Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	28th May 2025	**Level(s)**	Foundation, IMT, GPST
Type of visit	Triggered (virtual)	**Hospital**	Dr Gray's Hospital
Specialty(s)	General Internal Medicine (including group 1 specialties)	**Board**	NHS Grampian

Visit Panel	
Dr Fiona Drimmie	Visit Chair – Associate Postgraduate Dean (Quality)
Dr Alistair Milne	Associate Postgraduate Dean (Foundation South-East)
Dr Imali Fernando	Training Programme Director
Dr Siobhan Duffy	Trainee Associate
Ms Sarah Summers	Lay Representative
Mrs Jennifer Duncan	Quality Improvement Manager
In Attendance	
Dr Gaynor Macfarlane	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, Dr 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	4
Resident Doctors in attendance	(5-F1, 1-F2, 3-IMT, 1-GPST)

Feedback session: Managers in attendance	Chief Executive	0	DME	1	ADME	0	Medical Director	0	Other	9

Report approved by Lead Visitor / Lead Dean	Dr Fiona Drimmie 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 is being arranged to General Internal Medicine (including Group 1 specialties) at Dr Gray's Hospital. This visit was requested by the following Transitional Quality Review Panel: Medicine, Surgery, Occupational Medicine & AICEM.

NTS (2024)

Acute Internal Medicine

All Trainee – All Grey

General Internal Medicine

All Trainee – Red Flag – Educational Governance, Overall Satisfaction, Rota Design, Supportive Environment, Workload. Pink Flag – Clinical Supervision, Clinical Supervision Out of Hours, Educational Supervision, Reporting Systems, Teamwork.

Medicine

GPST, IMT, F2 Medicine – All Grey

F1 Medicine – Red Flag – Clinical Supervision Out of Hours, Educational Governance, Induction, Overall Satisfaction, Reporting Systems, Rota Design, Supportive Environment, Workload. Pink Flag – Clinical Supervision, Educational Supervision.

STS (including up to February 2025)

Acute Internal Medicine

All Trainee, IMT – All Grey.

General Internal Medicine

STS bottom 10%.

All Trainee – Red Flag – Clinical Supervision, Educational Environment & Teaching, Handover, Induction.

Foundation – All white.

GPST/IMT – All Grey.

Geriatrics

STS bottom 10%.

All trainee, IMT – All Grey.

Medicine

IMT – Red Flag – Educational Environment & Teaching.

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 Louise Millar delivering an informative presentation to the panel. This provided detailed information including structure of the department along with challenges and improvements against the indicators within recent survey data.

2.1 Induction (R1.13):

Trainers: Trainers reported that there is a generic NHS Grampian corporate induction which the team add specific information relating to Dr Gray's hospital to. This is offered to all training grades. There is focused F1 induction as part of shadowing week in August which is in-person and includes input from consultants and previous F1s. It also includes a night shift to ensure they are familiar with services overnight. Departmental induction is face-to-face and delivered by Dr Louise Millar. Feedback received on inductions and the shadowing week have been positive and F1s have commented that they feel they have prepared them well for working in the department during the day and out of hours

(OOH). To support induction a PowerPoint presentation and induction handbook is sent to all, with induction material updated on a yearly basis. There is bespoke induction session arranged for those who are out of sync which are delivered by a consultant and manager. Finally international medical graduates (IMGs) are also provided with a clinical attachment to enhance their induction.

F1/F2/IMT/GPST: RDITs confirmed receiving good quality hospital and departmental inductions. They noted seeking a lot of support on day-to-day activities from those who were previously in post. Suggested improvements for hospital induction were noted as:

- more time on wards prior to starting
- more in-depth tour of the hospital
- greater explanation of what is expected of on-call doctors

Suggested improvements for departmental induction were noted as:

- ensure all trainees receive an in-person induction/catch up induction
- update list of ASCOM phone numbers
- update handbook

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

Trainers: Trainers reported that regional teaching for IMT and GPSTs is held off-site in Inverness. They submit study leave request to attend and arrange shift swaps should they be on a day or late shift. Unfortunately, due to staffing numbers the department cannot support requests to swap night shifts. F1 and F2 teaching is either held in-house or is combined with Aberdeen to which sessions are attended via Microsoft Teams. Trainers noted challenges with some members of the team covering bleeps to allow attendance which is being addressed. Due to the size of the hospital, it is not possible to map departmental teaching to all the different curricula however the programme covers a broad spectrum of topics and interesting cases and is well received. Topics for the departmental teaching programme are based on requests from RDITs and staff. It is overseen by the physician's associate (PA) to ensure there is no duplication and that all are given the opportunity to present.

F1/F2: FYs reported that departmental teaching should take place on a Tuesday and Thursday. They noted that it is not bleep free and can often be cancelled however when it takes place it is of good

quality. They often miss departmental teaching as ward rounds can still be taking place, if wards are busy or if there are staff shortages. They noted difficulties in attending regional teaching or finding time to catch-up on missed sessions. Rest days, late and night shifts can prevent attendance.

IMT/GPST: RDITs confirmed attending 1-hour of departmental teaching and being invited to attend regular morbidity and mortality meetings (M&M). They are unable to attend teaching if on-call, night shift or on a zero day. GPSTs, noted having a heavy on-call commitment and find it difficult to attend teaching. They also commented that wards are staffed by locums who change frequently. They are frequently moved wards and have little time to attend teaching especially if new to a ward as they spend a significant amount of time familiarising themselves with that ward. Suggested improvement to departmental teaching was to occasionally have presentations by consultants. They confirmed being able to attend only 50% of regional teaching due to the rota being tight and therefore challenging to arrange swaps.

2.3 Study Leave (R3.12)

Trainers: Trainers reported no challenges in supporting study leave requests which are made in a timely manner. As commented in the previous section requests cannot be supported should they involve swapping a night shift.

F2/IMT/GPST: Most reported no problems in requesting or taking study leave and find the system easy to use. Some noted difficulties in arranging swaps and being unable to attend events. There are multiple rotas and only certain individuals within these that they can swap with.

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

Trainers: Trainers noted that they can attend training and are all recognised trainers with adequate time in job plans for supervisory roles. A series of GMC workshops and training sessions relating to support within the team were held earlier in the year which will be followed by a performance support session in the autumn. Trainers commented they feel well supported in their roles and look to Dr Louise Millar for support and advice particularly should they have concerns regarding a RDIT. As a small department they work closely and acknowledge that they are heavily dependent on short-term and long-term locums to deliver service and clinical supervision across general medicine. They

confirmed that they would receive a supporting trainee entering practice form (STEP) or transfer of information form (TOI) should the department be allocated an RDIT requiring additional support or reasonable adjustments. Dr Louise Millar often provides supervisors with briefs on any Foundation RDIT prior to them commencing in post which trainers find very beneficial.

F1/F2: FYs reported being allocated an educational supervisor who they meet twice while in post. Difficulties were noted in making initial contact with some supervisors and the quality of meetings was variable.

IMT/GPST: RDITs confirmed having designated educational supervisor who they meet with regularly in post.

2.5 Clinical supervision (day to day) (R1.7, 1.8, 1.9, 1.10, 1.11, 1.12, 2.14, 4.1, 4.6)

Trainers: Trainers reported that there are clear escalation pathways for support during the day and OOH which are documented in the handbook which is distributed to all. Ms Tracey Elliott and Dr Louise Millar also issue ward allocations on a weekly basis. Teams are made up of a consultant, middle grade and an advanced nurse practitioner (ANP) or PA. They acknowledge previous concerns relating to escalation pathways OOH and to enhance support they now ensure anyone appointed to a locum consultant position has a relevant certificate of completion of training (CCT). They found it difficult to answer whether RDITs have felt they have had to cope with problems beyond their level of competence. They believe this may be an issue for F2s who are on a generic middle grade rota. They acknowledge that most will feel out of their depth at some point. However, are confident that appropriate levels of support are available, that RDITs are aware who to contact and that consultants are responsive and happy to come into the hospital OOH.

F1/F2: FY1s confirmed they are aware of who to contact for clinical supervision both during the day and out of hours with approachable consultants however they do not feel that all of those providing supervision have the ability or experience to do so. On a night shift there is one medical F1 and one middle grade who maybe be within the emergency department and are therefore not immediately available for support. Ward rounds vary depending on the consultant and result in FYs and middle grades splitting the patients across the wards evenly to ensure they are reviewed. There can be difficulties in escalating as consultants can be busy elsewhere.

They all agreed that they regularly cope with problems out with their level of competence particularly when on night shift. F1s commented that it can depend on who is providing middle grade cover and would be more comfortable escalating to an IMT rather than an F2. They believe that this is an unfair level of responsibility to place on an F2 and would feel uncomfortable if they were in this role. They believe that night shift and on-call support should be provided by an IMT1 as a minimum. Overall, they would appreciate more support OOH. There are also times when consultants are extremely busy and there is not always a middle grade on shift which can leave the F1 on for medicine and the F1 on for surgery OOH covering the entire hospital. Some areas of the hospital do not have a second tier of support and its F1 directly to consultant. Additionally, there are different pathways for the different specialties covered with some requiring consultant to consultant referrals. Often on-call consultants/locums are unaware of this and can request the FYs undertake this task. They noted difficulties in contacting the consultant/locum on-call when at home. They gave examples of lengthy delays in receiving support on the ward for varying reasons and on occasion not being able to contact the consultant/locum on-call at home after several attempts. Contact is made via mobile phone and there are regular signal problems and no landlines as back-up.

IMT/GPST: RDITs confirmed they were aware who to contact for clinical supervision both during the day and OOH however accessibility and approachability can vary. They find it relatively easy between the hours of 9am – 5pm however after 5pm it becomes more difficult particularly overnight. They noted difficulties in contacting seniors and sometimes contact consultant's personal mobile phones. There are often significant delays in getting help from seniors and they have to seek support through different avenues such as the emergency medicine department. They also described times when they have had no support from the consultant/locum on-call. These concerns have been raised with the management team. They confirmed working beyond their level of competence and commented that there is an expectation that as middle grades they will manage. There is also consider there to be a culture that unless it is 'serious emergency' then they should manage.

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

Trainers: Trainers confirmed being familiar with the different curricula for RDITs rotating through the department. They believe that RDITs can achieve all required competence when in post. They acknowledge challenges with clinic access which is considered a work in progress. They noted that some of the current RDITs have required a significant number of clinics to meet minimum requirements, and the department have worked extremely hard to accommodate these requests. They believe that adequate training opportunities are provided for middle grades within an extremely difficult rota and recognise the challenges that come with providing the service component along with training. A concerted effort is put in to utilise other resource to back fill and maximise training opportunities and hope this is recognised by RDITs.

F1/F2: FYs reported no difficulties in achieving learning outcomes for the post and believe the post allows them to develop skills and competence in managing acutely unwell patients. They spend very little time carrying out duties that are little or no benefit to their education and training however note a significant amount of time undertaking general service provision.

IMT/GPST: IMT1s reported difficulties in accessing clinics unless scheduled due to workload. GPST also noted difficulties in obtaining supervised clinical examination and procedural skills (CEPS) and find it extremely difficult to get consultants to complete assessments using the GP portfolio as very few have experience in using the system. IMT3 noted that they have had help in making up shortfall of clinics and are aware of list of consultants on Microsoft Teams who can be contacted to arrange clinics. They believe that the post allows them to develop skills and competence in managing acutely unwell patients. They believe there is a balance of duties that support education and training however note a significant amount of wasted time due to additional steps added to processes that they consider to be unnecessary. They provided examples of all x-rays being vetted by a radiographer, CT scans being reviewed by a radiologist and requesting scans on the instruction of consultants that are not always necessary and are often declined by the radiologist. In these cases, they must add superfluous and questionable details to ensure scans are undertaken. They find that there is no difference in day-to-day ward jobs regardless of grade and believe this is unfair to the IMT3/GPSTs who at their stage of training should be leading on ward rounds. This is due to the need for IMT3s to complete discharge letters and take bloods which severely limits their opportunities, they acknowledge that these jobs must be completed.

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

Trainers: Trainers reported sufficient training opportunities to allow RDITs to easily achieve minimum assessment requirements.

F1/F2: FYs reported no difficulties in obtaining workplace-based assessments in post which are fair and consistent.

IMT/GPST: IMTs reported good opportunities to obtain assessments with supportive and approachable seniors and consultants. GPSTs noted difficulties as most consultants are unfamiliar with the GP portfolio and are therefore reluctant to provide educational feedback.

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

Trainers: Trainers reported that all teaching is made available to all staff apart from regional teaching which is delivered by the deanery and is not multi-disciplinary. The hospital also offers shared learning once a month.

F1/F2/IMT/GPST: RDITs noted that they work closely with ANPs on the weekend and when covering the ward. They interact regularly with pharmacists on discharge letters and medication. Tuesday teaching also includes ANPs.

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

Trainers: Trainers reported they have little time to support quality improvement (QI) activity. They hope this is a task that can be taken on once a clinical lead is appointed. Ward 7 did run weekly QI meetings however these no longer take place as regularly however requests to undertake a project are facilitated.

F1/F2/IMT/GPST: FYs stated that general medicine has been the most difficult post to take part in any quality improvement activity. They find it difficult to undertake a project as they move wards frequently and middle grades have a high on-call commitment.

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

Trainers: Trainers stated that all patients are seen by a consultant and RDIT who admitted the patient within 12 hours. They acknowledge that feedback is an area they could improve upon. They commented that the night middle grade receives informal feedback at the morning handover on overnight cases.

F1/F2: FYs reported receiving direct feedback when on the clerking shift and from consultants on post-take. Feedback is available when on the wards from middle grades however they must actively seek senior feedback. They are provided with no feedback OOH this relies entirely on them following up on a case. They noted that when feedback is received it is constructive and meaningful.

IMT/GPST: RDITs noted that informal feedback varies depending on the consultant, some are happy to take time to discuss a case. They described one consultant who will attend the ward post-take, take someone from shift and undertake a quick ward round. If you are not around there is no opportunity to discuss cases, management plans or get any formal feedback on decisions. They noted that the post-take review is not protected like handover, and they can be fielding incoming calls at the same time. There is no set time or structure for post take ward rounds these take place at varying times depending on the consultant.

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

Trainers: Trainers reported that feedback is gathered on RDITs experience within their end of post meeting and via the NTS and STS surveys. There is no group feedback where RDITs can provide feedback on the quality of their training apart from the RDIT representative and trainee forum which take place quarterly with any concerns taken forward to the associate director for medical education, Dr Louise Millar and Dr Laura Nicoll.

F1/F2/IMT/GPST: RDITS are unsure of any formal opportunities to provide feedback to trainers or the management team on the quality of their training. They noted a junior doctor’s forum taking place in August however due to lack of attendance this was stopped. There have been e-mails recently regarding reinstating the group.

2.12 Culture & undermining (R3.3)

Trainers: Trainers reported a recent incident relating to a locum who has now left post. The matter was taken very seriously and support provided to those involved. The department offer an open-door policy and encourage RDITs to raise any concerns they may have early. They are also encouraged to use the datix reporting system.

F1/F2: FYs noted varying levels of support. IMTs are very supportive, F2s are supportive but less experienced and some locum's covering gaps are not as supportive. They noted having experienced undermining behaviours from some seniors and locums who are no longer in post. There were also concerns raised around the capabilities of some fellows which has resulted in them escalating to the consultant on-call rather than the fellow. They have raised concerns with a lack of senior support on nights which were addressed. They provided examples of waiting significant lengths of time when contacting a senior for support and on more than once occasion have attempted to call consultants/locums at home OOH and have had no response.

IMT/GPST: RDITs note several instances or poor team culture and behaviours of undermining. They provided examples of being referred to as 'just an SHO' in a group setting which they found humiliating and patronising. Detail was also shared of waiting for support for lengthy times e.g. 45 minutes in some cases, in emergency situations where in some instances should support have been provided sooner, they believe there could have been a different outcome for the patient. Comments have also been made about interrupting the senior's lunch when called for support. Locums can often become defensive if questioned on a decision that the RDIT considers might be inappropriate. They noted difficult relationships with locums who they do not consider to have a vested interest in training.

2.13 Workload/Rota (R1.7, 1.12, 2.19)

Trainers: Trainers noted no long-term rota gaps. As described in the site presentation the department work hard to cover the high rate of short-term sickness gaps. They acknowledge that the middle grade rota although compliant is unpleasant and may compromise RDIT wellbeing as it leaves them tired and is linked to increased sickness absence. The run of 4 late shifts into 3 nights for the weekend is highlighted as a major issue along with concerns regarding rest days after weekend on-call after the 7-day run. Possible solutions were noted as adding more people to the rota, faster

turnaround of job adverts after resignations, encouraging specialty doctors to undertake late and weekend shifts which is currently not part of their contract, replace one late RDIT with an ANP once the trainee ANPs have graduated in the summer, revise rota to ensure 7-days are broken up by rest day or extra rest day after weekend on-call.

F1/F2: FYs believe that a locum and IMT resigned. They are unsure if the IMT space has been filled on the middle grade rota. They noted being frequently pulled to cover short-term sickness gaps. This also includes being pulled from anaesthetics and the high dependency unit to cover medical wards. Locums tend to be brought in to cover weekend shifts with RDITs moved to provide cross cover during the week. OOH there should be one F1 for medicine and one F1 for surgery however there is often only one F1 covering both roles. They believe that there are aspects of the rota that compromise wellbeing such as the F2 being placed on the middle grade rota which entails them taking on far more responsibility than any other F2 post. The 7-day stretch is extremely difficult. They recognise that rotas are under immense pressure, they cover a lot of additional shifts which put a strain on their mental health. They commented on a WhatsApp group being used to co-ordinate cover for short-term sickness absence. They find it difficult to say no to requests for cover and noted feeling uncomfortable and guilty in the event of them taking a sick day or if they do not feel they can take on an additional shift without compromising their own health as they see all messages. They noted gaps almost every weekend.

IMT/GPST: RDITs noted constant gaps within all rotas. Some gaps have been filled with long-term locums who are placed on a different rota to the middle grades therefore it can be difficult to quantify filling a gap should they resign. Short-term sickness gaps are managed through a WhatsApp group. They believe that the middle grade rota and available support compromise their wellbeing.

2.14 Handover (R1.14)

Trainers: Handover was described in the site presentation as taking place at 9am, 4.45pm and 9pm. 9am handover is from the night to day team, where the middle grade presents all cases from the shift, deaths and those who are sick and require review. The 4.45pm handover is from the day on-call to the late shift team again highlighting any sick patients who require review. The 9pm handover is from the late team to the night team.

F1/F2: FYs reported that formal handovers take place at 9am and 9pm. They noted that ward staff do not attend 9am handover and described leaving notes to highlight cases which require discussion. 9am handover is attended by the consultant and middle grade on-call and consultants and middle grade on that day. FYs and middles grades on the wards do not attend and must go round the ward to find out what has happened overnight. They believe it would be hugely beneficial if they were included in the 9am handover during the week. They confirmed that those on shift over the weekend attend both the 9am and 9pm handover and are assigned an arrest team. There is a weekend handover list for each ward however due to workload it can be difficult to review all patients, often only those highlighted by the weekday team are reviewed. In a handover setting consultants discuss patients on the board, talk about jobs and ask if there are any sick patients they should be aware of. They believe that improvements could be made over the weekend to include new admissions on the handover list along with step downs from HDU. Currently they are not part of the handover list and FYs must ensure these patients are reviewed. Handover can be used as a learning opportunity however this varies depending on consultant.

IMT/GPST: RDITs reported that F1 on-call provides direct handover to the day F1. They noted adhoc post takes and no afternoon handover with a consultant. 9am and 9pm handovers are structured and attended by all consultants, middle grades and night team. They believe that handover arrangements provide safety continuity of care for new admissions however do not believe the same process is applied to those who remain sick on the ward as they are not added to the whiteboard for discussion. They then have to seek information from F1s and trust that if they are busy F1s will escalate any concerns they have. They commented on a strong F1 cohort because they must be. They noted learning from handover as variable. There can be discussion of an interesting case on occasion.

2.15 Educational Resources (R1.19)

Trainers: Trainers confirmed that there is a doctor's mess with IT, a library and computers in all doctor's room. They believe IT could be improved. The department has also grown significantly, and space is becoming inadequate for holding things such as departmental teaching and M&M. They noted that the digital officer is aware the IT structure is less than ideal and is trying to support a way forward.

F1/F2/IMT/GPST: FYs reported that the library is an excellent resource and staff are very helpful. They noted a lack of IT equipment and described one computer mainly used by nurses and a mobile unit which does not support access to e-mail. Lack of resources in the department have been raised.

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.

F1/F2: FYs believe that support would be available to them if they were struggling with the job or their health. Supervisors often check in and they are aware of services provided by occupational health. The believe adjustments were made to remove a person from nights however that person was required to arrange cover for the shifts they had been allocated which they felt should not have been that person's responsibility to manage.

IMT/GPST: RDITs commented that support if they are struggling with the job or their health is variable. The department do try to provide pastoral support.

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

Trainers: Trainers reported that there is no dedicated committee that oversees the management and quality of postgraduate medical education and training however it is a standard item at the senior staff meeting to which all senior doctors in the hospital are invited to attend.

F1/F2: FYs stated that they would raise any concerns relating to the quality of training within the post with Dr Louise Millar as Foundation Programme Director. They commented that once a concern is raised a meeting is arranged and feedback is given. They noted a junior doctors forum used to take place however due to lack of attendance was stopped.

IMT/GPST: Within the pre-visit questionnaire RDITs noted that they would raise any concerns relating to the quality of training in post with the deputy manager who they meet regularly or supervisors.

2.18 Raising concerns (R1.1, 2.7)

Trainers: Not asked due to time constraints.

F1/F2: FYs stated that they would raise any concerns relating to patient safety with their educational supervisor, consultant or Dr Louise Millar. They believe that patient safety can be affected as they are moved wards frequently; they therefore have no continuity of care and never get to know patients. Difficulties were noted when they are requested to speak to family members as they may not be aware of all issues or details of a patient.

IMT/GPST: Not asked due to time constraints.

2.19 Patient safety (R1.2)

Trainers: Trainers believe the department is as safe as possible. There is a lot of time spent ensuring the blended workforce is well balanced. Patient safety issues can a risk in periods of sickness absence or if long-term gaps remain unfilled.

F1/F2: FYs found it difficult to answer when asked if they would have any concerns if a friend of family member were to be admitted to the department. They noted that due to staffing and workload things can often be missed. Ward rounds are variable and often RDITs are conducting their own ward rounds to ensure patients are reviewed. No concerns were raised regarding the system for boarding patients in the hospital. They noted that medical patients can be boarded to surgery however there is no medical team person assigned to surgery. Patients can also be sent to surge wards should wards reach capacity and finally they can be moved to the discharge lounge if they are awaiting discharge papers and medication. They are happy with escalation pathways should they have any concerns.

IMT/GPST: RDITs noted that they would have concerns about the quality and safety of care should a friend of family member be admitted to the department. The main concerns related to limited services available within the hospital rather than the quality of care provided i.e. no immediate recourse to renal replacement therapy if required as this is only provided in Aberdeen.

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

Trainers: Trainers confirmed that the datix system is used to report adverse incidents, RDITs are encouraged to use the system. They noted that adverse incidents are rare however if it involved a Foundation RDIT then Dr Louise Millar would meet with them to ensure they were appropriately supported and provided with feedback. If the incident involved an IMT/GPST then the educational

supervisor would meet with them to provided support and feedback. They use M&M meetings which involve the whole team to learn from adverse incidents with people asked to present cases. They are currently working on how cases presented at an M&M could be turned into an educational event through simulation.

F1/F2: FYs confirmed they are aware of the datix reporting system for adverse incidents and believe these are well reported. They would speak to their educational supervisor or Dr Louise Millar if they were involved in an incident however are unsure how they would receive feedback on an incident or if there is learning from an incident.

IMT/GPST: Within the pre-visit questionnaire RDIT's noted being aware of the datix system for reporting adverse incidents and were aware of these being discussed within a regular meeting.

2.21 Other

Overall Satisfaction Scores taken from pre-visit questionnaire:
F1 (4) – 3.5/10
F2 (0)
IMT/GPST (5) - 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 noted the considerable efforts being made to improve training. Serious concerns were raised relating to support, patient safety and wellbeing which were discussed with the Director of Medical Education and Clinical Director immediately after the visit. The panel also noted positive comments relating to induction, teaching, adverse incidents, supervision, assessments and feedback. Areas for improvements were noted as rota, handover and boarders. 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 within this report.

Serious concerns (discussed with DME and MD 28/05/2025)**:**

- Resident doctors in training (RDITs) noted concern regarding supportiveness of some locum consultants. They noted several occasions where they have been unable to contact the on-call consultant for support overnight. They also noted the significant time it can take between contacting the on-call consultant out of hours and them arriving to see the patients which can be up to 45 minutes. High risk to patient safety and trainee wellbeing. The panel also heard one specific example relating to a person feeling undermined and belittled after an unexpected death.
- The escalation policy to ensure immediate advice out of hours is always available requires to be enhanced.

Positive aspects of the visit:

- Excellent engagement from the Medical Education team and site management teams in supporting the visit.
- Recognition of the substantial efforts and engagement to make sustainable improvements.
- Resident doctors in training (RDITs) described robust hospital and departmental inductions.
- The teaching programme is well structured with reasonable levels of attendance.
- RDITs are aware of Datix reporting and consider adverse incidents to be well reported.
- Positive development of learning opportunities from M&M meetings being converted into simulation sessions.
- RDITs reported good levels of supervision during the day with approachable and accessible consultants.
- FY/IMTs noted no concerns in completing workplace-based assessments.
- FYs reported receiving good levels of feedback during the day when on the clerking shift and post take.
- It was heard throughout the visit that when RDITs raise issues they are dealt with appropriately and solutions offered.
- Measure to support RDITs in achieving clinic requirements were appreciated with thanks paid to Tracy Elliott and Dr Louise Millar.

Less positive aspects of the visit:

- IMT/GPST's reported working an extremely difficult rota which they do not consider a suitable experience for an F2.
- RDITs commented on the use of a WhatsApp group to cover gaps which they consider to be undermining to the person that is off as they are included in the group chat. They worry that in covering gaps they risk burnout and must first consider the shifts they have coming up and whether they deem this a risk to their wellbeing.
- The panel have concerns that the medical department has a number of active and engaged educational supervisors but is reliant on one consultant for the leadership and overall responsibility for most training related activity. This is considered to constitute a high risk of burnout for that individual.
- The same individual consultant is providing the bulk of assessment support for GPSTs within the GP portfolio due to the challenges in using the 14 fish system. This poses a risk inherent in the educational support system.
- Underlying theme of the rotas, at consultant level this is heavily reliant on locum consultants and at other levels is stretched and affecting wellbeing and training.
- RDITs noted challenges with radiology when referrals made by consultants are disputed, they often must elaborate referrals to ensure they are processed. Should a RDIT disagree with the requests being put forward and attempt to discuss with the locum consultants they can be met with defensive practice.
- RDITs commented on frequent moves from their base ward to cover short term sick gaps.
- 9am and 9pm handovers appear to be working well however concerns were noted that downstream patients who have been admitted for more than 24 hours are not discussed. IMT/GPSTs heavily rely on F1s highlighting any of these patients that require review.
- Accommodation for RDITs was discussed however the panel are aware of wider discussions relating to this as taking place in NHS Grampian.

4. Areas of Good Practice

Ref	Item	Action

4.1	Measure to support RDITs in achieving clinic requirements were appreciated with thanks paid to Tracy Elliott and Dr Louise Millar.	
4.2	Work being undertaken to turn cases presented at an M&M into educational events through simulation.	

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	A service entirely reliant on locums OOH makes long term sustainable solutions difficult. Continued efforts to attract and retain substantive staff should be continued.	
5.2	Accommodation for RDITs was discussed however the panel are aware of wider discussions relating to this as taking place in NHS Grampian. These should be progressed with suitable solutions identified	

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Resident doctor cohort in scope
6.1	RDITs must be provided with clearly identified and immediately accessible senior support with reliable communication methods out of hours for all clinical areas they cover. Those providing supervision must be supportive of trainees who seek their help, they must respond in a timely manner and must never leave trainees dealing with issues beyond their competence.	Immediate	ALL
6.2	All staff must behave with respect towards each other and conduct themselves in a manner befitting Good Medical Practice guidelines. This should include those providing daytime and emergency cover doing so in a supportive manner when RDITs raise queries around decisions.	Immediate	F1 and F2
6.3	The Rota pattern must be reviewed with the trainees who are on the rota to reduce reliance of them to fill short term gaps.	December 2025	F1
6.4	The Rota pattern must be reviewed to minimise the reliance on short term locum cover and impact on wellbeing. Consideration should be given to the appropriateness of F2s on this rota.	December 2025	F2/IMT/GPST
6.5	The site must develop an effective handover system of tracking and managing downstream patients and ensuring appropriate clinical ownership and oversight of these patients.	December 2025	ALL
6.6	The discontinuity of ward placements for Foundation, GPST and CMTs 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	December 2025	F1 and F2

	of Foundation doctors must be increased to be for at least 4 weeks.		
6.7	There must be senior support, including from consultants/recognised trainers to enable doctors in training to complete sufficient WPBAs/SLEs and portfolio entries to satisfy the needs of their curriculum. The governance of this should provide adequate supervising staff to avoid reliance on one individual.	December 2025	ALL
6.8	A trainee forum should be established and supported so trainees can safely raise concerns and provide feedback.	December 2025	ALL