Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	19th & 20th March 2025	**Level(s)**	Foundation, IMT, GP, Specialty
Type of visit	Triggered (virtual)	**Hospital**	Royal Alexandra Hospital
Specialty(s)	General Internal Medicine (including group 1 specialties)	**Board**	NHS Greater Glasgow & Clyde

Visit Panel	
Dr Reem Al-Soufi	Visit Chair – Associate Postgraduate Dean (Quality)
Dr Fiona Cameron	Foundation School Director & Associate Postgraduate Dean (Foundation East)
Dr Carol Blair	Training Programme Director
Dr Ananya Santosh	Trainee Associate
Mr Edward Kelly	Lay Representative
Mrs Jennifer Duncan	Quality Improvement Manager
In Attendance	
Ms Claire Rolfe	Quality Improvement Administrator

Specialty Group Information	
Specialty Group	Medicine, Surgery, Occupational Medicine & AICEM
Lead Dean/Director	Professor Adam Hill
Deputy Dean/Director	Dr Alastair Murray
Associate Postgraduate Deans	Dr Reem Al-Soufi, Fiona Drimmie, Dr Kerry Haddow, Dr Alan McKenzie & Mr Phil Walmsley
Quality Improvement Manager(s)	Mrs Jennifer Duncan & Ms Vhari Macdonald
Unit/Site Information	
Trainers in attendance	15
Resident Doctors in attendance	(12-F1, 3-F2, 8-IMT, 5-GPST, 5-ST)

Feedback session: Managers in attendance	Chief Executive	0	DME	1	ADME	1	Medical Director	1	Other	12
Report approved by Lead Visitor / Lead Dean		Dr Reem Al-Soufi Professor Adam Hill								

1. Principal issues arising from pre-visit review:

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.

Following review and triangulation of available data, including the GMC National Training Survey and NES Scottish Trainee Survey, a Deanery visit was arranged to General Internal Medicine (including Group 1 specialties) at Royal Alexandra Hospital. This visit was requested by the following Transitional Quality Review Panel: Medicine, Surgery, Occupational Medicine & AICEM around the following concerns:

No data Palliative Medicine.

NTS

General Internal Medicine

All Trainee – Red Flag - Adequate Experience, Clinical Supervision, Educational Governance, Feedback, Local Teaching, Overall Satisfaction, Reporting Systems, Rota Design, Supportive Environment. Pink Flag - Educational Supervision, Handover, Regional Teaching, Teamwork.

Medicine

GPST Medicine – Red Flag – Local Teaching. Pink Flags - Adequate Experience, Clinical Supervision, Clinical Supervision Out of Hours, Educational Governance, Educational Supervision, Facilities, Induction, Overall Satisfaction, Rota Design, Supportive Environment, Teamwork.
IMT – Red Flags – Induction, Local Teaching, Regional Teaching, Reporting Systems, Rota Design. Pink Flags - Adequate Experience, Educational Supervision, Overall Satisfaction.
F1 Medicine – Red Flag – Rota Design. Pink Flag – Clinical Supervision.
F2 Medicine – Red Flag - Rota Design, Workload. Pink Flag - Adequate Experience, Clinical Supervision, Educational Supervision, Overall Satisfaction, Supportive Environment, Teamwork.

Acute Internal Medicine

All Trainee – Red Flags – Feedback, Local Teaching, Reporting Systems, Rota Design, Supportive Environment, Teamwork, Workload. Pink Flag – Clinical Supervision Out of Hours. Overall Satisfaction, Regional Teaching.

ST – All grey.

Cardiology

All Trainee – Pink Flags - Educational Governance, Local Teaching, Reporting Systems.

ST – All Grey.

Endocrinology & Diabetes

All Trainees & ST – All Grey.

Gastroenterology

All Trainee – All Grey.

Geriatrics

All Trainee – Green Flag - Educational Governance, Reporting Systems, Supportive Environment.

ST – Lime Flag – Educational Governance. Green Flag - Supportive Environment.

Respiratory

All Trainee & ST – All Grey.

Rheumatology

All Trainee – All Grey.

STS

General Internal Medicine

All trainee - Clinical Supervision, Discrimination, Educational Environment & Teaching, Equality & Inclusivity, Induction, Team Culture, Wellbeing Support, Workload, Catering Facilities, Travel.
Foundation – Red Flag – Discrimination, Educational Environment & Teaching, Workload, Catering Facilities, Travel. Pink Flag - Equality & Inclusivity, Wellbeing Support.
GPST – Red Flag – Educational Environment & Teaching, Equality & Inclusivity, Induction. Pink Flag - Clinical Supervision.
ST – Red Flag – Clinical Supervision, Educational Environment & Teaching, Equality & Inclusivity. Pink Flag – Induction.

Medicine

IMT – Red Flag - Discrimination, Educational Environment & Teaching, Equality & Inclusivity, Catering Facilities. Pink Flag – Handover.

Acute Internal Medicine

All Trainee – Red Flags - Educational Environment & Teaching, Induction. Pink Flags - Catering Facilities.
Core – Grey Flags.
ST – Red Flags - Induction, Catering Facilities. Pink Flags - Educational Environment & Teaching.

Cardiology

All Trainee – Red Flag – Catering Facilities.
IMT – All White. Grey Flag – Induction.
ST – All Grey.

Endocrinology & Diabetes

All Trainee – All White.
IMT & ST – All Grey.
GPST – Red Flag – Induction.
ST – Lime Flag - Educational Environment & Teaching. Green Flag – Induction.

Gastroenterology

All Trainee & IMT – All Grey.

Geriatrics

All Trainee & Foundation – All White.

Respiratory

All Trainee – All White.

IMT & ST – All Grey.

Rheumatology

All Trainee – Red Flag - Discrimination, Educational Environment & Teaching, Equality & Inclusivity, Team Culture.

IMT & ST – All Grey.

At the pre-visit teleconference the visit panel agreed that the focus of the visit should be around the areas highlighted in the survey data, and the pre-visit questionnaire.

Department Presentation:

The visit commenced with Dr Sally Mcadam delivering an informative presentation to the panel. This provided detailed information including developments and challenges in the following areas: induction, rotas, training experience, handover, supervision and teaching.

2.1 Induction (R1.13):

Trainers: Induction was discussed within the site presentation where it was confirmed that General Internal Medicine (GIM) induction is timetabled within F1 shadowing. F2s undertake departmental induction within their base ward which includes introductions to the wider team. This is followed by GIM induction with the option to attend via Microsoft Teams. Induction sessions are offered at all changeover dates, are recorded and accessible to all within the induction Teams channel. This channel also holds the induction handbooks, medical assessment unit (MAU) handbook, short induction videos from consultants in each of the specialties and role cards developed for each on-call shift detailing page holder roles and explanatory videos. Those who are unable to attend induction are offered an alternative date. Finally, after each induction session an e-mail is sent summarising key points with links to further information. They recognise that cardiology pathways are not clear, and a working group has been set up to investigate this.

F1/F2/IMT/GPST/ST: All resident doctors confirmed receiving good quality hospital and departmental induction. Within the pre-visit questionnaire they suggested improvements to departmental induction: section on the right decision app. A frequently asked questions guide for each ward detailing any specific elements to that ward. A resource detailing ward round dates and multi-disciplinary meeting (MDT). Information on which consultants are on the wards each week and an up-to-date diary of clinics.

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

Trainers: Teaching was discussed within the site presentation where various local teaching sessions were described along with sessions offered by Greater Glasgow and Clyde (GGC) via Teams. There is also a monthly interprofessional simulation programme which has recently been redesigned and mapped to IMT stage 2 and F2 curriculum. These sessions are open to all resident doctors in GGC. Finally, consultants have delivered teaching sessions specifically for STs undertaking the PACES exam.

F/F2/IMT/GPST/ST: The pre-visit questionnaire provided details of available teaching: Monday OPSS teaching, Wednesday GIM teaching, Thursday core teaching, Friday F1 teaching and grand rounds. In addition, there are also educational meetings, morbidity and mortality meetings (M&M), IMT and stroke teaching. They confirmed being able to attend 50-75% of teaching and that workload or clashes with ward rounds prevent attendance**.** F2s also attend a full day regional teaching which they must request through study leave and should they miss a session they are given a day back to catch-up. They confirmed that most teaching takes place over lunch time and only attend if ward rounds are finished or if they feel they won't have to stay late to complete tasks. They suggested that it would be beneficial if all teaching sessions were recorded. IMTs commented that the rota team are very accommodating in allowing attendance for teaching. GPSTs noted difficulties attending teaching due to staffing issues which they have raised with the rota team and as yet has had no response. STs also commented on weekly consultant lead teaching and lots of opportunities within GIM.

2.3 Study Leave (R3.12)

Trainers/F1/F1/IMT/GPST/ST: Not asked, no concerns raised within pre-visit questionnaire.

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

Trainers: Trainers reported that all educational and clinical supervisors are given adequate time within job plans and generally feel very well supported by the Department of Medical Education. They offer regular scheduled meetings to ensure resident doctors are meeting objectives for the post.

F1/F2/IMT/GPST/ST Resident Doctors: Resident doctors confirmed having designated educational supervisor and have no concerns seeking support during the day and out of hours (OOH).

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: Clinical supervision was discussed within the site presentation and described some improvements such as role cards for each on-call shift detailing roles and responsibilities with clear escalation pathways and contact numbers. There is a standard operating procedure for STs acting up into more senior roles. There is on-call consultant presence in acute medical unit (AMU)/MAU/high dependency unit (HDU) from 8am – 9pm during the week and 8am – 6pm at weekends. MAU also have an acute medicine consultant present 9am-5pm during the week for real time patient discussions, review and feedback. Trainers described clear and robust escalation policies which are included in induction and detail who to contact for support during the day and OOH. Trainers were not aware of any specific instances where resident doctors have felt they have had to cope with problems beyond their level of competence. They recognise that there can be tension when someone is on-call and that debriefs can feel stressful however they are confident all are well supported.

F1 Resident Doctors: F1s confirmed they were aware of who to contact for clinical supervision both during the day and out of hours. They believe they have had to cope with problems out with their level of competence. They commented that often patients who come into AMU overnight from resus or emergency medicine are quite unwell and there is no senior support immediately available in AMU during the night. They find support in general isn’t easily accessible in AMU as seniors are very busy with other issues however, they are contactable. Most were unable to comment on support from cardiology as they have not had to contact them. They reported no concerns and a clear pathway to seek appropriate support for gastrointestinal (GI) bleeds OOH.

F2 Resident Doctors: F2s confirmed they were aware who to contact for clinical supervision both during the day and out of hours. On-call are contactable via page and as long as they are not busy, they respond quickly. There are times when they must manage the patient until support arrives. They do not believe they have had to deal with problems out with their level of competence. They are aware of site wide issues with cardiology support OOH however have not experienced this and believe there is a clear escalation pathway. They are also aware who to contact for support with GI bleeds and have experienced no problems.

IMT Resident Doctors: IMTs confirmed they were aware who to contact for clinical supervision both during the day and OOH. They noted that the IMT3 carries the medical registrar page overnight which can see overnight admissions to HDU. They confirmed supervision is very good despite not being on site and feel well supported and able to escalate when necessary. They do not believe they have had to cope with problems out with their competence only that which is required by the job and have no issues in seeking appropriate support. They noted that the cardiology West of Scotland resident doctor is only available for pacing. On occasion some will give advice if not they must seek support through the on-call medical consultant who will then contact the cardiology consultant. If the patient is non-pacing, there is clear escalation through the consultant. They noted those providing cover for GI bleeds are helpful and are always willing to take calls.

GP Resident Doctors: GPSTs reported clear escalation pathways and are aware of who to contact for supervision both during the day and OOH. They acknowledge that there are times when they may need to wait for support however have no issues making contact. They believe that when carrying the page for the critical care unit (CCU) that they often work beyond their level of competence. As the GPST they can be asked to see a lot of critical patients including cardiology. In hours there are consultants on shift they can contact for support however OOH it can be difficult to get appropriate support for cardiology issues and they must call the medical consultant who is off site or the third on-call. They commented that they would follow the same procedure if they required support for a GI bleed OOH.

ST Resident Doctors: STs reported clear escalation pathways and are aware of who to contact for clinical supervision during the day. However, they noted that some consultants don't introduce themselves at the handover, and although they are aware they are consultants they don't know their name or their role. For cardiology advice OOH/overnight non-pacing they would contact the GIM consultant first if they were unable to help then they would contact the cardiology ST. They do not believe there is a clear escalation pathway for cardiology and find it confusing. They have experienced the cardiology ST refusing to provide advice over the phone for cases not requiring pacing. They are all aware of the escalation pathway for a GI bleed OOH however do not believe the pathway to request an endoscopy overnight for the next morning is clear.

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

Trainers: Clinic access was described in the site presentation where resident doctors are provided with 1 week of 9am-5pm shifts dedicated to clinic attendance. Resident doctors are encouraged to choose clinics from the available spreadsheet and contact consultants in advance to arrange. Trainers acknowledged that there is a lack of out-patient clinic space with some clinics having to take place in consultant rooms. They believe resident doctors are better supported to get off the ward which had been an issue previously. There is also a better understanding of the needs of dual accrediting STs and how to support them in achieving the required number of clinics. They reported that procedures can be challenging and gave an example of central lines being undertaken by IMTs, there is less intervention which is a challenge for all.

F1 Resident Doctors: F1s reported no difficulties in achieving learning outcomes for the post. They noted 80% of their time is spent completing discharge letters and that phlebotomy services are limited.

F2 Resident Doctors: F2s raised no concerns regarding achieving intended learning outcomes or obtaining assessments in post. They noted that consultants are very supportive and some in AMU e-mail with opportunities. They confirmed attending ward rounds daily where they review and discuss patients with STs. They consider around 30% of their time to be spent carrying out jobs that are of little benefit to their education and training. Time spent doing discharge letters and making phone calls are not hugely beneficial however they accept these jobs must be done.

IMT Resident Doctors: IMTs reported difficulties for IMT1/2's in attending clinics unless scheduled as it can be difficult to get away due to workload. IMT3's are allocated 2 clinic weeks in the rota. Unfortunately, a few were allocated clinic weeks when undertaking MRCP part 2 and could not attend. They believe the theory behind allocating clinic weeks is good however out with clinic weeks it is challenging to attend, and they are extremely difficult to reschedule. They noted that time spent carrying out duties which are of little benefit to their education and training is variable and depends on jobs and consultants on the ward. The believe support is available however ward staffing doesn't always facilitate getting away to educational activities.

GP Resident Doctors: GPSTs noted some concerns in achieving intended learning outcomes in post. A requirement of the GP portfolio is that assessments can only be completed by ST4 or above which can be challenging on some ward if there are no seniors. GPSTs have no scheduled outpatient clinics and do not have allocated clinic weeks within the rota however this is not a requirement as clinic experience should come from OOH in GP however it would be beneficial to get different clinic experiences. Clinic attendance has been raised however the rota is tight and there is a need for GPSTs on the ward. They believe that most of their time is spent undertaking jobs that are of little or no benefit to their training or education. They describe feeling like they are there solely for service provision and often feel like they are back in Foundation. Their time is spent doing discharge letters, bloods that have been handed back from phlebotomy services, making calls to social work and administration tasks. A few stated that they attend ward rounds where there is learning. Others commented that they would like to attend ward rounds however cardiologists tend to only see their own patients on different days of the week. On these days consultants do partial ward round and F2s/GPSTs see all other patients unsupervised. They are responsible for making the management plan and should they have any concerns they can ask the consultant conducting the ward round who will give general advice however will not review the patient themselves. Other wards have consultant led ward rounds where GPSTs can review and discuss plans with consultants.

ST Resident Doctors: STs reported previous issues relating to obtaining ACATs. They noted that some GIM procedures can be difficult to achieve and gave an example that there are times when there is no one to support central lines. They have no concerns obtaining workplace-based assessments. They commented on no formal opportunities to attend clinics within GIM, often they must take time out of their parent specialty to meet minimum numbers and believe these should be part of the rota when in GIM. Most consider their time to be spent undertaking appropriate tasks for their level of training. Some believe that 20-30% of their time in GIM is spent doing discharge letters. They believe the 4th on nights could be removed from the rota as it is purely service provision with no training opportunities.

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

Trainers: Trainers reported sufficient opportunities to allow resident doctors to meet assessment requirements. The presentation from site detailed a morning handover checklist which includes asking the night team if any assessments are required. The physician of the week being post-receiving ward rounds at 8am 7 days a week to allow members of the night team to attend ward rounds if they require an assessment and discuss appropriate patients. Finally, within induction resident doctors are encouraged to raise any concerns regarding obtaining assessments as early as possible.

F1 Resident Doctors: F1s reported opportunities to obtain assessments however can struggle to get feedback which makes it difficult to complete the assessment. Consultants also struggle to use the portfolio system and have difficulties with the placement supervision group (PSG) form. Most of the consultants point out cases that can be used for assessments.

F2/GPST/ST Resident Doctors: Covered in section 2.6.

IMT Resident Doctors: IMTs reported good opportunities to obtain assessments with supportive and approachable seniors and consultants. IMT1/2's noted difficulties when second on covering the back of hospital and CCU and are spread over multiple areas on shift however note that people are approachable. They are aware of the feedback clinic however have not used it.

2.8 Adequate Experience (multi-professional learning) (R1.17)

Trainers/F1/F2/IMT/GPST/ST Resident Doctors: Not asked, no concerns raised in pre-visit questionnaire.

2.9 Adequate Experience (quality improvement) (R1.22)

Trainers: Trainers commented that all staff are sent a yearly open invitation to learn how to do a quality improvement project. There have been several FY and STs who have attended and presented projects locally and within conferences. Consultants are also happy to help suggest suitable projects when requested. There is also an Improvement Den which includes a variety of projects and CIFS course. FYs have been encouraged to sign up to this 6-week programme, 5 have currently signed up.

F1 Resident Doctors: F1s reported being encouraged to take part in quality improvement projects however have no time during the working day to undertake a project. They are aware of the QI Den and of an e-mail invitation to the CIFS course. Only one had signed up to the course and had no communication after submitting the application. They are aware of projects that are underway in AMU where they can get involved with data collection.

F2 Resident Doctors: F2s commented on feeling overwhelmed at trying to get involved in a project and doing their job. They noted that it is very difficult to find time to take part in a project during working hours and to take part would mean having to do so in their own time. They all agree that there are a lot of opportunities available to them and are aware of the QI den which is a good resource however time to take on a project is challenging.

IMT Resident Doctors: IMTs reported that the QI den and QI huddles are excellent resources. They noted that it is difficult to undertake a project due to having no time during the working day for the amount of additional work it would require. They commented that there is a lot of support should you have any ideas for a project.

GP Resident Doctors: GPSTs reported that they undertake a quality improvement project when in GP however are aware of resources and have been offered opportunities to get involved with projects.

ST Resident Doctors: STs reported having adequate opportunities to take part in quality improvement projects. Most are aware of the QI den.

2.10 Feedback to resident doctors (R1.15, 3.13)

Trainers: Trainers reported that there is a post take ward round at 8am and consultant presence from 9am – 5pm in MAU and therefore feedback in provided in real time. They acknowledge it can be more difficult to provide regular feedback to FYs and IMTs as they can move around the wards. Resident doctors are also offered the opportunity for assessments at the end of handover. In respiratory STs split and manage the ward, if there are enough STs then FYs can attend the consultant ward round where there is the opportunity to receive feedback. They commented that feedback is a difficult subject. There have been a few sessions delivered to consultants and STs on how to deliver appropriate constructive feedback. Finally, within the presentation from site a handover at 8.30am to critical care HDU consultants was described. This provides an opportunity for feedback and assessments which has been positively received by resident doctors.

F1 Resident Doctors: F1s reported that the level of feedback they receive varies across the department. F1s move wards frequently, often up to 3 times per week which can make receiving feedback difficult. They noted that it can depend on how busy they are as to whether they receive any feedback and that often they can be the only one on the ward OOH. They can attend around half of the post take ward round however they may not review all the patients they have seen on shift. They noted only receiving feedback on HEPMA discharge letters if a patient is readmitted. They noted that they must be enthusiastic and proactive if they wish to receive regular feedback.

F2 Resident Doctors: F2s reported not receiving enough feedback on their clinical decisions and often go home wondering if they have made the right decisions. They agree that during the day is an easier time to receive feedback however if they are on-call or working OOH they receive little or no feedback. They rarely interact with the person dealing with the patient after them therefore if they want feedback on a specific case, they must track that person down. Unless they stay late after a night shift, they do not attend post take ward rounds. It's unlikely if they did stay on that they would review patients that they have reviewed on shift. They commented on a good number of consultants asking if there is a patient they'd like to see together and highlighted one consultant Dr Gordon McKinnon who e-mails them directly offering assessments and feedback which they greatly appreciate.

IMT Resident Doctors: IMTs reported receiving a lot of informal on the job feedback. They noted a friendly culture with approachable consultants who are happy to provide feedback when asked. They commented that OOH when 3rd on during the week they meet with the anaesthetist for the day and will discuss cases there are further opportunities to seek feedback and discuss cases at handover where at least 2 consultants are present. They noted it can be difficult to attend post take ward rounds as they must attend the CCU handover.

GP Resident Doctors: GPSTs reported that they rarely receive feedback on their clinical decisions during the day and OOH. If they were unsure of a decision they would ask advice of a senior. They are aware of the morning handover checklist where they can ask for assessments.

ST Resident Doctors: Most STs reported receiving regular feedback and confirmed working closely with nursing staff and consultants. Not all can attend post take ward rounds as they take place at the same time as HDU handover.

2.11 Feedback from resident doctors (R1.5, 2.3)

Trainers: Trainers reported that resident doctors can provide feedback on their training via resident doctor forum.

F1 Resident Doctors: F1s stated they can provide feedback to trainers on the quality of their training via the junior doctor's forum. There are also regular feedback clinics where they can talk about a specific case however it may not be the clinician they have worked with on the case.

F2 Resident Doctors: F2s commented on providing feedback on their training within the survey's which they are encouraged to complete. Educational supervisors are always keen to hear experiences within supervisor meetings. They are aware of the junior doctor's forum and chief resident's forum. They are also happy to raise any concerns they may have with consultants who they feel are approachable and supportive.

IMT Resident Doctors: IMTs stated that they can provide feedback on the quality of their training via the monthly resident doctors forum. They are also comfortable in discussing any issues with their supervisors.

GP Resident Doctors: GPSTs reported that they have not been asked for feedback on the quality of their training. They were asked to provide feedback on the induction session. They noted attending sessions held by senior management and are aware of the doctor's forum chaired by the chief resident.

ST Resident Doctors: STs confirmed in the pre-visit questionnaire that they provide regular feedback in the National and Scottish Training Surveys and via the resident doctor's forum. They can also provide feedback at the GIM handover.

2.12 Culture & undermining (R3.3)

Trainers: Trainers believe the hospital is a nice place to work with a supportive group of consultants. Civility saves lives sessions have been offered to all. They consider it to be part of their educational role to challenge behaviours of bullying and undermining if witnessed. They acknowledge working in a high stress environment however aim to keep culture and undermining a topic of discussion and encourage resident doctors to come forward to allow any issues to be taken forward quickly.

F1 Resident Doctors: F1s reported that it can be challenging when requesting scans from some radiologists even if they have had consultant review. They have experienced difficulties contacting neurosurgery particularly OOH. They reported that although they have had a good experience in medicine that there can be issues with team culture where some have witnessed colleagues being spoken to rudely by nursing staff/advanced nurse practitioners. They find it difficult to raise issues due to frequent moves making it difficult to build relationships with seniors.

F2/IMT/GPST/ST: Resident doctors reported no concerns regarding bullying and undermining. They are comfortable in raising any concerns with consultants or supervisors.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Improvements to the rota were discussed within the site presentation which detailed a full rota redesign based on feedback from the resident doctor's forum. Additional senior presence over the receiving floor to better support junior staff, procedures and help to reduce patient backlog in MAU. MAU nights resident doctors primarily based in MAU to clerk GP referrals and provide medical cover for MAU. 2nd on-call page split role providing CCU cover and ward referrals during the week 9am – 5pm. Addition of a clinic week and spreadsheet of clinics to allow resident doctors to choose clinics they wish to attend and liaise with consultants in advance. Increase from 1 to 2 FY1 at the weekend to cover AMU. They also aim to reduce cross cover arrangements to allow resident doctors to remain on their base ward for longer and there is a live weekly rota spreadsheet held on Teams plus e-mail communications for short-term sickness cover which they acknowledge is an ongoing issue. There is also a plan to increase clinical development posts from 5 to 8 which will include weekend cover. Trainers noted an increased patient footprint and a rise in boarders and unfunded bed which they are actively managing however acknowledge that this can lead to stress.

F1 Resident Doctors: F1s reported gaps within the rota which are either filled by a locum or staff are moved to cover the gaps which can see them moving up to 3 times a week often at short notice. They confirmed they are given the opportunity to engage with rota organisers however do not believe they are always listened to. Within the pre-visit questionnaire F1s noted that OOH workload on certain shifts can impact on patient safety due to the number of wards and patients they cover. They believe increased workload due to staffing issues can delay investigations due to volume of urgent tasks requiring their attention. Final comments related to the long shift where they believe it could be easy to miss things left over from the day team due to workload. This can result in them having to stay late to ensure reviews of complex patients are fully documented.

F2 Resident Doctors: F2s reported gaps within the rota which are usually unfilled. Often wards either run with less staffing or people are moved to cross cover gaps. Medical boarders is a substantive gap. Due to the number of patients there should be 2 doctors covering however most of the time there is only one. This can result in the ward doctor seeing the additional patients. They described a morning reviewing 15 patients, doing the jobs for those patients and then going out to see medical boarders in other wards.

IMT Resident Doctors: IMTs stated they were unaware of any long-term rota gaps but are aware of occasional short term sickness gaps which they consider to be proactively managed.

GP Resident Doctors: GPSTs stated they were unaware of any long-term rota gaps. Some confirmed being moved wards 1-2 times a week to cover short term sickness gaps.

ST Resident Doctors: STs reported no gaps in the senior tier rota.

2.14 Handover (R1.14)

Trainers: Trainers reported structured handover as taking place at 9am and 9pm, morning handover has at least 2 consultants in attendance who discuss decisions, processes and management plans with resident doctors. A handover checklist is now in use which specifically asks if any assessments are required.

F1 Resident Doctors: F1s commented that handover is not always safe for direct admissions. They commented on being invited to attend morning handover however it is not always possible to attend. They noted that handover for well patients in acute admission is covered within the morning huddle with nursing staff however they do not go through all patients. They are happy to ask questions or report something if not mentioned.

F2 Resident Doctors: F2s agreed that handover arrangements in AMU and on-call provide safe continuity of care for new admissions and downstream wards.

IMT Resident Doctors: IMTs reported handover arrangements provide safe continuity of care for new admissions. Downstream medical wards are not covered in their handover and need to be covered after which they do not believe is an effective way to handover especially for those coming off nights as this can be time consuming.

GP/ST Resident Doctors: GPSTs reported handover arrangements provide safe continuity of care for new admissions and consider handover for downstream wards to be comprehensive. They are aware of the handover checklist.

2.15 Educational Resources (R1.19)

Trainers: The presentation from site detailed a library and desk space available to resident doctors along with 4 pods which can be booked via a QR code.

F1/F2/IMT/GPST/ST: Not asked, no concerns raised in pre-visit questionnaire.

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

Trainers: Trainers believe that support is available to resident doctors requiring additional support. Resident doctors are encouraged to speak to supervisors as early as possible to allow appropriate support to be put in place.

F1 Resident Doctors: F1s were unaware of what support was available to them should they be struggling with the job or their health.

F2/IMT/GPST Resident Doctors: Resident doctors believe adequate support would be provided should they be struggling with any aspect of the job or their health. They are aware of reasonable adjustments to training being made such as less than full time training and excellent levels of support for pregnancy and those returning from sick leave.

ST Resident Doctors: STs believe adequate support would be provided should they be struggling with any aspect of the job or their health. They are not aware of anyone requiring reasonable adjustments to training.

2.17 Educational governance (R1.6, 1.19, 2.1, 2.2, 2.4, 2.6, 2.10, 2.11, 2.12, 3.1)

Trainers: Trainers reported that regular meetings taking place with the management team and resident doctors. There is a standing agenda item in the consultants meeting for resident doctor issues to allow any concerns to be addressed and taken forward appropriately.

F1/F2/IMT/GPST Resident Doctors: Resident doctors noted that if they had any concerns relating to their training, they would be comfortable to raise with their clinical or educational supervisor. They can also raise any concerns via the National and Scottish Training surveys. They are not aware of a local resident doctor forum where concerns relating to training can be raised these meetings tend to focus on wellbeing/parking.

ST Resident Doctors: Resident doctors noted that if they had any concerns relating to their training, they would be comfortable to raise with their clinical or educational supervisor or the postgraduate dean. They are aware of specialty meetings and the resident doctor's forum.

2.18 Raising concerns (R1.1, 2.7)

Trainers: Trainers reported numerous points where resident doctors can raise concerns, they may have with patient safety such as informal conversations, handover and post take ward rounds. They adopt an open-door policy and encourage resident doctors to raise any concerns they may have. There are also regular robust M&M these are consultant lead, promote open discussion and have an action log.

F1 Resident Doctors: F1s stated that they would raise any concerns relating to patient safety with the consultant on the ward however how concerns are addressed can vary.

F2/IMT Resident Doctors: F2s stated that they would raise any concerns relating to patient safety with the senior nurse or consultant.

GP Resident Doctors: Not asked.

ST Resident Doctors: STs reported that they have concerns regarding patient safety due to capacity. They can also raise concerns within handover or on-call with consultants.

2.19 Patient safety (R1.2)

Trainers: Trainers reported concerns relating to the quality and safety of patients regarding increased numbers, continuous flow and continuity of care for boarders within the hospital. The site presentation detailed locum shifts going out to help cover boarders during the week to help reduce workload of resident doctors. There is a full boarders list available on Teams and a daily morning e-mail to update on boarders, locum cover and which boarders are required to be seen by the parent team that day.

F1 Resident Doctors: Covered in section 2.13.

F2 Resident Doctors: F2s commented that often they can be asked to make decisions relating to medical boarders and whether they can be boarded or discharged and do not believe this is appropriate for their level of training. In general, the ward is split between the ST and F2. There are consultant ward rounds for boarders twice a week and a patient list are available on Teams which is updated daily with a plan for each patient.

IMT Resident Doctors: IMTs noted concerns regarding the system for boarder however believe the hospital try hard to get regular boarding doctors which makes a notable difference to doctors on the ward. They believe that when there are no boarding doctors there is a risk to patient safety. They noted receiving a daily e-mail with the number of boarders and if the parent team are required to see patients that day. The boarders list on Teams is update every evening with direct admissions from overnight.

GP Resident Doctors: GPSTs noted concerns regarding the system for boarders and do not believe ward staffing is managed well. There is often only one short term locum covering which results in wards having to see their own boarders. They commented that most days patients are boarded through the flow system when there are no available beds leaving patients waiting on chairs or in corridors for lengthy periods of time. These patients cannot be formally assessed until they have a bed.

ST Resident Doctors: STs raised concerns with the system for boarders overnight and often feel forced to board 4 or 5 patients which can feel unsafe as they have no consultant review and may not be safe enough to be boarded. Consultants finish at 9pm during the week and 5pm at the weekend which leaves STs as the most senior person on shift. They confirmed attending safety huddles and commented on the spreadsheet which is updated daily and available to all.

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

Trainers: Trainers reported that if a resident doctor is involved in an incident that their educational supervisor would be contacted, and they would meet with the resident doctor to discuss. If it is a particularly distressing incident, then a cold debrief would take place. Discussions can foster learning depending on the situation. They believe that a key tenant of feedback is that resident doctors do not make mistakes in isolation, adverse events tend to be due to a failure in the system.

F1/F2/IMT/GPST/ST Resident Doctors: Resident doctors are aware of the Datix reporting system however have not been involved in an adverse incident. They confirmed attending regular M&M meetings where adverse incidents are discussed. Meetings are run by a different specialty each month and are senior lead with consultants present cases.

2.21 Other

Overall Satisfaction Scores:

F1 – 7/10

F2 – 6/10

IMT - 8/10

GPST - 6/10

ST – 6/10

3. Summary

Is a revisit required?	**Yes**	**No**	**Dependent on outcome of action plan review**

The panel commended the engagement of the site and medical education team in supporting the visit and note the considerable efforts being made to improve training. Concerns were still present regarding escalation and OOH cover within Cardiology. The panel noted areas for improvement at the visit relating to educational governance, non-educational tasks, adequate experience and feedback. SMART objectives and action plan review meetings will be arranged in due course where the department will be given the opportunity to show progress against the requirements listed below.

Positive aspects of the visit:

- Excellent engagement from the Medical Education team and site management teams in supporting the visit.
- Recognition of the work and engagement of the Trainers who are working extremely hard to make sustainable improvements and are committed to providing a good training environment.
- Resident doctors described robust induction to the hospital and base wards which they are asked to provide feedback on. Right Decision app is found to be very useful. Notable amount of work undertaken by Sally Mcadam on the induction programme.
- Resident doctors commented on a wide variety of teaching opportunities available to them.
- Resident doctors reported good levels of supervision during the day and OOH with supportive, approachable and accessible seniors/consultants.
- Resident doctors commented on robust and clear escalation policies.
- F2/IMTs noted receiving meaningful and constructive formal and informal feedback.
- IMTs noted having designated time within the rota to attend clinics.
- Most resident doctors noted engagement from consultants in offering assessments. IMTs highlighted Dr Gordon McKinnon as being very supportive.
- Resident doctors reported good opportunities for involvement in quality improvement projects and noted the QI Den as a useful resource.

- Resident doctors noted the difference to workload relating to boarders when two locums are on shift. They also find the boarders excel spreadsheet which is available on Microsoft Teams to be useful.
- Resident doctors commented on regular handovers taking place and noted the use of a handover checklist which offers the opportunity for assessment on a case.

Less positive aspects of the visit:

- Cardiology and GI (unstable bleeders) escalation/cover OOH remains a concern with no clearly documented pathways (excluding PCI or pacing).
- It was noted in Cardiology there is no specific consultant who leads daily ward rounds for all patients. Consultants hold ward rounds on different days of the week for their own patients. GPST/F2's are unable to attend these ward rounds as they are undertaking reviews themselves on the remaining patients on the ward. These resident doctors may also have no cardiology experience. They can ask the consultant for support however they will provide general advice and will not necessarily see the patient with the resident doctor.
- Foundation resident doctors commented on frequent moves from their base ward to cover short term sick gaps (sometimes up to 3 per week). This is particularly difficult on a day they rota and there is no consultant ward round, they are then seeing patients they have no previous knowledge of and without consultant cover. Lack of continuity for training and workload or feeling part of a team.
- ST's also noted difficulties in attending GIM clinics and obtaining assessments as time within this component is generally OOH.
- High volume of non-educational tasks noted for FY1 (IDLS and phlebotomy), with phlebotomists only covering 25% of workload during workdays and the FY1s being expected to cover the remaining 75% and all OOH phlebotomy service. Due to this workload and need to complete jobs foundation resident doctors are unable to attend ward rounds. A consequence of this is there is a lack of formal/informal feedback.
- Lack of feedback to STs who are not based within the receiving wards (AIM) but who are only covering acute medicine during OOH. It is expected they will lead the team however have no exposure to daytime interactions with consultants or the acute care set up. Their ability to attend post-take ward rounds was also unclear as they tend to review patients in multiple areas during their OOH shifts.

4. Areas of Good Practice

Ref	Item	Action
4.1	Resident doctors described robust induction to the hospital and base wards which they are asked to provide feedback on. Right Decision app is found to be very useful.	
4.2	Resident doctors reported good opportunities for involvement in quality improvement projects and noted the QI Den as a useful resource.	

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	Lack of feedback to STs who are not based within the receiving wards (AIM) but who are only covering acute medicine during OOH. It is expected they will lead the team however have no exposure to daytime interactions with consultants or the acute care set up. Their ability to attend post-take ward rounds was also unclear as they tend to review patients in multiple areas during their OOH shifts.	

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Resident doctor cohort in scope
6.1	There must be a clear escalation policy including pathways for cover out of hours in Cardiology/GI particularly covering unstable bleeders which is understood and followed by all involved.	February 2026	ALL
6.2	There must be regular Consultant ward rounds which review resident doctor decisions and care plans and offer constructive feedback & teaching particularly to GPST/F2's in Cardiology.	February 2026	Foundation, GP
6.3	The discontinuity of ward placements for Foundation resident doctors, 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.	February 2026	Foundation
6.4	Dual accrediting resident doctors must have more structured G(I)M training including access to G(I)M clinics to meet their curriculum.	February 2026	ST
6.5	Tasks that do not support educational and professional development and that compromise access to formal learning opportunities for Foundation resident doctors should be reduced.	February 2026	Foundation