Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	22 May 2019	Level(s)	Foundation Year 1 & 2 (FY1 & FY2), Core (CT), Specialty (ST) *No GP trainees available*
Type of visit	Scheduled	**Hospital**	Ninewells, Perth Royal Infirmary (PRI)
Specialty(s)	Emergency Medicine	**Board**	Tayside

Visit panel	
Mo Al-Haddad	Visit Lead, Associate Postgraduate Dean for Quality
Graeme McAlpine	Programme Representative
Stuart Holmes	Lay Representative
Hazel Stewart	Quality Improvement Manager
In attendance	
Gayle Hunter	Quality Improvement Administrator

Specialty Group Information		
Specialty Group	Anaesthetics, Emergency Medicine, Intensive Care Medicine	
Lead Dean/Director	Adam Hill	
Quality Lead(s)	Mo Al-Haddad	
Quality Improvement Manager(s)	Kelly More	
Unit/Site Information		
Non-medical staff in attendance	4	
Trainers in attendance	8	Including Training Programme Director, Clinical Lead and Clinical Director
Trainees in attendance	13	3 x Foundation, 1 x core, 1 x clinical fellow, 6 x ST, no GPST attended the visit.

Feedback session: Managers in attendance	Included Associate Director of Medical Education (ADME) and Medical Education Manager

Date report approved by Lead Visitor	10/06/2019

1. Principal issues arising from pre-visit review

The panel examined all available data from the GMC national trainee survey 2018 (NTS), the Scottish trainee survey (STS) and pre-visit questionnaires (PVQ). The following were the main issues of note prior to the visit:

Issue	Foundation	GPST	Higher
Adequate Experience		NTS	
Clinical Supervision		NTS	
Feedback	NTS	NTS	PVQ
Induction		NTS STS PVQ	
Overall Satisfaction		NTS	NTS
Study Leave	NTS		
Supportive environment	NTS STS	NTS STS PVQ	NTS
Work Load		PVQ	NTS PVQ
Reporting systems	NTS		
Teamwork		NTS STS	
Curriculum Coverage	NTS	NTS	
Educational Governance	NTS	NTS	NTS
Rota Design		NTS	
Educational Environment		STS	STS
Teaching	STS	NTS STS	NTS STS PVQ

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.

2.1 Induction (R1.13)

Trainers: Trainers reported that there is an effective 2-day induction provided to trainees. Induction time is protected. They advised that the induction includes information about PRI, which is followed up with a tour of the hospital and the 'shop floor' of the department. Trainers reported that feedback is requested following each induction with changes considered or made in response to trainee feedback. They advised that the department is looking into ways of providing a supportive 'shop floor' induction only as they felt this would be of more value to trainees.

Trainees: All trainees, new to Ninewells received a hospital induction. Trainees reported that there is a useful 2-day, consultant led, departmental induction. This includes presentations as well as practice skills training. Trainees felt the induction prepared them to undertake work in the department. However, some trainees reported that when they started working within Perth Royal Infirmary (PRI), they had not been provided with a 'shop floor' induction and tour of the department. Trainees reported that anyone unable to attend induction is provided with an individual catch-up induction.

Non-Medical Staff: Staff reported that there is a comprehensive, structured induction programme in place, which is protected. They felt this equipped trainees to start working in the department. Staff contribute to the induction.

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

Trainers: Trainers reported there is 2 hour weekly protected teaching provided to trainees. They felt that the teaching for junior trainees compliments the induction, expanding on a variety of common presentations and practical skills. Trainers reported that the protected teaching time for ST trainees is also their regional teaching and is mapped to the college curriculum.

Trainees: All levels of trainees reported there is a 2-hour protected, consultant led, teaching session each week. This is also the regional teaching for specialty trainees. Foundation doctors are able to attend their regional teaching. They advised that their teaching is repeated at PRI to better enable trainees to achieve their required attendance at regional teaching. None of the trainees could offer suggestions for improvements to the teaching provided.

Non-Medical Staff: Staff felt there was no need to support the trainee's attendance at the formal teaching sessions as this time is protected.

2.3 Study Leave (R3.12)

Trainers: Trainers reported there are no issues with supporting study leave.

Trainees: Trainees felt it was generally easy to request and take study leave, particularly for exams and interviews. They advised that if there leave request is for an educational event, such as a conference, they must arrange a shift swap with another trainee, but none of the trainees reported any difficulties with this.

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

Trainers: Trainers reported that the educational supervisors for Foundation trainees are appointed by the Foundation Programme Director through a historical allocation pattern via the Deanery with a pre-agreed list of trainers. This allocation is adjusted if necessary by the EM TPD. ST trainees are allocated by the Emergency Medicine Training Programme Director using cohort allocation. They advised that the cohort allocation ensures specific supervisors are appointed for each cohort of trainee and for the various levels of specialty trainee. Trainers felt this enabled them to be familiar with the curriculum and assessments of trainees. All trainers confirmed they had undertaken the deanery clinical supervisor course or were signed up to do so. Trainers reported that they have sufficient time in the job plan for their educational role and their role is reviewed during their annual appraisal.

Trainees: Core and specialty trainees are notified in advance of who the educational supervisor will be. They reported that there are specific supervisors for the trainees, dependent on their stage ofr training. Foundation trainees reported that they are informed who their supervisor is at induction. Most trainees reported that they met regularly with their supervisors, however, some of the foundation trainees had still not had their first meeting with their supervisor at the time of the visit, despite sending many requests to arrange a meeting.

Non-Medical Staff: Staff felt that trainees can always access senior support when needed. They reported that there is always a senior member of staff allocated to each area in the department and other senior staff are approachable if the initial contact is busy.

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

Trainers: Trainers reported that they are aware of the different curricula needs of trainees by regularly being allocated to supervise the same trainee cohort. Whilst trainers felt that most learning outcomes were easily achievable, they did acknowledge that it was difficult for trainees to be signed off for ultrasound competency. Trainers reported that at present, they are very reliant on finishing schools to sign off this competency. Trainers reported that the department now has a new machine for trainees to undertake ultrasounds, but the consultant team first requires to be approved to sign off the trainee's skills. Trainers felt that the balance between educational and non-educational work was very good. They reported that trainees are well supervised, and many patient management reviews require senior sign off, although this requirement is adjusted accordingly to the seniority of trainee, therefore they felt the majority of work undertaken was of educational benefit.

Trainees: Foundation trainees reported that they see a broad spectrum of patients and had no concerns about achieving their required competences. Specialty trainees felt that having the opportunity to see both paediatric and adult emergencies from the start of their training was a particularly positive aspect for their training. In addition, core and ST3 trainees felt that they had greater responsibility when working within PRI, which provided them with the opportunity to step up in their role. ST3 trainees found that achieving relevant paediatric experience was more challenging when working within PRI, as known emergencies are automatically diverted to Ninewells. ST trainees also reported that achieving their ultrasound requirements was difficult and often require to go to a 'finishing school' to get signed off for this competency. ST trainees reported that when working a

standard day shift, they can lead their own review clinic which is built into the rota. All trainees felt that the balance between educational and service work was very good, with some viewing every aspect of their work as educational.

Non-Medical Staff: Staff reported that they work in partnership with trainees and utilise their experience to guide and support trainees. Staff felt that the trainees are good at seeking nurses' opinions before approaching a senior trainee or consultant.

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

Trainers: Trainers felt that trainees could easily achieve their portfolio assessments. All trainers had received training, or were relatively new consultants, to understand how to undertake workplace-based assessments (WPBAs). Trainers also have the opportunity to benchmark their assessments with each other.

Trainees: Trainees reported that it is generally easy for them to complete their assessments. They felt that their assessments were completed in a fair and consistent way, with good discussion and constructive feedback. Specialty trainees reported that they had a lot of educational opportunities within Ninewells and due to accessible consultants, they can easily achieve their workplace-based assessments. Consultants would go out of their way and sometimes come in, in the evenings, to complete the WPBA for trainees.

The one challenge reported was for ST3 trainees when working in PRI as there are no consultants in the department, therefore trainees' have no opportunity to have a competency signed off.

Non-Medical Staff: Staff reported that they complete TAB assessments for foundation trainees.

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

Trainers: Trainers reported that the quality improvement projects and "Joy in work, learning from excellence, practice development and civility" (JEDI) sessions provide opportunities for multi-professional learning. Trainers also advised that a pilot project is underway (EducatEM) which will provide joint teaching sessions for both medical and nursing staff.

Trainees: Trainees reported that there are no opportunities for multi-professional learning at present. However, one of the trainees is involved with a pilot project which will provide multidisciplinary teaching and be jointly led with nursing staff.

Non-Medical Staff: Staff reported that the department are developing a new education programme which will involve joint learning amongst trainees and nurses/allied health professionals.

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

Trainers: Trainers reported that there are ongoing quality improvement (QI) opportunities within the department, including audits. Trainers encourage trainees to put forward their own ideas for a QI project. Trainers also highlighted that the department has been involved in a Health Board wide QI initiative which involves trainees, consultants and nursing staff.

Trainees: Trainees reported that there is a continual quality improvement cycle, and everyone is allocated to a project at the start of their placement. ST trainees reported they have no issues undertaking an audit.

2.9. 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 rotas are displayed in a central area and there is a whiteboard with all of the on-call numbers so that trainees know who to contact for support. They reported that there are specific procedures when a call is mandatory. When working within PRI the phone system for senior advice from Ninewells ED records all calls to ensure there is a recorded audit trail of patient care. Trainers were not aware of any instances where a trainee has had to cope with a situation beyond their competence. They did, however, site an example where a trainee had felt they were not coping in PRI and adjustments were made until the trainee was confident enough to return to PRI. Trainers were aware that working in PRI could be daunting and regularly make a point of highlighting to trainees that they are not alone as other on-site specialties can provide support. They also mitigate some of the risk with the telephone system, but acknowledge that some risk can still exist.

Trainees: Trainees reported that they always have access to clinical supervision and know who to contact for that support when needed. Trainees reported that they had not had to cope with a situation beyond their competency as senior colleagues are accessible and approachable. One trainee also reported that there is an IT system in place where consultants can track the number of patients at the PRI and send another trainee from Ninewells to provide additional support if needed. ST3 trainees felt working in PRI was challenging but felt this was of a positive benefit as they have more decision-making opportunities. Trainees also reported that although there are no senior trainees or consultants in the department at PRI, they have standard procedures in place to seek support from senior trainees or consultants from the 'in-house' specialties such as medicine and anaesthetics. Although there have been no issues, foundation trainees reported that they felt apprehensive between 8am – 9am at PRI as they are the only doctor in the department, but they can contact an in-house specialty senior for support.

Non-Medical Staff: Staff reported that there is a gallery in the staff area which includes a picture of each trainees and their stage of training. None of the staff were aware of any instances where a trainee had been left to cope with a problem beyond their competence. Some staff, however, felt that some trainees at the start of the post believe they are more competent than nursing staff perceive them to be.

2.10. Feedback to trainees (R1.15, 3.13)

Trainers: Trainers reported that, in Ninewells, feedback on patient management plans is given in real time as trainees discuss all patients with a senior colleague. Trainers advised that if an adverse incident occurs or a complaint is received, time is set aside to meet and discuss with the trainee.

Trainees: Trainees reported that they are constantly presenting patients and their management plans to senior colleagues. This results in trainees receiving a lot of feedback which trainees felt is constructive and meaningful.

2.11. Feedback from trainees (R1.5, 2.3)

Trainers: Trainers reported that a feedback survey is completed by trainees at the end of their induction and post. Changes have been made in the department based on feedback from trainees.

Trainees: Trainees reported that they complete forms which provide positive feedback to trainers. Senior trainees reported they have about 3 meetings with consultants each year to feedback about their training and experiences. Trainees felt that they work within a close-knit team and would be able to feedback to trainers at any time.

2.12. Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Trainers reported that protected teaching time is built into the rota for all levels of trainees to maximise learning opportunities for trainees. Where trainees have been working night shifts, they are given a minimum of 2 days rest before returning to work

Trainees: Trainees reported that their rota and workload are manageable, and they are actively encouraged to take their breaks. One trainee reported that this had been the best post for being able to take their natural breaks. Trainees did not feel that their rota impacted on their training or patient safety as they are given a good amount of rest time following nightshifts.

Non-Medical Staff: Staff reported that they were not aware of any workload or rota issues the impact on a trainee's wellbeing. Although, some staff thought that trainees only received a single rest day after finishing night shifts causing them to return to work too soon.

2.13. Handover (R1.14)

Trainers: Trainers reported that senior staff will handover patients through discussion with the senior staff coming on. Junior staff will handover patients to senior colleagues. Trainers reported that handover is not used as a learning opportunity.

Trainees: Trainees reported that handover works well but is not the normal large team format. Trainees had no concerns regarding handover. Incoming and outgoing senior and junior trainees will handover anything outstanding; e.g. who is in resus and the various streams. They advised that they are encouraged to see a patient through to the end and therefore rarely have anything to handover to the incoming team. Trainees reported that at changeover, PRI is generally empty, and they therefore have nothing to handover to the oncoming team.

Non-Medical Staff: Staff reported that there is a structured and effective handover in place for both senior and junior staff. They felt that discussion of management plans during handover provided trainees with learning opportunities.

2.14. Educational Resources (R1.19)

Trainers: Trainers reported that trainees have access to a seminar room with computers. There is also an office for senior ST trainees. Trainers also reported that a request has been submitted for interactive smart boards and simulation equipment to further enhance the educational resources available to trainees.

Trainees: Trainees reported that they have good computer access and access to wi-fi within the hospital. Senior trainees also reported that they are allocated office days once or twice per month to undertake educational work, such as their quality improvement projects.

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

Trainers: Trainers reported that trainees can feedback on their experience in post through the end of post survey. Where concerns are more immediate, trainers advised that trainees can speak to the supervisor. In addition, trainers reported that there are meetings with senior trainees three times per year where trainee concerns can be raised. Where there are concerns about a trainee's performance, trainers would discuss this and raise with the clinical lead and if needed, escalate to the Deanery for additional support.

Trainees: Trainees reported that support is available to them if they are struggling. It was also highlighted that due to the close working of the team, senior staff will pick up if a trainee is struggling and will ask trainees how they are feeling. Trainees felt the department was very supportive.

Non-Medical Staff: Staff reported that they would speak to a senior member of staff if they had concerns that a trainee's performance could impact on patient safety. Senior staff reported that, if it was a one-off situation, they would initially discuss their concern with the trainees. Where a concern is ongoing, staff would raise their concern with the trainee's supervisor.

2.16 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 discussions around the quality of training and education is discussed at the specialty training committee and specialty training board meetings which involves representatives from both the health board and deanery. There was clear awareness of the role of the director for medical education and until recently, the clinical lead was an associate DME.

Trainees: Trainees had no awareness of the educational governance structures within their hospital.

2.17 Raising concerns (R1.1, 2.7)

Trainers: Trainers reported that they encourage trainees to speak to a senior colleague if they have any patient safety concerns. They also advised that the hospital has a clear process in place for more significant patient safety concerns which can be escalated to the DME.

Trainees: Trainees reported that they have not had to raise any concerns due to the level of supervision. They felt they could easily raise concerns with a senior colleague if any concerns were to arise.

Non-Medical Staff: Staff reported that they can raise concerns about patient safety with senior nursing staff or a consultant and felt their concerns would be appropriately addressed.

2.18 Patient safety (R1.2)

Trainers: Trainers felt that the department provided a very safe environment for both patients and trainees. They reported that the department takes a patient centred approach to the flow of patients. The department also undertakes an audit every quarter specifically looking for cases where harm could have occurred to determine what further improvements could be made in the unit.

Trainees: Trainees had no concerns regarding patient safety and would be happy about the care a friend or family member would receive from the department.

Non-Medical Staff: Staff felt that they department was a safe environment for both trainees and patients. They advised that in addition to handover, there are regularly morbidity and mortality (M&M) meetings to monitor the safety of patients.

2.19 Adverse incidents (R1.3)

Trainers: Trainers reported that adverse incidents are recorded through the datix system. Reports are reviewed at the local adverse event review (LAER) meetings and trainers encourage trainees to attend these meetings. Trainers advised that any actions to be undertaken following a review and given to the consultants with any learning outcomes shared via email. Trainers reported that where a trainee is involved in an adverse incident, they would have a one to one discussion with the trainee and provide support. Adverse incidents are also discussed and reviewed at the M&M meetings. Where a datix is submitted due to positive outcomes, this is also shared with all staff at the JEDI meetings.

Trainees: Trainees reported that the Datix system is used to record adverse events. They advised that case reviews are undertaken by senior staff and feedback is given to whoever submitted the Datix in addition to learning outcomes being shared with the wider team. Trainees reported that adverse incidents can also be discussed during the M&M meetings. Trainees reported that they are also encouraged to attend critical incident and complaints meetings. Where a trainee is involved in a significant adverse incident, they are invited to attend LAER meetings. Trainees felt that consultant support prior to LAER meetings was very good and the process is explained to them so that trainees know what to expect.

Non-Medical Staff: Staff advised that following completion a report about an adverse incident, the report is reviewed at the senior team meeting. They reported that this is also discussed during the quality meetings and any learning outcomes following this are shared with all staff.

2.20 Duty of candour (R1.4)

Trainers: Trainers did not feel that trainees would be exposed to speaking with patients if something went wrong, due to the high senior presence in the department.

Trainees: Trainees felt they would be well supported by the senior team if they were involved in an incident where something went wrong. They reported that there is always a debrief following major incidents to support trainees.

2.21 Culture & undermining (R3.3)

Trainers: Trainers felt there was a good team culture in the department. Those coming off nightshift will have breakfast together and JEDI meetings promote a positive team culture. Trainers also felt there was a flattened hierarchy which further promoted a strong team ethos. Trainers advised that if a trainee was undermined or bullied, there are encouraged to raise this with any of the consultants or follow the official process. Trainers also advised that there is a bullying and undermining champion that trainees can approach. One of the trainers reported that they now spend more time explaining why there's a need for a senior colleague to review a patient, to ensure the trainee is aware that they are being given feedback and don't feel their decision-making skills are being undermined.

Trainees: Trainees reported that they work within a very supportive team and have not experienced or witnessed any bullying or harassing type behaviours from other members of staff. Trainees did indicate that when they initially start in the department, the senior nursing staff can come across as slightly aggressive with the potential to undermine as the trainees feels competent, but feel the nursing staff do not perceive that to be the case. They did not feel that any particular trainee is targeted, and once senior nursing staff get to know the trainees, the relationship with them improves over the following weeks and months.

Non-Medical Staff: Staff reported that trainees are made welcome in the department and viewed as part of the team. They also advised that social events are organised to further build the team culture. Staff also felt that the development of JEDI within the meetings helped to further promote a positive culture.

2.22 Other

Trainees were asked to rate their experience in their post on a scale of 0 (very poor) to 10 (excellent). There results were as follows:

Foundation: Range: 8 – 9, Average: 8.25

Core & Specialty: Range: 8 – 10, Average: 8.56

3. Summary

This was a positive visit to a department that has a strong ethos towards teaching, promoting positive culture and further development through quality improvement.

Positive aspects of the visit

- Very supportive department that trainees overall are happy to work in.
- Close knit department which is supportive of trainees both for training and with regards to their wellbeing.
- Trainers go out of way to complete WPBA for trainees, such as ESLE for ST trainees.
- JEDI sessions involve the multi-disciplinary team & promote learning from excellence.
- The appointment of a civility champion.
- Comprehensive induction which has protected time and MDT involvement. In addition, trainee feedback is sought following induction and improvements are made to the programme if needed.
- Formal teaching time is protected for all trainee cohorts.
- Following a known issue regarding natural breaks, the department has made adjustments and a trainee commented that this had been the 'best job' for enabling them to take their breaks.
- Excellent Educational Supervision with excellent educational governance involvement within the consultant team.
- Supervision is excellent for trainees including transition training.
- Overall training and experience are excellent with good access to clinics for ST trainees.
- Good opportunities for trainees to feedback to consultants through the quarterly registrar-consultant meeting which also encourages a team culture.
- ST trainees have rostered office days to enable them to undertake non-clinical activities such as audit.
- Excellent incident reporting system which is linked to M&M meetings.
- Trainees feel supported to report adverse events which are also used as a learning opportunity and can feed in to quality improvement meetings.
- There is a clear quality improvement ethos within the department which trainees are involved in.

- TQuIP includes participation from trainees and has resulted in a positive impact on work and patient flow.
- Quarterly audit for harm enables further improvements to promote a safety culture within the department.
- Positive experience on both sites with trainees highlighting the value of rotation to the PRI site to enable them to step up in their role and manage patient flow.
- Trainees are well supervised, with visible senior support who provide regular feedback on patient management plans.

Less positive aspects of the visit

- ST trainees have difficulty achieving their ultrasound competencies in both sites as well as paediatric competences when working in PRI.
- PRI induction is not consistent with some trainees not receiving the on-site departmental induction.
- The FY2 doctor is the only doctor on site within emergency medicine from 8am to 9am at PRI.
- Some FY2s have not had their initial meeting with their educational supervisor at the time of the visit. This is 2 months after commencing and 2 weeks prior to their ARCP.
- Trainees can find the relationship with senior nursing staff challenging at the start of their post. This improves over time.

Is a revisit required?	Yes	No	Highly Likely	Highly unlikely

4. Areas of Good Practice

Ref	Item
4.1	Promoting positive culture and learning from excellence through JEDI meetings.
4.2	Protected teaching time for all cohorts of trainees which is tailored to the curriculum.
4.3	The department seeks feedback about the induction programme and at end of the post and act on feedback to make improvements.
4.4	ST trainees have rostered office days to enable them to undertake non-clinical activities such as audit.

5. Areas for Improvement

Ref	Item	Action
5.1	Induction	The department should ensure that all trainees receive a tour of the department at Perth Royal Infirmary

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	Initial meetings and development of learning agreements must occur within a month of starting in post.	22 February 2020	FY2