived inaction or lack of improvement, due to staffing and workload issues.

2.18 Raising concerns (R1.1, 2.7)

Trainers: Trainers felt that trainees were comfortable to raise immediate patient safety concerns with a consultant. They also felt that there is a culture of openness and transparency which encourages trainees to raise concerns about patient safety.

FY: Trainees reported that although they are aware of datix to raise concerns, the system is too laborious, and they do not have time to complete it. Some trainees reported that consultants within geriatric medicine actively sought trainee feedback on any concerns and possible resolutions.

GP: Trainees reported that they would raise concerns with a consultant or nurse within the department and formalise this through datix if needed.

ACCS/IMT: Trainees reported that whilst their concerns seem to be listened to, there is no evidence of any actions taking place to address their concerns. A trainee also reported that they are told to think of a solution before they raise a concern. An example was given where a concern was raised but it was felt that such feedback was neither helpful nor constructive.

ST: Trainees felt that if they had a concern more specific to a single patient, this would be effectively addressed. However wider issues staffing levels on wards and ward expansion are not being addressed with trainees being told that due to covid nothing can be done

2.19 Patient safety (R1.2)

Trainers: Trainers reported that are all doing their best, but with the surging demands during covid it is a constant struggle to provide a safe environment for patients and trainees. Trainers reported that there are significant nursing staffing issues, which no level of mitigation will completely shield trainees from having to undertake more service delivery tasks. They highlighted that there have been a lot of improvement initiatives, but these cannot make up for not having enough staff. Trainers acknowledged that current issues are likely leading to delays with assessments and treatment which may lead to poorer outcomes, but a high level strategy is being developed to improve the experience for both patients and trainees.

FY: Trainees reported that they would have concerns if a friend or relative were to be admitted. They also reported concerns about boarded patients as there is no structure to tracking boarded patients and it relies on someone being made aware of a patient that is boarded in another department, and provided an example of delays to a review of a boarded patient with multiple morbidities. Trainees did report that one of the units does have a safety huddle to discuss patients but this was not the general experience in most wards. Trainees also had concerns about the lack of continuity as they can be moved to a different ward after just 3 days without being given a handover from the team they are joining.

GP: Trainees reported they have some concerns about patient care at the front door, due to the workload intensity but would not have concerns if a relative was in the downstream wards. The trainee at the visit had little experience of any patient boarders and was not aware of any processes for boarded patients. It was suggested that having a multidisciplinary team huddle, rather than only a charge nurse huddle, would be beneficial to ensure all staff are aware of any high risk patients or hospital wide issues.

ACCS/IMT: Trainees reported they had significant concern about boarding as there is no medical input regarding what patients are suitable to board. A concern regarding delays to reviews and possible treatment of a boarded patient was also raised. Some trainees also had concerns about patient safety when a patient remains in the acute receiving unit for more than 2 days as the trainee then requires to make the decision on discharging a patient, but if there’s deterioration the trainee has

to seek out a specialist consultant for support, rather than the consultant that undertook the initial review of the patient.

ST: Trainees reported that they would have concerns if a friend or relative were admitted as they felt there are big gaps in the safety net. Trainees strongly felt that everyone in the department is working very hard and the care received is good, but that delays to care are concerning. Trainees reported that there is a boarding handover within respiratory which is useful, but boarding elsewhere is a disaster, with inconsistent input from staff. They would have significant concerns if a family member was boarded.

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

Trainers: Trainers reported they undertook a survey of the trainees, which found that there's little engagement with the Datix reporting system as there is a sense from trainees that there is not a good robust feedback system in place. They stated that during the height of the pandemic, morbidity and mortality meetings had been put on hold, but are now slowing being reintroduced, to provide learning from adverse incidents.

FY: Trainees reported that adverse incidents should be recorded through datix, however, most felt that they did not have the time to complete them. Trainees reported that support is given if an incident does occur, but there was a lack of knowledge of any hospital wide escalation plans and they are not aware of any meetings that would provide the opportunity to share lessons learned following an incident.

GP: Trainees reported that adverse incident would be recorded through the Datix system. The trainee the panel met with had not been involved in any incidents, but believed that support would be provided if they were involved in one. Trainees were unclear if they would receive feedback if they were to submit a datix report and there's a mixed awareness of meetings for shared learning from adverse incidents.

ACCS/IMT: Trainees reported that adverse incidents are recorded through the Datix system. Whilst feedback can be requested on the datix form, trainees reported that this is normally just an email

acknowledgement of the submitted form and there have only been a few occasions where discussion around an incident has taken place.

ST: Not asked due to time constraints, but the pre-visit questionnaire noted that trainees are aware that adverse incidents are recorded through the Datix system, with only one trainee being aware of any meetings to discuss shared learning from such incidents.

2.21 Other

Prior to meeting with the trainers and trainees, the department provided the panel with a very useful presentation, highlighting the changes within the hospital and challenges brought by both the service changes and the impact of COVID. The panel would like to thank those involved in delivering the presentation and providing a high level summary of the challenges and potential improvements being undertaken.

Trainees were asked to rate their overall satisfaction at the training experience they're having in their current post, rating from 0 (worst) to 10 (best). This was problematic on the day of the visit and there were limited responses following the visit. The scores provided below are taken from the pre-visit questionnaire which was completed no more than 4 weeks prior to the visit.
FY Range: 2 – 7, Average: 4.7 out of 10
GP Range: 6 – 7, Average: 6.7 out of 10
ACCS/IMT Range: 1 – 8, Average: 3.2 out of 10
ST Range (Parent Specialty): 0 – 8, Average: 6 out of 10
ST Range (GIM): 0 – 7, Average 4 out of 10

3. Summary

Is a revisit required?	Yes	No	Highly Likely	Highly unlikely

University Hospital Wishaw is clearly under significant strain due to the exceptionally high prevalence of COVID within Lanarkshire. The combination of a disproportionately high patient volume and staffing shortages relating to COVID has clearly had a significant impact on the training experience

being provided to trainees. Yet despite the ongoing challenges, it was very encouraging to note the acknowledgement from all levels of trainees regarding the hard work and level support they have receive from senior staff. Nevertheless, the department face significant challenges to address the quality of training currently provided within the hospital.

Positive aspects of the visit:

- There is a supportive and enthusiastic consultant team with a clear commitment to improve the training environment despite the exceptional circumstances of the pandemic and service redesign.
- Recognition of changes being undertaken to return to some more normal practices for trainees, such as the reintroduction of study leave.
- Very supportive ST3+ trainee cohort whom the junior trainees found very approachable and a very engaged and helpful Deputy Chief and Chief resident.

Less positive aspects of the visit:

Rota

- Rotas are not being provided with sufficient notice.
- Last minute changes to rotas without the trainees' knowledge or ability to check if any changes have been made resulting in trainees unknowingly arriving late.
- Very tiring rota when allocated to 7 days of long and night shifts involving a lot of high acuity work.

Teaching

- There is a lack of local teaching being delivered to trainees and no clear indication to trainees of when this will begin.
- Concerns that the ongoing workload demands and staff shortages would prevent attendance.

Trainee Competence

- There is a flattened hierarchy in the department which aids good communication and teamworking. However, the lack of awareness or acknowledgement of the different trainee cohorts results in trainees not receiving the adequate experience required for their development or trainees feeling that they are required to work beyond their competence.
- Regular use of SHO from all levels of trainee

Clinical Supervision

- Whilst consultants are readily providing support for the acute patients trainees feel there can be a lack of support when making difficult decisions, such as end of life care, within the downstream wards and in the acute wards when patients remain there more than 24 hours.

Raising concerns

- Perception that no action is being taken when clinical or educational concerns are raised, as there is no feedback to trainees as to why action may not be taken or if changes will be made.

Boarding

- There is no structured system in place to identify and track boarded patients resulting in a poorer quality of care and potential delays to treatment. This was a significant concern for trainees, and they would be unhappy, should a family member be admitted and boarded within the hospital.

Handover

- There is a lack of a structured handover, particularly in the weekday mornings. Some also felt that it was, at times, an intimidating environment when they are questioned about decisions made or work undertaken.
- Where safety huddles/briefs are undertaken, such as the covid ward, trainees felt this was very beneficial to developing a plan of action in the ward and suggested this should be taking place consistently across more of the wards.

Feedback

- There is a lack of feedback and availability of consultant staff to undertake WPBA impacting on both trainee progression and workload

4. Areas of Good Practice

Ref	Item
4.1	Not applicable

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	Trainees should be made aware of the availability of induction presentations outwith the planned induction days.
5.2	Educational Resource	The department should look into ways of providing more working IT systems to enable trainees to access online teaching whilst on site.
5.3	Feedback	The department should continue with the reinstatement of trainee forum meetings to ensure feedback is provided to trainees on consideration and actions taken on concerns raised.
5.4	Teaching	Continue to re-establish local teaching sessions for all levels of trainee
5.5	Supervision	Foundation doctors should be made aware of who to contact when support is needed for non-urgent issues, such as discussion of end of life care
5.6	Supervision	Current processes for supervision of IMT trainees undertaking procedures, such as LVPs, should be reviewed to minimise the risk of delays to patient treatments.
5.7	Adverse Incidents	All trainee cohorts should be made aware of M&M meetings and when they happen, increasing the frequency of the meeting could be of benefit.

6. Requirements - Issues to be Addressed

It was recognised that COVID has had a significant impact at this site and is reflective in the large number of requirements. However, it was felt that these are areas of concern that will need to be addressed. Whilst it may take some time to effect change, we hope that the burden caused by COVID will reduce and enable the departments to work towards addressing the requirements listed below.

Ref	Issue	By when	Trainee cohorts in scope
6.1	The site must develop an effective system of safe selection, tracking and managing boarded patients and ensuring appropriate clinical ownership & oversight of patient care, with subsequent monitoring of the system's impact and effectiveness.	Immediately	All Levels
6.2	Doctors in training must not be expected to work beyond their competence.	15 December 2022	FY, GP, IMT/CT
6.3	Involve trainees in the ongoing design of their rota and provide access to a master rota, including off-site rota access	15 December 2022	All Levels
6.4	Measures must be implemented to address the patient safety concerns described in this report	15 December 2022	All Trainees
6.5	Ensure that service needs do not prevent trainees from attending clinics, which must have active participation as is appropriate to the level of trainee, and other scheduled learning opportunities	15 December 2022	All Levels (IMT & GP for clinic access)
6.6	Weekday morning handover processes must be improved to ensure there is a safe, robust handover of patient care with adequate documentation of patient issues, senior leadership and involvement of all trainee groups who would be managing each case.	15 December 2022	All Levels
6.7	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. Handbooks or online equivalent may be useful in aiding this process but are not sufficient in isolation	15 December 2022	All Levels
6.8	Trainers must engage in developing a culture of routinely supporting opportunities to provide informal feedback.	15 December 2022	All Levels

6.9	WPBAs must be facilitated during the working hours of trainees.	15 December 2022	FY, IMT/CT
6.10	Educational supervisors must understand curriculum and portfolio requirements for their trainee group.	15 December 2022	IMT/CT
6.11	Initial meetings and development of learning agreements must occur within a month of starting in post.	15 December 2022	FY, IMT/CT, GP
6.12	Ensure trainees engage in use of the Datix system and highlight the importance of utilising this reporting mechanism. Provide feedback on Datix cases logged and ensure trainees are aware of this feedback to ensure the system is seen as responsive and a learning opportunity.	15 December 2022	All Levels