Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	29th May 2019	**Level(s)**	ST3+
Type of visit	Triggered Programme	**Hospital**	All Sites within West of Scotland Respiratory Medicine
Specialty(s)	Respiratory Medicine	**Board**	NHS Ayrshire and Arran, NHS Forth Valley, NHS Dumfries and Galloway, NHS Greater Glasgow and Clyde, NHS Lanarkshire.

Visit panel	
Dr Stephen Glen	Visit Chair – Associate Postgraduate Dean – Quality and Internal Medicine
Marie Therese Allison	Lay Representative
Dr Reem Al-Soufi	Associate Postgraduate Dean – Quality
Dr Jessie Sohal-Burnside	Trainee Associate
Alex McCulloch	Quality Improvement Manager
In attendance	
Patriche McGuire	Quality Improvement Administrator

Specialty Group Information	
Specialty Group	Medicine
Lead Dean/Director	Professor Alastair McLellan
Quality Lead(s)	Dr Stephen Glen Dr Reem Al-Soufi Dr Alan McKenzie
Quality Improvement Manager(s)	Alex McCulloch and Heather Stronach
Unit/Site Information	
Non-medical staff in attendance	N/A

Trainers in attendance	10
Trainees in attendance	9
Feedback session: Managers in attendance	None (TPD only)

Date report approved by Lead Visitor	Dr Stephen Glen 17th June 2019

1. Principal issues arising from pre-visit review

Following the review and triangulation of available data, including the GMC National Training Survey (NTS), the Scotland Deanery Scottish Trainee Survey (STS) and the GMC's programme national ranking data, the Deanery's Quality Review Panel decided to trigger a visit to the Respiratory Medicine programmes across Scotland.

A summary of the discussions has been compiled under the headings in section 3 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. Introduction

Placements in the West of Scotland Respiratory Programme typically last for one year and trainees will often commence training in a District General Hospital. Later years will include a year each in the two large Glasgow teaching hospitals.

3.1 Induction (R1.13)

Trainers: Trainers reported a regional programme induction was provided for trainees. This was led by the Training Programme Director and delivered at the deanery usually in August/September. The induction gave a broad view of the programme and was inclusive of local site information and the trainees were also provided with a Trainee Handbook. If a trainee was unable to attend the initial programme induction then the Training Programme Director would make arrangements for them to get a follow up induction. As well as the programme induction to Respiratory Medicine, each department within the hospitals provided departmental inductions for trainees, inclusive of departmental induction booklets.

Trainees: Trainees reported a good programme induction was provided for them, all trainees present had attended and confirmed it was inclusive of a trainee handbook. Trainees had attended departmental inductions which they also felt were comprehensive.

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

Trainers: Trainers confirmed a regional teaching programme was in place and there were 6 training days organised per year. There was also a national training day organised by the South East deanery region, that trainees were able to attend. Across the local sites, departmental teaching comprised of local educational meetings, Morbidity and Mortality meetings and weekly teaching sessions.

Trainees: Trainees felt their regional teaching programme was of a high standard. They estimated they were able to attend 70-80 % of the available sessions. Trainees also confirmed they had input into the topics that were delivered by providing feedback to their trainers on what they required. Local departmental teaching for Respiratory was felt to be more variable. The Queen Elizabeth University Hospital (QEUH) sessions took place on a Friday and were highlighted as good, as were the local sessions in Glasgow Royal Infirmary (GRI) which were organised by and involved trainees. Local x-ray meetings were highlighted at Forth Valley Royal Hospital (FVRH). The trainees present were not aware of any local Respiratory teaching at University Hospital Crosshouse (UHC), University Hospital Monklands (UHM) and Inverclyde Royal Hospital (IRH). Trainees confirmed that University Hospital Wishaw (UHW) was in the process of setting up a local teaching programme. Where local teaching was available to trainees, it was rated highly. Trainees felt more Radiology and pulmonary function laboratory teaching would be valuable to them.

3.3 Study Leave (R3.12)

Trainers: Trainers across the sites felt that trainees had access to study leave unless they were working on nights. It could be more difficult for them to access study leave in more rural sites as vacancies on the rota could affect their ability to take study leave but generally access was felt to be good.

Trainees: Trainees reported no issues with accessing study leave.

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

Trainers: The trainers confirmed that Educational and Clinical Supervisors were allocated to trainees before they started their posts. Trainers from NHS Greater Glasgow and Clyde described their

concerns around the effect the 1 SPA contract has had on the ability of consultants to provide supervision for their trainees and described the demands on the consultants who were employed on these contracts as heavy. They also felt it was difficult to attend training events as a result.

Trainees: Trainees present had all been allocated Educational Supervisors and had met with them. No issues were raised regarding Formal Supervision by trainees.

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

Trainers: Trainers advised they would discuss training requirements with trainees at their induction and compared their experience with the curriculum in order to identify gaps in their experience. In the QEUH, clinics were now planned into the rota for trainees and were protected unless there were any unexpected medical emergencies. This was also the case in FVRH and GRI. Trainers from GRI highlighted pastoral meetings with trainees as a supportive way of discussing any concerns trainees may have with their training. A lack of appropriate clinic rooms was highlighted as an issue in UHC and UHW. A curriculum competency that was highlighted as particularly difficult for trainees to get was Occupational Lung Disease and this had been an issue at Penultimate Year Assessments (PYA) this year. This issue was escalated by the TPD and discussions had taken place with the Associate Post Graduate Dean (Dr David Marshall) in the West to find a solution to the issue. Trainers highlighted their concerns regarding deanery ARCP letters being issued to trainees without a deadline date for submission of ARCP evidence, this issue has been raised with the deanery outside this visit report.

Trainees: Trainees highlighted some concerns around competences they felt were difficult to get. Non-invasive ventilation (NIV) in Forth Valley and Crosshouse is provided in a critical care setting rather than in a respiratory ward. As trainees are not attached to these units, they felt it made it difficult to get enough experience in NIV to meet their curriculum requirement. The structure of sub-specialty opportunities was highlighted as ad hoc and self-directed.
The trainees had requested that members of the Specialty Training Committee should consider block allocation of opportunities and felt this would help them achieve their competences. Sub-specialty areas such as HIV, transplant clinics, occupational lung disease and formal radiology teaching were other competences that trainees felt were difficult to get. Trainees advised that clinic access was generally good, with the exception of those based at FVRH and UHC, where General Medicine

commitments were affecting their ability to attend. Trainees across the region felt there was a lack of awareness amongst Educational Supervisors of their Curriculum and ARCP requirements. Trainees confirmed the issue raised by trainers in relation to being unaware of a deadline date for submission of ARCP evidence, as no date was specified on deanery letters sent to them. As a result of the error, no evidence was submitted and the ARCP was conducted on the basis the trainees had not submitted the evidence. This has been raised with the appropriate deanery team out with this visit report.

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

Trainers: Trainers felt trainees could access Workplace Based Assessments and they had received training through an online training course on how to undertake Workplace Based Assessments. Trainers had not had an opportunity to benchmark their assessments against those of others.

Trainees: Trainees confirmed it was easy for them to complete Workplace Based Assessments and did not raise any concerns.

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

Trainers: Opportunities for multi-professional learning highlighted by trainers were:
GRI Educational Meetings – Allied Health Professionals deliver some sessions.
FVRH – Morning meetings/huddles.
QEUH – Trainees are invited to attend the training sessions conducted by AHPs.
Physiotherapists also participated in and delivered sessions at the national training day.

Trainees: Trainees highlighted the National Teaching day as a multi-professional learning opportunity but also felt that some multi-disciplinary learning was a tick box exercise.

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

Trainers: Trainers felt there were good opportunities provided for trainees to undertake quality improvement or audit projects.

Trainees: Trainees confirmed there were opportunities for them to engage in Quality Improvement projects or audit and raised no concerns.

3.9. 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 confirmed trainees were made aware of who to contact for support or advice during the day or out of hours at departmental inductions. Trainers felt the supervision of trainees was a team responsibility and as such the staff within the multi-disciplinary teams would be able to differentiate between different grades of trainee and abilities across the Respiratory Medicine departments. Trainers were not aware of any instances where trainees have had to work beyond their competences and felt they would call on their senior colleagues for support, if they found themselves in that situation.

Trainees: Trainees felt that access to clinical supervision was good both during the day and out of hours in Respiratory Medicine, however it was highlighted by trainees in UHC that cross-cover arrangements for consultants were not formalised and trainees were expected to cover their patients for them in their absence. Trainees felt they were sometimes felt overwhelmed and unsupported while dealing with inpatient referrals at the QEUH and GRI, where some found it difficult to get advice from the on-call consultant. This had been raised by trainees and trainees present from QEUH confirmed changes to the arrangements to improve the trainees support.

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

Trainers: Not covered.

Trainees: Trainees felt they got feedback on their clinical decisions, but it was often self-directed with them having to seek it out.

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

Trainers: Trainers confirmed feedback from trainees was gathered through the National Training Survey (NTS). Trainers felt because the NTS took place at the end of the training year, it was too late to react to any concerns or flags raised in the data for that cohort of trainees The trainers at Glasgow

Royal Infirmary confirmed follow up meetings had been arranged to investigate the red survey flags that had been received in previous years. Feedback was generally given to trainees on an informal 1 to 1 basis. A trainee representative was on the Specialty Training Committee and would bring feedback from trainees to the meeting and take it back to their colleagues.

Trainees: Trainees advised that trainee forums took place at most of the sites within Respiratory Medicine and this was highlighted as the main opportunity for trainees to feedback on the quality of the training they were receiving.

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

Trainers: Trainers felt there were no issues with regard to Respiratory rotas that would affect patient or trainee safety.

Trainees: Trainees felt their Respiratory rotas were manageable during the day and the out of hours rota cover they provided was in General Internal Medicine. Workload was highlighted at the QEUH as being heavy, although trainees felt well supported by their consultant colleagues and considered the environment was safe for patients.

3.13. Handover (R1.14)

Trainers: Trainers confirmed that handover arrangements varied across the sites and were for General Internal Medicine rather than Respiratory patients. Day to day handover on the Respiratory wards was generally via informal daily multi-disciplinary huddles or meetings.

Trainees: Trainees felt that handover across the sites was safe and effective and a variety of different handovers took place, generally in the morning and in the evening. However, handover at GRI was highlighted by trainees to be ad hoc and without structure.

3.14. Educational Resources (R1.19)

Trainers: Trainers confirmed a variety of resources and facilities were in place to support trainee learning. Most of the sites had libraries accessible to the trainees and trainee messes or rooms were provided at the QEUH and FVRH. Access to WIFI was confirmed to be difficult in GRI and FVRH.

Trainees: Not asked and no issues raised in the pre-visit questionnaire.

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

Trainers: Trainers advised that trainees were able to feedback concerns about their training through trainee forums and through local Medicine Chief Residents. Support for trainees in difficulty would be provided by their Educational Supervisors and the Training Programme Director.

Trainees: Trainees from most sites felt support would be available to them, should they require it. A concern was raised in regard to the support for reasonable adjustments not being taken into consideration by a rota co-ordinator, when allocating night shifts and long day shifts in University Hospital Crosshouse.

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

Trainers: Not asked.

Trainees: Not asked and no issues raised in the pre-visit questionnaire.

3.17 Raising concerns (R1.1, 2.7)

Trainers: Trainees were able to raise concerns through Datix and feedback is generally made to the trainee through their Educational Supervisor.

Trainees: covered in 3.19 and no issues raised in the pre-visit questionnaire.

3.18 Patient safety (R1.2)

Trainers: Trainers felt the environment provided in the Respiratory wards within their sites was safe for both trainees and their patients. They confirmed that trainees were supported to raise concerns about patient safety through ward safety huddles and Morbidity and Mortality meetings.

Trainees: Trainees had no concerns about patient safety in their sites with the exception of University Hospital Crosshouse, where concerns were raised around the way boarded patients were managed in Medicine. Trainees did not feel that boarded patients received the same level of care as patients in their own wards and were often seen last.

3.19 Adverse incidents (R1.3)

Trainers: Trainers advised that trainees could report adverse incidents through Datix and their Educational Supervisors were made aware when a trainee submits a Datix report or are involved in a Datix incident. Routine systems in place to monitor patient safety included safety huddles and unit Morbidity and Mortality meetings.

Trainees: Trainees confirmed that Datix was the main reporting method for adverse incidents, although Nursing staff would normally complete the reports. Trainees felt the feedback they received on Datix incidents was variable. Learning around Datix incidents generally took place at Morbidity and Mortality meetings.

3.20 Duty of candour (R1.4)

Trainers: Not asked.

Trainees: Not asked and no issues raised in the pre-visit questionnaire.

3.21 Culture & undermining (R3.3)

Trainers: Trainers felt a non-hierarchical culture was in place in their sites. They felt it was important to meet regularly as a team and to be vigilant of undermining behaviours and to discuss any issues

openly and transparently. Trainers were aware of incidents of perceived undermining in relation to a consultant which had been reported at a site by trainees, this was being addressed locally to their knowledge.

Trainees: Although there was a consensus of good supportive relationships between trainees and their senior colleagues and clinical teams, perceived undermining concerns were raised by trainees in relation to a Respiratory consultant at one site and the details of the concern have been passed on to the local Director of Medical Education, out with this report.

4. Summary

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

The visit panel found trainees in the West of Scotland Respiratory Medicine programme were receiving a mostly positive training experience, this is evidenced by the high overall satisfaction scores they gave their training programme which ranged between 5 – 9 out of 10 with an average score of 7 out of 10. The visit panel identified many positive aspects of the training programme and some areas for improvement which are highlighted below.

Positive aspects of the visit:

- Regional programme induction with handbook and site-specific handbooks were highly rated by trainees.
- National Teaching days were thought to be of a high standard, are mapped to curriculum and trainees can attend regularly.
- Access to Quality Improvement opportunities were available to trainees across the sites.
- Local Respiratory specific teaching was highlighted as good at the QEUH and GRI.
- Trainees are able to attend Morbidity and Mortality meetings regularly.

Less positive aspects of the visit:

- Structure of sub-specialty opportunities, they are self-directed and can be difficult to get. The trainees recommended the Specialty Training Committee consider block allocation of opportunities and felt this would help them achieve their competences.
- Trainees felt there was a lack of awareness amongst Educational Supervisors of their Curriculum and ARCP requirements.
- Trainees reported difficulty accessing some sub-specialty areas such as HIV, transplant clinics, occupational lung disease and formal radiology teaching.
- Non-invasive ventilation in Forth Valley and Crosshouse is provided in a critical care setting rather than in a respiratory ward. Trainees are not attached to these units which makes it difficult to get enough experience to meet ARCP requirements.
- Trainees found it difficult to obtain feedback on their inpatient referral activity at Glasgow Royal Infirmary.
- Trainers in NHS Greater Glasgow and Clyde highlighted the difficulty of meeting their educational commitments whilst on 1 SPA contracts.
- Boarding and safety of patients was highlighted as a concern in University Hospital Crosshouse.
- Datix – feedback was felt to be slow and sporadic across sites.
- A refresher programme induction including procedural skills (such as pleural procedures) would be beneficial to trainees returning from Out of Programme or Maternity Leave.
- Undermining behaviour was highlighted and witnessed at a site by trainees – formal details will be fed to the Director of Medical Education outwith the published report.

5. Areas of Good Practice

Ref	Item	Action
5.1	N/A	

6. Areas for Improvement

Ref	Item	Action
6.1	N/A	

7. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
7.1	Postgraduate training programmes must give doctors in training: A: training posts that deliver the curriculum and assessment requirements set out in the approved curriculum. B: sufficient practical experience to achieve and maintain the clinical or medical competences (or both) required by their curriculum. For this programme, training in non-invasive ventilation, transplant clinics, occupational lung disease and radiology should be improved.	26th February 2020	ST
7.2	University Hospital Crosshouse must develop an effective system of safe selection, tracking and managing boarded patients and ensuring appropriate clinical ownership & oversight of patient care.	26th February 2020	ST
7.3	Ensure trainees engage in use of the Datix system and highlight the importance of utilising this reporting mechanism. Provide feedback on Datix cases logged and ensure trainees are aware of this feedback to ensure the system is seen as responsive and a learning opportunity.	26th February 2020	ST
7.4	Trainees coming back from maternity or long-term breaks should receive a departmental induction to ensure they are aware of all their roles and responsibilities and feel able to provide safe patient care. Handbooks or online equivalent may be useful in aiding this process but are not sufficient in isolation. Trainees should receive focused training	26th February 2020	ST

	(e.g. practical procedures such as pleural procedures) and pastoral support to allow them to regain the confidence and competence levels they were at prior to their period of absence.		
7.5	Allegations of undermining behaviour must be investigated, and if upheld, put in place an appropriate action plan must be instigated to address them.	26th February 2020	ST
7.6	Educational supervisors must understand curriculum and portfolio requirements for their trainee group.	26th February 2020	ST
7.7	Trainers within Glasgow Royal Infirmary must provide more regular 'on the job' feedback, particularly in regard to trainee's inpatient referral activity.	26th February 2020	ST
7.8	All Consultants who are trainers must have time within their job plans for their roles to meet GMC Recognition of Trainers requirements".	26th February 2020	ST