Scotland Deanery Quality Management Visit Report

Date of visit	30th & 31st March 2022	Level(s)	FY/GPST/IMT/ST
Type of visit	Enhanced Monitoring re-visit	Hospital	Queen Elizabeth University Hospital
Specialty(s)	General Internal Medicine	Board	NHS Greater Glasgow and Clyde

Visit panel	
Professor Alastair McLellan	Visit Chair - Postgraduate Dean
Dr Reem Al-Soufi	Associate Postgraduate Dean for Medicine
Kate Bowden	Education QA Programme Manager (GMC Representative)
Lorna Salmon	GMC Representative (shadowing)
Gary Keatings	Lay Representative
Dr Nick Dunn	Deputy Director for General Practice (GP representative)
Dr Marie Mathers	Associate Postgraduate Dean – Quality (Foundation representative)
Dr Susan McGeogh	Training Programme Director Representative
Alex McCulloch	Quality Improvement Manager
Dr Sarah Gillett	College Representative
In attendance	
Emma Stewart	Quality Improvement Administrator

Specialty Group Information	
Specialty Group	Medicine
Lead Dean/Director	Professor Alastair McLellan
Quality Lead(s)	Dr Reem Al Soufi Dr Alan McKenzie Dr Greg Jones
Quality Improvement Manager(s)	Alex McCulloch and Kelly More

<table>
<tr><td></td><td colspan="5"></td></tr>
<tr><td colspan="6">Unit/Site Information</td></tr>
<tr><td>Non-medical staff in attendance</td><td colspan="5">0</td></tr>
<tr><td>Trainers in attendance</td><td colspan="5">16</td></tr>
<tr><td>Trainees in attendance</td><td>FY1 - 21</td><td>FY2 - 5</td><td>GPST – 5</td><td>IMT – 10</td><td>ST - 10</td></tr>
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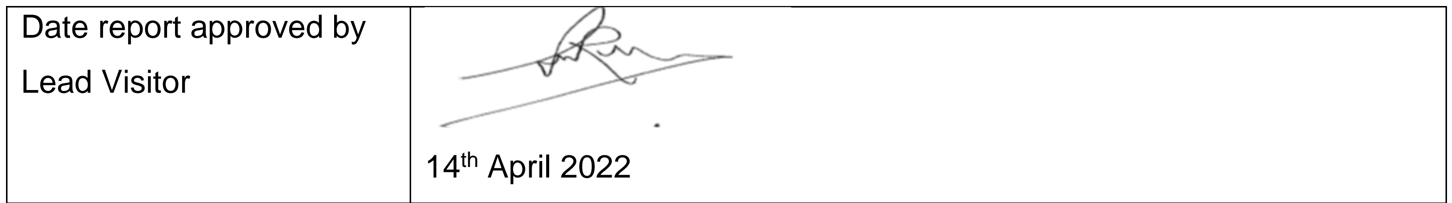
Feedback session: Managers in attendance	Chief Executive	✓	DME	✓	ADME	✓	Medical Director	✓	Other	Clinical Services Managers, Rota Managers, Medical Education leads

Date report approved by Lead Visitor	 14th April 2022

1. Principal issues arising from pre-visit review:

General Internal Medicine (GIM) at the Queen Elizabeth University Hospital has been under the GMC Enhanced Monitoring process since 2016. The site has been visited on several occasions over the past 7 years, as listed below:

- 27 October 2015 (new site visit)
- 13 May 2016 (triggered revisit)
- 02 December 2016 (enhanced monitoring visit)
- 21 February 2018 (enhanced monitoring revisit)
- 22 February 2019 (enhanced monitoring revisit)
- 04 February 2020 (enhanced monitoring revisit)
- 25th & 26th March 2021 (enhanced monitoring revisit)

As the 2021 visit took place during the 2nd wave of Covid 19 pandemic, the Deanery took the decision to produce an abbreviated report focussing on progress against the previous 2020 visit requirements. The visit panel found that despite the significant challenges QEUH had faced as a result of the COVID-19 pandemic, a huge amount of work had gone into sustaining training during unprecedented service pressures. Of the 10 visit requirements from 2020, the panel found the site had addressed 2, noted some progress against 3 and had little progress against 5. There are 8 visit requirements that remain in place following the 2021 visit:

- The burden of tasks for all cohorts of doctors in training that do not support educational or professional development and that compromise access to formal learning opportunities must be significantly reduced.
- The scope of the ward cover and the associated workload for Foundation Trainees at weekends (in the wards in 'the stack') must be reduced as currently they are not manageable and safe.
- Handover of care of patients transferred from the ED to Pods must be provided to support safe continuity of care and to ensure unwell patients are identified and prioritised.
- The site must foster a culture of learning that includes doctors in training both in reporting critical incidents using channels such as the Datix reporting system, but also in the consequent

learning that comes from an effective system. Trainees must receive feedback on the incidents they raise and there must be a forum for learning from adverse events.

- The training opportunities provided to GPSTs must meet the needs of the curriculum.
- The discontinuity of ward placements for GPST and 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 for Foundation trainees must be increased to at least 4-weeks.
- Work must be undertaken to ensure that trainees are supported to attend clinics and other scheduled local learning opportunities without compromise because of service needs.
- Alternatives to doctors in training must be explored and implemented to address the chronic gaps in the rota that are impacting on training.

This visit aims to review progress against the previous 8 visit requirements and also take the opportunity to gain a broader picture of how training is carried out within the department visited and to identify any points of good practice for sharing more widely. The deanery would like to thank NHS Greater Glasgow and Clyde for supporting this visit, which was conducted in the midst of very challenging circumstances due to significant staffing pressures created by the continuing Covid 19 pandemic. At the beginning of the visit an informative presentation was delivered by Dr Colin Perry, Dr Jacqueline Adams, and Dr Neil Ritchie. This provided an update on progress against the previous visit requirements which was supported by SMART (Specific, Measurable, Achievable, Realistic, Timebound) objectives evidence.

Pre-visit information including the Pre-Visit Questionnaire conducted in the 6 weeks prior to the visit provided sufficient clarity around a number of areas that these did not need to be explored during this visit. A summary of the discussions at the visit 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.

2.1 Induction (R1.13):

Trainers: Not covered

FY1 Trainees: Trainees reported that most departments provided induction with good departmental inductions provided by Endocrinology and Diabetes, Gastroenterology and Respiratory. Trainees commended the 'role cards' as being very helpful. The content of the departmental induction in Cardiology was suggested could be improved, for example, with guidance on how to handle referrals.

FY2 Trainees: Not asked.

General Practice Trainees: Not asked.

IMT Trainees: Not asked.

Specialty Trainees: Not asked.

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

Trainers: Trainers advised that Acute Internal Medicine and Respiratory Medicine had teaching sessions scheduled into the rota. In all the Medicine specialties efforts were made to allow trainees to attend live teaching sessions; in some departments (such as Acute Internal Medicine) trainees were given study leave sessions to catchup up on recorded virtual teaching sessions. Most teaching was conducted through virtual live sessions on MS Teams which were recorded.

FY1 Trainees: Gastroenterology, Rheumatology, Respiratory Medicine, and Infectious Diseases offered 1-hour departmental teaching sessions that took place weekly. Access to teaching in some specialties such as Endocrinology and Diabetes was reported to be difficult, due to staffing and workload issues; this teaching was different by junior medical staff without consultant input, and they felt the subject content could be improved. Access to teaching sessions for those working in acute receiving was reported to be very difficult. Trainees reported they could attend 1 hour of interruption-free FY1-specific teaching on a Thursday. Overall FY1 trainees estimated they got to between 1-2 hours of teaching weekly.

FY2 Trainees: Trainees estimated they got to between 1 – 2 hours of teaching on a weekly basis across most specialties, although this was not protected. They could get to their FY2-specific teaching sessions too. Trainees felt teaching content was of a high quality, but often they couldn't attend the live virtual sessions and had to catch up on the recorded sessions in their own time. Staffing issues and workload where the main reasons that trainees struggled to attend teaching. They suggested improvements such as provision now of more in-person teaching sessions and protection of time for them to attend or watch sessions un-interrupted.

General Practice Trainees: Trainees estimated they got to between 30 minutes – 1 hour of teaching weekly. Trainees had difficulties attending teaching whilst working on call. Trainees in some departments struggled to access local teaching more than others. There are also 1 hour monthly regional GP-teaching sessions.

Internal Medicine Trainees: Trainees felt they could access very little teaching; they estimated they could get to between nil and 30 minutes local teaching per week. Trainees who were based in Acute Internal Medicine and Gastroenterology advised that little or no departmental teaching was provided for them and what was provided was difficult to attend due to ward workload and staffing. In Diabetes there was access to 15-30minutes of teaching that was junior-led, and without consultant input. Trainees reported they watched recorded virtual sessions in their own time with limited opportunity to attend during their working hours.

Specialty Trainees: Trainees could access between 0 and 2hr per week of local teaching but it difficult to attend. Trainees highlighted Infectious Diseases and Respiratory Medicine as departments providing good access to local teaching. They could generally access their regional teaching.

2.3 Study Leave (R3.12) – Not asked.

2.4 Formal Supervision (R1.21, 2.15, 2.20, 4.1, 4.2, 4.3, 4.4, 4.6) – Not asked.

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 advised consultant presence was available to trainees on all wards and consultant cover across the day had been expanded. Consultants were now available on site in most wards until 10.00 pm on Monday, 9.00 pm on Tuesdays, 8.00 pm on Wednesdays, 4.00 pm on Thursday and Friday and 4.00 pm on Saturday and Sunday. Trainers felt escalation pathways were structured and that trainees could reach consultant support should they require it.

FY1 Trainees: Trainees in Endocrinology and Diabetes noted twice weekly consultant presence for ward rounds with little consultant presence in between. Along with the FY1 there was a middle tier trainee. More senior trainees were busy elsewhere. In 6B/GIM again there were twice weekly consultant ward rounds but no middle tier trainees. In Gastroenterology there wasn't consultant presence every day, but there was for a minimum of two ward rounds per week; the consultants were accessible if required, although busy elsewhere. Infectious Diseases was reported to be well supported with seniors in hours, having a minimum of 2 trainees per ward, plus consultant input. Consultant presence across most of the other GIM specialties was felt to be generally good.

FY2 Trainees: Trainees felt a robust escalation process was in place across Medicine. All trainees felt they could contact more senior support including a consultant should they require. They felt the level of clinical supervision ensured safe care.

Trainees felt the out of hours period, whilst working in acute receiving could be an area of potential risk if there was staff absence (as there has been at short notice due to COVID).

General Practice Trainees: Trainees reported the supervision they received to be good in some departments but less so in others. Support and access to senior support was reported to be good in Gastroenterology and whilst working in Acute Receiving. In Endocrinology and Diabetes wards 5A & 5B they felt less supported as the registrars were often very busy elsewhere in the hospital dealing with large numbers of ward referrals or off-site at clinic and consultants tended only to be on the ward twice weekly during their rounds.

Internal Medicine Trainees: Trainees said they felt well supported in Gastroenterology, Respiratory and Acute Receiving and felt the supervision they received ensured safe care was provided for patients. However, trainees advised that cover was fragile and could be affected by sickness absence due to COVID and long-term vacancies. They noted that at weekends there is always a senior registrar supporting the stack and there was access to another based in the High Dependency Unit (HDU). Boarders were noted to be covered by a Boarders' Team.

Specialty Trainees: Trainees felt generally well supported by their senior colleagues. They noted that in Endocrinology and Diabetes trainees felt less well supported because trainees on their tier were busy seeing many ward referrals or were off-site at clinics.

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

Trainers: Trainers advised that training opportunities such as clinics were included in the rota for trainees working in Infectious Diseases and Respiratory Medicine, efforts were made to allow trainees time off the wards to attend them (although this was acknowledged to be difficult at times due to workload). Trainers in Gastroenterology advised it was very difficult to allow their trainees to get to clinics, most were off-site, and this would leave the Gastro ward cover very short. Trainers highlighted daily 'hot clinics' in Acute Internal Medicine as good learning opportunities. Trainers felt increased consultant presence in most wards had reduced the non-educational tasks for trainees and efforts were made to ensure that the work they undertook was as educational as they could be with consultant input.

FY1 Trainees: Trainees felt their rotations were long enough for their supervisors to get to know them to be able judge their performance. Departments that provided a good educational experience were highlighted as the Immediate Assessment Unit (IAU), Infectious Diseases, Respiratory Medicine and Rheumatology. Trainees felt that the Gastroenterology and Endocrinology and Diabetes departments provide less of an educational experience and were more service provision driven. However, all reported that their posts provide adequate opportunities to manage acutely unwell patients.

FY2 Trainees: Trainees said they were encouraged to go to clinics but in practice it could be very difficult for them to attend due to staffing issues; the majority had been to none. Trainees highlighted the experience they received whilst working in acute receiving as good, offering good exposure to develop their competences in managing acutely unwell patients. They felt their placements were long enough for their supervisors to get to know them to be able to judge their performance accurately. Trainees estimated around 75% of their workload was service provision vs 25% as educational experience. An international medical graduate who was new to the NHS and was working in their first U.K job in Medicine at QEUH had a very positive experience of working there describing QEUH Medicine as a very supportive environment.

General Practice Trainees: Trainees described very limited access to clinic opportunities; most had been to none so far in 2 months; one had got to one. Trainees for the most part remained on the same ward they started in, although they could be moved occasionally to cover gaps. They described the time they spent in acute receiving as a very good learning experience with plenty of exposure to the management of acutely unwell patients and with provision of feedback on a significant proportion of their cases. Trainees felt their workload was more administrative service provision whilst working in the wards in the stack.

Internal Medicine Trainees: Trainees' experience of clinics was variable; trainees could get to clinics in Respiratory Medicine, Renal Medicine and Cardiology. They felt it challenging to get to clinics in most other specialties such as Acute Medicine and Gastroenterology. Since December trainees estimated they had got to between 0 and 9 (in Respiratory) clinics. Staffing and ward workload were given as the main reasons affecting trainees' ability to attend clinics. Trainees felt the majority (80%) of their workload was supporting service provision, although this was exacerbated by staffing challenges through COVID. They had plenty of exposure to the management of acutely unwell patients and had received feedback on their input to at least 33% of their acute cases both through the board round and by day and through evening ward rounds in the Acute Receiving Unit (ARU) block.

Specialty Trainees: Trainees felt the breadth of competences they were required to get signed off was challenging due to the effect of COVID skewing the case-mix, although they received good experience of practical procedures. Trainees highlighted the positive learning experience in Respiratory Medicine as well as Endocrinology and Diabetes during the week but less so at weekends. Clinics access was variable for but adequate for most trainees and were easier to get to in some specialties (Respiratory Medicine and Clinical Pharmacology and Therapeutics), less so for trainees working in Acute Internal Medicine and Gastroenterology. There was plenty of access to opportunities to manage acutely unwell patients. Feedback on their management of these cases was mixed – with some opportunities at morning post-receiving rounds, with excellent feedback available from HDU but more limited opportunities around their input to cases in the Specialist Assessment and Treatment Area (SATA).

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

Trainers: Trainers felt trainees could obtain their Workplace Based Assessments and portfolio requirements without difficulty. Extended consultant presence in the hospital provided more interaction and opportunity to get Workplace Based Assessments signed off.

All Trainee Cohorts: Trainees were content that could achieve sign-off of sufficient Workplace Based Assessments. Acute Care Assessment Tools (ACATs) were highlighted as more challenging than others to get signed off. Trainees reported that COVID had somewhat narrowed the range of presentations they see (but not the volume), and this added challenges around accessing CBDs.

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

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

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: Trainers felt opportunities to receive feedback on their performance were regular and highlighted the post night shift ward round in acute receiving as a good opportunity for trainees to present cases from their overnight workload to receive feedback on.

FY1 Trainees: Trainees described the feedback they received as variable. Regular feedback from consultants was provided in Infectious Diseases and Acute Receiving. Trainees based in Endocrinology and Diabetes felt they could receive feedback from FY2/GPST/IMT trainees but feedback from consultants was less common.

FY2 Trainees: Trainees described being moved around wards frequently which made it difficult to maintain continuity and to receive feedback from consultants. However, post-receiving ward rounds did provide opportunities to get feedback on their acute cases in the morning after a night shift and in the evening after a backshift.

General Practice Trainees: Trainees described access to feedback as variable but estimated overall that they received feedback on around 20% - 25% of the patients they had seen, contributing to a positive learning experience.

Internal Medicine Trainees: Trainees felt that although Acute Receiving was very busy, it also provided and opportunity for feedback in the morning post take ward round. They estimated they received feedback on around 30 – 50% of the patients they had seen overnight.

Specialty Trainees: Trainees said they received feedback on a fairly regular basis and highlighted the post take ward round following night shift as good for receiving feedback. Trainees felt they had to seek feedback to receive it. Consultant feedback was thought to be lacking in the Endocrinology and Diabetes wards 5A & 5B and during the out of hours period including at weekends and in the Specialist Assessment and Treatment Area (SATA).

2.11 Feedback from trainees (R1.5, 2.3) – Not covered.

2.12 Culture & undermining (R3.3)

Trainers: Trainers were unaware of any current undermining incidents and felt that any incidents reported were taken seriously and addressed. Trainer's culture was supportive of training and concerns about training were generally raised through the trainee forum.

All Trainee Cohorts: Trainees generally conveyed a sense of a positive culture around this training environment, noting support for training and very supportive and committed consultants - and all of this despite the substantial additional workload and disruption of staffing due to COVID. Dr Sarvesvaran was particularly commended for his pastoral support.

Trainees did not report any specific undermining incidents, although occasionally unsupportive and upsetting comments are made to junior trainees.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Trainers said there were multiple gaps in the middle tier rotas (FY2/GPST/IMT). Departments particularly affected by gaps were Gastroenterology, Endocrinology and Diabetes and Acute Internal Medicine. The gaps in the rota were described as a mix of long-term gaps in the rota which were proving difficult to fill and short term COVID-related absences.

All Trainees Cohorts:

The impact of COVID on workload and on staffing levels at short notice were confirmed by all. Staffing pressure pre-dated COVID. Trainees described their rotas as very stretched and felt they often missed taking breaks whilst on shift because of workload. Trainees had concerns around interactions with the rota team and felt communication with them was challenging.

All on this rota regarded the rota pattern as very challenging - describing 7-day stretches of long days on the rota with one day break and then back on to another 7-days of long days. They found this exhausting.

At weekends the 12hour shifts on the stack remain challenging. The staffing for 5th floor comprised 1xFY1 plus 1 middle-tier doctor to cover 4 x 27bed wards. We understand the ANP plan may help and that there is potential for support from a registrar in acute medical receiving and there may also be a registrar covering 5th-8th floors. Gastroenterology can also be very busy at the weekends with 40 unwell patients, although as noted a registrar can provide some support. There is a Gastroenterology consultant on-call, but he/she is covering ARU5, 3 ward rounds and is on for GI haemorrhage.

2.14 Handover (R1.14)

Trainers: Trainers felt ground floor weekend ground floor handover as robust and the most established handover. Trainers felt there was consultant presence at most handovers and highlighted the post receiving night shift ward round handover as a good learning opportunity for trainees.

FY1 Trainees: Trainees described lack of doctor-to-doctor handover from acute receiving to the downstream wards and patients were moved out of receiving to the medicine wards without trainees being aware of this, although they noted there was a nurse-to-nurse handover.

FY2 Trainees: Trainees felt acute receiving handover was robust; trainees were aware of the Trakcare system used for handover. Trainees were aware of the recent introduction of the SBAR (Situation, Background, Assessment, Recommendation) handover format that had been put in place to support transfer of patients from ED to the pods. They questioned whether the bar for the application of the SBAR might have been set too high, as patients with DKA or neutropenic sepsis would not necessarily be within its scope and yet would merit prompt attention when in the pod.

General Practice Trainees: Trainees appeared unaware of a formal medical handover of patients between ED and the pods. Trainees noted lack of doctor-to-doctor handover from acute receiving to the wards in the stack, but again noted there was a nursing handover.

Internal Medicine Trainees: Trainees appeared to be aware of the SBAR for handover of sick patients between the Emergency Department and pods but didn't feel it was applied consistently. They noted the lack of handover to downstream wards.

Specialty Trainees: Trainees were aware of the handover arrangements both on the ground floor and in the wards in the stack and felt handover was both adequate and provided safe patient care. Trainees felt handover of sick patients from ED to acute receiving had got better since the implementation of the SBAR. They noted the lack of medical handover of patients from the receiving area to down stream wards.

2.15 Educational Resources (R1.19) – Not covered

2.16 Support (R2.16, 2.17, 3.2, 3.4, 3.5, 3.10, 3.11, 3.13, 3.16, 5.12) – Not covered

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.

All Trainee Cohorts: Trainees advised they would raise any concerns they had about the quality of their training with either their Clinical or Educational Supervisor.

2.18 Raising concerns (R1.1, 2.7)

Trainers: Trainers advised that trainees could raise concerns through the local Chief Residents or through their Clinical or Educational Supervisors.

All Trainee Cohorts: Trainees confirmed they could raise any concerns they had about the quality of their training or about the quality & safety of patient care through their Clinical or Educational Supervisors and were aware of routes of escalation for concerns. Staffing concerns were highlighted by trainees again at this section of the visit, the most significant of which was the impending reduction of middle grade trainees in the Endocrinology and Diabetes wards from 9 to 5 trainees.

2.19 Patient safety (R1.2)

Trainers: Trainers advised trainees would have minimal contact with boarded patients as they were looked after by a dedicated multi – disciplinary boarders' team. Trainers felt the culture of Datix reporting was improving and trainees could expect to receive feedback on those incidents they were involved in. Trainers described Clinical Governance meetings and Morbidity and Mortality (M&M) meetings as forums for learning from patient safety incidents. Trainers highlighted the safer use of Medicines newsletter as another method of learning from incidents that was shared through e-mail.

All Trainee Cohorts: Trainees did not highlight any specific patient safety concerns, however all the trainee cohorts felt staffing levels had the potential to affect the quality and safety of care generally but also at the weekends and in the IAU and SATA, where delays to be assessed for patients on trolleys could be lengthy. COVID was contributing significantly to these concerns. There were no concerns about the safety of care linked to any individuals at all. Ill patients on the stack could go without senior review over the weekend until a ward round on Monday or Tuesday.

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

Trainers: Trainers highlighted Datix as the system used for reporting adverse incidents and trainees would receive feedback on any incidents, they were involved in. Cases were discussed informally with trainees and also through M&M and Clinical Governance meetings that trainees were able to attend. Trainers highlighted the Clinical Governance section of the GGC website and a safety newsletter as another learning resources.

FY1 Trainees: Trainee's present had not been involved in Datix incidents. They highlighted the Cardiac Arrest team debrief as a positive learning experience.

FY2 Trainees: The trainees in the session confirmed they had submitted 1 - 2 Datix reports. Of those submitted one had received feedback on their Datix and the other didn't receive feedback. Trainees highlighted M&M meetings as providing learning from adverse incidents. There was awareness of the HEPMA email through which awareness of prescribing errors was raised.

General Practice Trainees: Trainees highlighted Datix as the reporting system for adverse incidents. One of the trainees has submitted a Datix report but had yet to receive feedback on it. Trainees were aware of the M&M meetings but none of them had been to one. Trainees appeared unaware of the newsletter regarding prescribing errors.

Internal Medicine Trainees and Specialty Trainees: Trainees' awareness of M&M meetings was variable, and trainees based in Acute Internal Medicine were unaware of any taking place. Trainees working in Renal, Respiratory Medicine, HDU and Gastroenterology were aware of M&M and some had attended them. Trainees were aware of the prescribing errors newsletter and had received it through e-mail.

3. Summary

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

The visit panel found that Queen Elizabeth University Hospital continues to be challenged by the significant service pressures created by the Covid 19 pandemic, which continues to have an impact on staffing (at all levels) as well as training. Despite these challenges the visit panel acknowledges the significant efforts the local training team and post graduate medical team have put into supporting post graduate medical training. The visit panel's questions were targeted around assessing progress against the 8 previous visit requirements from 2021 and these form the basis of the output of this report.

Positive aspects of this visit:

- The positive culture around this training environment generated by hard working staff who are under considerable additional pressure due to COVID-19.
- Supportive environment created by the consultant workforce and education team
- Engagement to resolve the concerns with multiple references to awareness of changes although many are in their infancy
- Acute medical receiving provides an excellent learning environment
- Respiratory, Cardiology and Infectious Diseases all mentioned as positive training environments supporting access to learning; some of these specialties rota'd clinics and all provided access to teaching
- Support to an International Medical Graduate commended by a trainee working in their first NHS job at QEUH
- Post-cardiac arrest debrief that foundation trainees found valuable

Less positive aspects of this visit:

- Staffing for workload – pre-existing issue but exacerbated by COVID. (We noted the ongoing GGC medical workforce review that is underway).
- Rota pattern is considered by trainees to be heavy and demanding (especially the grouping of long days and nights).

Progress against 2021 visit requirements that have been categorised into Addressed, Progress Noted and Little progress noted:

Requirement	Status
The burden of tasks for all cohorts of doctors in training that do not support educational or professional development and that compromise access to formal learning opportunities must be significantly reduced.	This is an ongoing concern, and we note work is underway to address. **– Progress noted.**
The scope of the ward cover and the associated workload for Foundation Trainees at weekends (in the wards in 'the stack') must be reduced as currently they are not manageable and safe.	This is an ongoing concern and is particularly challenging in the Diabetes/Endocrinology wards and the Gastroenterology wards. We noted plans for an extra 'float registrar' and that the appointment of ground floor ANPs will in future 'free up' 2 trainees to support the team covering the stack – **Progress noted.**
Handover of care of patients transferred from the ED to Pods must be provided to support safe continuity of care and to ensure unwell patients are identified and prioritised.	SBAR handover introduced, and progress noted although yet to be applied consistently. Has the correct threshold been set to include handover of all patients who would benefit from being handed over? – **Progress noted.**
The site must foster a culture of learning that includes doctors in training both in reporting critical incidents using channels such as the	**Progress noted** around the culture in that trainees can raise concerns. Progress noted around learning from incidents – with some

Datix reporting system, but also in the consequent learning that comes from an effective system. Trainees must receive feedback on the incidents they raise and there must be a forum for learning from adverse events.	feedback on Datix submissions, some awareness of M&M meetings and some awareness of HEPMA emails relating to drug errors; work still needs to be done to engage with doctors in training around these processes.
The training opportunities provided to GPSTs must meet the needs of the curriculum	**Progress noted** especially in acute medical receiving where they are getting a lot of experience and feedback on their acute cases. However, clinic access and access to other learning opportunities remain challenging.
The discontinuity of ward placements for GPST and 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 for Foundation trainees must be increased to at least 4-weeks. Progress noted and requirement is ongoing	**Progress noted** and requirement will be amended to reflect this; this appears to be resolved for the most part for GPSTs but remains an issue for other trainees (FY1/FY1/IMT).
Work must be undertaken to ensure that trainees are supported to attend clinics and other scheduled local learning opportunities without compromise because of service needs.	**Some progress noted** in some specialties such as Respiratory Medicine but remains a challenge for most others. The COVID-19 pandemic has presented additional challenges.
Alternatives to doctors in training must be explored and implemented to address the chronic gaps in the rota that are impacting on training.	**Progress noted.** We acknowledge the significant work that is being done to resolve this issue (including the appointment of ANPs and the NHS GGC-wide medical staffing review).

Overall Satisfaction scores:

FY1 trainees: Trainees scored between 5 – 9 out of 10, with an average score of 4.

FY2 trainees: Trainees scored between 4 – 7 out of 10, with an average score of 5.6.

General Practice Trainees: Trainees scored between 5 – 7 out of 10, with an average score of 5.4.

Internal Medicine Trainees: Trainees scored between 3 – 7 out of 10, with an average score of 4.8.

Specialty Trainees: Trainees score between 5 – 8 out of 10, with an average score of 6.5.

4. Areas of Good Practice

Ref	Item	Action

Nil

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	**Local teaching provision in Diabetes/ Endocrinology**	Apart from providing better access to trainees, the educational impact would be improved if there was consultant input rather than this being led and delivered only by junior trainees.
5.2	**The threshold for application of the SBAR handover to patients transferring from ED to pods**	Review the threshold that has been set for the new SBAR handover format to support handover from ED to pods to ensure that all patients who need prompt ongoing care can access it (with references to the types of examples cited).

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	The scope of the ward cover and the associated workload for Foundation Trainees at weekends (in the wards in 'the stack') must be reduced as currently they are perceived to be very demanding. **(this applies in particular to Endocrinology and Diabetes wards 5A & 5B and the Gastroenterology wards 8B, 8C and 8D) [Evidence of impact of planned solutions awaited]**	16th December 2022	DME
6.2	The rota pattern that required 7-day stretches of long days on the rota with one day break and then back on to another 7-days of long days must be revised as it is impacting on trainees' well-being		
6.3	Handover of care of patients transferred from the ED to Pods must be provided to support safe continuity of care and to ensure unwell patients are identified and prioritised. **[Evidence of impact of planned solutions awaited]**	16th December 2022	DME
6.4	All handovers of cases between Acute Receiving and the downstream wards must be more structured (with Doctor-to-Doctor interaction) and more robust written or electronic documentation.	16th December 2022	DME

6.5	Work must be undertaken to ensure that FY1, FY2, GPST, IMT & ST trainees are supported to attend local teaching opportunities without compromise because of service needs. **[Evidence of impact of planned solutions awaited]**	16th December 2022	DME
6.6	Work must be undertaken to ensure that FY2, GPST & IMT trainees are supported to attend clinics without compromise because of service needs. **[Evidence of impact of planned solutions awaited]**	16th December 2022	DME
6.7	Work must continue to ensure sufficient staffing including medical staffing is available for the workload and to ensure trainees have access to quality training. **[Evidence of impact of planned solutions awaited]**	16th December 2022	DME
6.8	Trainees must receive feedback on the incidents they raise and there must be a forum for learning from adverse events. **[Evidence of impact of planned solutions awaited]**	16th December 2022	DME