Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	3 May 2019	**Level(s)**	FY2, GP, ST
Type of visit	Triggered	**Hospital**	Queen Elizabeth University Hospital
Specialty(s)	Obstetrics & Gynaecology	**Board**	Greater Glasgow & Clyde

Visit panel	
Alastair Campbell	Visit Lead, Associate Postgraduate Dean for Quality
Amjad Khan	GP Representative and shadow visit lead, GP Director East of Scotland
Paul Mills	Programme Representative
Andrew Watson	College Representative
Fahd Mahmood	Trainee Associate
Marie Therese Allison	Lay Representative
Hazel Stewart	Quality Improvement Manager
In attendance	
Fiona Conville	Quality Improvement Administrator

Specialty Group Information		
Specialty Group	Obstetrics & Gynaecology and Paediatrics	
Lead Dean/Director	Amjad Khan	
Quality Lead(s)	Alastair Campbell and Peter MacDonald	
Quality Improvement Manager(s)	Hazel Stewart	
Unit/Site Information		
Non-medical staff in attendance	7	
Trainers in attendance	8	
Trainees in attendance	20	4 x FY2, 5 x GPST2, 11 x ST1 – ST7
Feedback session: Managers in attendance	Associate Director of Medical Education, Clinical Director and Chief of Medicine Women and Children's services	

Date report approved by Lead Visitor	31/05/2019

1. Principal issues arising from pre-visit review

This department was last visited in 2015 following the opening of the new hospital. This was a positive visit overall with 6 requirements being made of the department which the OGP SQMG were satisfied had been addressed through the action plan. Both the report and final update are available within the VPP.

Unfortunately, following the 2018 national training survey, there was a significant deterioration in the trainee's experience and both General Practice and Obstetrics and Gynaecology and Paediatrics QRPs recommended a triggered visit. Due to the significant deterioration, the board conducted their own internal quality review to investigate the causes of the negative data, and it was agreed that the triggered visit would be delayed allowing this initial investigation

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 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.

2.1 Induction (R1.13)

Trainers: Trainers reported a new induction programme was created for 2018-19. Trainers reported the departmental induction is held over 2 days (Wednesday afternoon and Friday all day) during which trainees are given a tour of the department and consultants will discuss and present each ward to enable trainees to understand their roles and responsibilities. The induction is split between the junior rota (FY2, GP, ST1) and senior rota (ST2 – ST7) to provide a more tailored package. Although it was acknowledged that the newer style induction was not provided to the junior cohort due to a consultant being on leave. In addition, an induction booklet is emailed to trainees in advance of them starting their post and includes information such as: handovers, how the department works and a map of the hospital. A tailored short induction is provided to trainees unable to attend their normal induction. Trainers did not feel that any further improvements required to be made to the induction following the changes already implemented.

Foundation: Most trainees received a hospital induction, which is mostly online. Those unable to attend were told they would receive a departmental induction, so no follow-up was provided. Trainees

reported the hospital induction was useful for providing login details and issuing their ID badges. They suggested being given a tour of the main hospital would be useful to be able to navigate to relevant areas during out of hours. All trainees received a departmental induction which they felt worked well. This included a tour of the maternity building, information on their roles and responsibilities and basic clinical examination skills training. It was also reported that the information booklet was useful as they can refer to this when moving to a different ward in the department. Trainees suggested that including a top 5 gynaecology emergencies and how to manage them would further improve their induction.

GP: Trainees reported they received a hospital induction, but this was historical for some as they had previously worked in the hospital. Trainees suggested that it would have been useful to have been provide training on how to complete immediate discharge letters as the computer system had changed. One trainee reported that a useful e-learning module for the new Trakcare discharge system is available but felt it should have been highlighted during the hospital induction. Trainees felt that their induction was inadequate due to inadequate coverage of their roles and responsibilities in clinical areas. Whilst they were shown how to access protocols and guidelines they felt that it would have been helpful to discuss these in more detail, particularly those which cover emergency scenarios. It was also suggested that a glossary of common acronyms would have been useful to better understand what is being discussed at handover.

ST: Trainees reported they received an online corporate induction but no face to face training. They suggested that orientation of the main hospital would have been useful to know, such as how to get to emergency gynaecology out of hours, to prevent delays in them attending to patients. Trainees reported the departmental induction was adequate. All trainees received their departmental induction but felt the onus was on them to attend, even if working nightshift, rather than being informed they would be provided with a catch-up induction.

Non-Medical Staff: Staff reported that they are involved in the departmental induction to talk to trainees and highlight what the expectations are when working in the different wards.

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

Trainers: Trainers reported formal local teaching is held on Tuesday afternoons and covers CTG teaching plus a topic related to the O&G curriculum. In addition, trainers reported that trainees are invited to attend various other teaching opportunities, including:

- Morbidity and mortality meetings
- Risk management meetings and
- Gynaecology multidisciplinary (MDT) meetings.

Clinical work is reduced on a Tuesday afternoon to better facilitate attendance, but local teaching is not bleep free. Trainers also highlighted that some trainees may want to attend theatre rather than local teaching if the theatre session supports their ATSM. The trainer responsible for the organising local teaching highlighted that it is challenging to organise speakers and attendance is variable, indicating that more time is needed for planning and organising teaching. This trainer is also looking at providing short lunchtime teaching sessions more relevant for Foundation and GP trainees.

Trainers reported that regional teaching for specialty trainees is known in advance and repeated annually, therefore trainees do not require to attend every session annually. Trainers reported that trainees apply for study leave to attend regional teaching.

Foundation: Trainees reported there is local teaching on Tuesday afternoons. Although Foundation trainees have only been in post for 4 weeks at the time of the visit, they reported that often no-one clearly knows if the teaching is taking place and what topic will be covered. Some trainees also reported that they have been unable to attend any teaching sessions to date due to workload or teaching being cancelled. This resulted in trainees reporting that, to date, they've received 0 – 1 hour of teaching per week. Trainees suggested that providing regular 1 hour teaching aimed at foundation and GP level such as general obstetrics and gynaecology presentations, would improve their teaching. Trainees reported they are able to attend their required regional teaching sessions.

GP: Trainees reported that they are aware there is teaching on a Tuesday afternoon but receive no communication about the teaching sessions. One trainee reported that they have tried to attend the CTG teaching but were not encouraged to attend this. Trainees reported that they attend 0 hours of local teaching and are therefore unaware of who provides the teaching sessions. Trainees reported

that being provided with teaching sessions such as gynaecology assessment, common presentations in O&G, that are relevant to their curriculum needs would be welcomed. It was also suggested that holding local teaching sessions on different days of the week would give trainees who work less than full time a greater opportunity to attend. Trainees reported that they are able to attend regional teaching, but because regional teaching sessions are published after trainees start in post, they may need to swap shifts.

ST: Trainees reported there is weekly teaching on Tuesday afternoons which includes CTG training followed by another event such as the journal club. Trainees reported they also have the opportunity to attend other teaching opportunities, such as:

- PROMPT
- Monthly morbidity and mortality meetings, and
- Laparoscopy training (trainees are allocated time within their rota for this).

Trainees felt it was difficult to attend the local Tuesday teaching due to clashes with training opportunities in theatre. Junior trainees also found it difficult to attend as it is their understanding that they need to complete their full day's ward work prior to attending teaching. It was suggested that teaching could be improved by varying the day teaching is held and providing more consultant led teaching. Some trainees reported they find it difficult to attend the regional teaching days.

Non-Medical Staff: Staff reported that if they are informed by trainees that they are attending teaching, they will try to not page the trainee unless it's an emergency.

2.3 Study Leave (R3.12)

Trainers: Trainers reported that they encourage trainees to use study leave. They felt that the only challenge to supporting study leave would be if a request was made at short notice as there may already be a maximum number of trainee's already allocated leave for the same day.

Foundation: Trainees felt it is very easy to request and take study leave.

GP: Trainees reported it is usually easy to request and take study leave. One trainee did report that their approved leave was retracted once but that normally the rota co-ordinator is very accommodating, and they can take their leave.

ST: Trainees reported that taking study leave is easy if they can provide sufficient notice. They reported that if the leave request is for a date they are rostered to be on-call, the onus is on the trainee to find someone else to swap.

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

Trainers: Trainers reported that supervisors are allocated to specialty trainees through a combination of specific requests from a trainee and which supervisor is best suited to support the trainee's educational needs. They reported that the Deanery will inform them if a trainee due to start in post has any known concerns. If this occurs, trainers reported that they will meet with the trainee to review both their educational and pastoral needs, with one of the college tutors often taken on the role of supervisor for a trainee that requires additional support. Trainers reported they have 0.25 PA per trainee allocated in their job plan.

Foundation: Most trainees reported that they had met with their educational supervisor. One trainee reported that, despite a number of attempts, they had not yet met with their supervisor. Trainees reported they are notified in advance of who their supervisor will be. Those who had met with their supervisor reported a good experience, with an agreed personal development plan.

GP: Trainees reported that they were notified in advance of their post, who their formal supervisor would be and advised to make contact to meet with their supervisor. Trainees reported their initial meeting with their supervisor took place between 2 to 6 weeks after starting in post. Some trainees reported that their meeting was of limited use as their supervisor only discussed clinical opportunities with the trainee and not their assessment needs or other requirements from the post.

ST: Trainees reported that they were informed of the name of their clinical supervisor prior to starting their post. Although it was indicated by some trainees that not all supervisors were aware of who their trainee(s) was. Trainees reported that they were uncomfortable with their supervisor being changed after 6 months in post as they were not informed why this happens and they felt they had to restart building a rapport with their new supervisor. They felt having the same educational supervisor for the whole year would be beneficial

Non-Medical Staff: Staff felt that trainees can always access senior support when needed. They highlighted that the consultants are very open and make clear, that they want to be kept informed on what is happening with a patient.

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

Trainers: There are specific consultants that develop the rota for ST2 – ST7 trainees and another for FY2, GP and ST1 trainees. There are also specific trainers allocated to FY2 and GP trainees to ensure a better understanding of the educational needs of these trainees. Trainees are also asked what they want to achieve and aim to enable trainees to attend the clinics which are most relevant to them. The consultant in charge of the junior rota provides trainees with a spreadsheet of various activities they can access to meet their curriculum requirement. Trainers were not aware of any competences that are difficult to achieve and they encourage trainees to highlight if there are any requirements which are outstanding. Although it was acknowledged that GP trainee access to clinics is adversely affected if there are rota gaps.

Foundation: Trainees reported that working on-call with a senior trainee is a good experience as it provides them with a lot of teaching opportunities. Trainees reported that they have found it difficult to attend clinics as they are expected to sign off numerous patient test results before joining the clinic, which can last the full clinic time. Trainees felt that balance between developing as a doctor and completing tasks of little to no educational benefit was poor. Trainees reported that when working on the gynaecology ward they require to take all patient bloods, which can range from 2 patients to the whole ward. In addition, trainees reported that some shifts predominantly involved completing immediate discharge letters (IDLs) for which they do not receive any feedback about these letters.

GP: Trainees reported that having allocated clinic time was good to help them meet their curriculum requirements. However, trainees reported that access to access to clinics is variable with some having attended 0 and others had attended ‘a lot’. Trainees reported that the colposcopy clinics are of particular relevance to their future career, but none had been able to attend these clinics despite many requests. Trainees felt there is a poor balance between developmental opportunities and time spent undertaking tasks of little or no educational benefit highlighting undertaking of bloods and cannulations when on-call and completing immediate discharge letters.

ST: Senior trainees reported that they are able to obtain their required ATSM sessions and junior trainees are able to attend clinics. Some senior trainees felt it is easier for them to highlight any requirements they still require to achieve as they know who to contact to access these opportunities. Trainees reported they can also email outstanding requirements to the rota co-ordinator who will try to allocate them to the relevant area, such as clinics or theatre. Some trainees have had difficulty accessing basic gynaecology scanning, reporting that they require to email a specific consultant, but the mailbox is full and so cannot receive emails. Junior trainees, particularly ST1, felt there is an excessive volume on non-educational tasks such as taking bloods and completing IDLs.

Non-Medical Staff: Staff reported that junior trainees have the opportunity to shadow midwives at some clinics.

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

Trainers: Trainers reported they are aware of the assessments needs of ST trainees through the royal college website and are sent alert emails regarding any changes. There are specific consultants who supervise FY2 and GP trainees to ensure they are aware of the assessments trainees require to complete. Trainers felt that trainees could easily achieve their assessment requirements. They reported that they remind trainees to request their assessments throughout the post but that some trainees are more proactive than others, which can result in a lot of assessment requests being submitted at the last minute.

Foundation: Not all trainees have requested to have an assessment as they had only been in the post for 4 weeks at the time of the visit. Those who had requested assessments reported that they asked and had them completed by ST trainees. They had not asked consultants for any workplace based assessments.

GP: Trainees reported that they have asked and had their assessments completed by ST trainees. They reported that they do not routinely work with the same consultant and have only met about 50% of the consultants in the department. Therefore, have not felt they’ve developed a relationship with the consultant team to ask them to complete an assessment. Trainees felt their assessments were completed in a fair and consistent manner.

ST: Trainees reported that it is usually easy to complete their assessments, but there are some consultants whom they would not ask to complete an assessment as they do not respond in a timely manner to ticket requests.

Non-Medical Staff: Nursing and midwifery staff reported that they complete multi-source feedback assessments for trainees.

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

Trainers: Trainers reported a variety of multi-professional learning opportunities, including:

- PROMPT
- SYNEGY
- CTG, and
- Tuesday afternoon teaching which is open to all staff.

Foundation: Some trainees reported they were aware of the PROMPT course provided the opportunity for multi-professional learning. However, they were unaware if they can attend this training or if they need to sign up to attend. Other trainees reported they were not aware of any opportunities for multi-professional learning.

GP: Trainees reported they were not aware of any opportunities for multi-professional learning.

ST: Trainees reported that PROMPT training offers the opportunity for multi-professional learning.

Non-Medical Staff: Staff reported that PROMPT, CTG teaching and perineal repair courses provide opportunities for multi-professional learning.

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

Trainers: Trainers reported there is a lot of enthusiasm in supporting trainees to undertake quality improvement (QI) projects. They reported there is a consultant lead for QI who engages with the ST trainees to undertake QI projects for which there are a lot of opportunities to do so.

Foundation: Trainees that want to undertake a QI project reported that their supervisors were very supportive, but that they require to go through the QI consultant whom they have not met with to date.

GP: Trainees reported that one of them has started a QI project and is being supported by a consultant. None of the other trainees are undertaking a QI project.

ST: Trainees reported there are many opportunities to undertake QI projects.

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 staff can differentiate between the different cohorts and levels of trainees through the colour coded name badges. They also reported that all members of staff introduce themselves at handover. Trainers also felt that over time, staff get to know the trainees are aware of their level of competence. Trainers reported that there is a strong consultant presence until at least 8.30pm every day and the out of hours consultant attends the evening handover and ward round with a clear escalation process if a trainees requires support out of hours. There is consultant presence at weekends until 8.30pm. They were not aware of any situations where a trainee had been left to cope with a situation beyond their competence. Trainers reported they could not think of a situation where a trainee would need to seek consent for a surgical procedure that they did not have the competency to perform due to the processes they have in place for undertaking surgical procedures.

Foundation: Trainees reported that they always know who to contact for supervision during the day and out of hours. Although, on occasion they felt uncertain of who to escalate to when the patients had general medical concerns. Trainees reported they had never been left to cope with a situation beyond their competence. However, at least one trainee reported that they had been asked to undertake a task out with their competency, but they were comfortable to state they could not action the task. Trainees reported that the senior trainees are very accessible and approachable when they require support, but at times they were not clear who to contact if it was not an emergency situation e.g. problems on the post-natal ward. Trainees reported there is no expectation for them to seek consent for operative procedures.

GP: Trainees reported that they always have access to and know who to contact for supervision. They reported that normally they would contact the senior ST trainee. Trainees reported that there is a lack of supervision within the post-natal ward and they did not feel it was clear who to contact, but in general they had not been left to cope with a situation beyond their competence. Trainees felt that staff were unaware of their level of competence as they are treated the same as an FY2 trainee and reported that staff refer to them as FY2s. Trainees reported that most senior trainees and consultants are accessible and approachable when support is requested. However, at least one trainee reported feeling disrespected and unsupported on more than one occasion. Some trainees reported that they had be asked to obtain consent for operative procedures, but all highlighted their concern in doing this and declined to proceed and following this they had not had any further problems.

ST: Trainees reported that they always have access to and know who to contact for supervision. Trainees felt that over their time in post, staff get to know their level of competence. They suggested that competency does not always correlate with the stage of training of a trainee. ST1 trainees reported the same issue as GP trainees, where staff would call them FY2. Trainees did not feel that they had to cope with a situation beyond their competence and experience. They reported that they have no concerns regarding obtaining consent from patients as the consultants take ownership of their work. Trainees reported that senior colleagues are accessible and approachable if they require support.

Non-Medical Staff: Staff reported that they are sent pictures of the trainees with their name and grade to help differentiate the different levels of trainees. Some staff were aware of the colour coded badge holders but suggested the profile of the colour coding needed to be raised. Staff reported that they know there is a difference in ability between FY2, GP and ST1 trainees. They were not aware of any instances where a trainee had been left to cope with a situation beyond their competence.

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

Trainers: Trainers reported that there is good consultant presence in the department to provide informal feedback such as telling a trainee they’re management plan is a good idea or querying why they decided on a particular management plan. Trainers also reported there is a board in the labour ward where they can write up positive feedback to trainees. The department are also looking to

develop a group to look at trainee's management plans to highlight positive feedback to email to trainees.

Foundation: Trainees reported that that they receive good feedback from the senior trainees with whom they are working with. They reported that when working a nightshift, unless they are in theatre, there is nothing to feedback to them about.

GP: Trainees reported that they receive feedback from senior ST trainees when working in the maternity assessment unit or when on-call. They reported that they rarely receive feedback from consultants.

ST: Trainees reported that it is difficult to obtain informal feedback. They reported that there is a 'greatix' board where consultants will leave positive feedback messages. They feel that this a positive initiative, but the board is now hidden behind a door and therefore not readily visible to view comments or for comments to be added. Trainees reported that feedback is sometimes given during handover, however trainees felt this was sometimes delivered in a judgemental rather than constructive manner.

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

Trainers: Trainers reported they have no formal mechanism for gathering feedback from trainees on their experience. They will seek feedback from trainees on an individual basis during the trainee's end of year review. Trainers also review survey data from the GMC national training survey and the royal college's trainee evaluation feedback survey.

Foundation: Trainees were not aware of any opportunities to feedback to the trainers about their experience in the post. Trainees were not aware of the chief resident and their role in the department.

GP: There was a lack of awareness of opportunities for trainees to feedback on their experience in the department. One trainee was aware that they could give feedback to the chief resident to raise at the senior staff meeting.

ST: Trainees reported that feedback is provided to trainers through the chief resident, who attends the senior staff meeting.

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

Trainers: Trainers reported that they encourage higher ST trainees to make contact prior to starting in post to provide a more personalised daytime rota that meets the trainees' educational needs. Trainers reported that they have faced rota issues due to gaps and staff on statutory leave, but they do all they can to ensure patient safety is not compromised.

Foundation: Trainees reported that their workload and rota are manageable. They did not feel that their rota has any implications on patient safety or their training. Trainees reported that their working rota is issued in 2 week blocks which provides them with little notice as to when they are working long shifts and on-call shifts and their approved leave is not visible until the relevant rota is issued.

GP: Trainees reported that the workload in the postnatal ward can be overwhelming. They were concerned about the rota regarding the postnatal ward as there is no consultant presence and senior ST trainees have often reviewed their patients and left the ward before the junior trainees have started. They were also concerned that the FY2 trainees may struggle to prioritise a sick patient with all of the competing demands of the ward. Trainees suggested it would be useful if they could be provided with the senior ST rota to ensure they know which ST trainees are covering the postnatal ward and on-call, to know who to contact for support if needed.

ST: Junior trainees reported that workload in obstetrics during the weekend is very demanding and often challenging to get any assessments completed as senior trainees are also extremely busy. In addition, trainees reported that due to workload pressures they cannot complete any IDLs for patients over the weekend. Trainees also reported that workload is high within the postnatal ward, with senior trainees stating that they quickly review their patient before starting a clinic. Trainees did indicate the postnatal ward was an area of risk as there is no consultant ward-round and a different junior and senior trainee on the ward each day.

Non-Medical Staff: Staff reported that the workload in the department was particularly challenging at the weekends due to less staff. Staff felt that everyone in the department works extremely hard but did highlight that it can be difficult to get a doctor to attend the postnatal ward.

2.13. Handover (R1.14)

Trainers: Trainers reported there is an effective handover held in the labour ward each morning. They ensure that any high-risk patients are discussed and include discussion of gynaecology patients. The out of hours consultant is not resident but will attend the evening handover before leaving the hospital. Trainers reported that handover is used as an educational opportunity through discussion of patients and the ward round, with trainees having the opportunity to also highlight their learning needs for the day.

Foundation: Trainees reported there is an handover between to on-call teams and did not have raise any concerns about the structure of this. However, trainees did report that there is no handover for postnatal ward patients and those working within the postnatal ward do not attend handover, which result in an unwell patient in that unit not being highlighted at handover.

GP: Trainees reported that handover works well.

ST: Trainees reported that handover is effective and used as a learning opportunity.

Non-Medical Staff: Staff reported that handover works well with those in attendance introducing themselves and their role for the day, with the majority of the planning for the day being agreed. They felt this was used as a learning opportunity as trainees can highlight what they are looking achieve from the day.

2.14. Educational Resources (R1.19)

Trainers: Trainers described a variety of resources available to trainees to support their learning, including:

- The teaching and learning centre,
- Access to laparoscopic simulation,

- Dummies for procedures, e.g. speculum, and
- Computer access

Foundation: Trainees reported that there are adequate facilities and resources to support their learning. They were not aware of any simulation equipment which they could access for their training development.

GP: Trainees felt that the educational resources available to them was sufficient and there is good wi-fi access.

ST: Trainees reported that there is a 'phenomenal' library but that due to its location in the Training and Learning centre that they cannot easily access this when working. They suggested that having access to Badgernet on the computers within the teaching and learning centre would be helpful.

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 raise concerns as a group about their experience in their post through the chief resident, who will discuss these at the senior staff meeting. They also felt that trainees could feedback their concerns directly to their supervisor. Trainers reported that if they had significant concerns about a trainee's performance they could raise this to the Deanery and the Performance support unit. They also reported that individualised support within the department would be provided to a doctor in difficulty in addition to occupational health support and deanery support. Trainers reported that they are happy to provide career advice to foundation doctors and encourage them to access the taster week.

Foundation: Trainees reported they would speak with the junior trainee tutor if they were struggling professionally or personally.

GP: Some trainees reported that they were either unsure of what support is available to them if they were struggling or that they would be unsure of what support they would be given if sought. However, at least one trainee had requested a specific modification, and this was accommodated by the department. Those working less than full time reported that they have felt supported and the department were able to meet their required adjustments.

ST: Trainees felt confident that support would be provided to them if they were struggling. Those working less than full time reported that the arrangements for training are working well.

Non-Medical Staff: Staff reported that they would raise concerns about a trainee's performance with their 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 they can attend the medical education committee and that the director for medical education is very approachable if they wish to raise any concerns.

Foundation and GP: Trainees were not aware of the educational governance structure within the hospital and were not aware of who the director of medical education (DME) is or their role in regarding the management of the quality of education and training.

ST: Trainees reported that there is no formal trainee forum, but they can discuss their training with the chief resident and this can be escalated to the Greater Glasgow and Clyde Director's meeting. They also felt they could discuss this with the college tutor and training programme director but were not aware of who the DME is, or their role regarding the management of the quality of education and training they receive.

2.17 Raising concerns (R1.1, 2.7)

Trainers: Trainers reported that they initially encourage trainees to raise patient safety concerns during their induction and this is further promoted and encouraged during handover. If the concern was more immediate, trainees are encourage to raise their concern with senior staff and follow the escalation policies in place.

Foundation: Trainees reported they would raise any patient safety concerns with the on-call senior trainee. They would raise concerns regarding their education and training with their foundation programme director.

GP: Trainees reported they would raise concerns about their education and training with their training programme director.

ST: Trainees reported they would raise concerns about their education and training with one of the college tutors or their training programme director.

Non-Medical Staff: Staff reported that they would contact a trainee or consultant if they had concerns about patient safety.

2.18 Patient safety (R1.2)

Trainers: Trainers felt the department provided an extremely safe environment for patients and trainees, due to the strong consultant presence in clinical areas. Trainers reported that some gynaecology patients are boarded in other departments. Those who are boarded out and named on the labour ward board and discussed during handover.

Trainees: Trainees reported that they would not have concerns about the quality or safety of care if a family member was admitted to the department. However, trainees felt concerned about patient safety on the post-natal ward. They reported that there is no postnatal ward round and unlike gynaecology and ante natal patients, who are seen daily by senior staff, trainees reported that patients on the post-natal ward are never seen by a consultant. Trainees also raised concerns regarding immediate discharge letters as trainees are completing IDLs many months after a patient is discharged with no notes or information to confirm the dose and duration of any medication and the reasons for the medication being provided to the patient. In addition, ST trainees felt that there can be a hostile environment in the maternity assessment unit but this is dependent on what midwifery staff are working and on occasion there is lack of respect for patients in the way that the midwives speak to patients.

Trainees reported that boarded out patients are discussed daily during handover to ensure they are receiving appropriate care.

Non-Medical staff: Staff felt the environment was as safe as it can be for patients. They reported that there is a safety culture within the department and will quickly escalate any concerns. In addition to

the handovers and risk management meets, staff reported that they attend safety huddles twice daily where concern about patient safety can be discussed.

2.19 Adverse incidents (R1.3)

Trainers: Trainers advised that adverse incidents are reported through the datix system. These are reviewed and discussed at the risk management meetings, where trainees have the opportunity to present. They reported that there is a tick box on the datix report which the trainee can select if they wish to receive feedback. In situations where an unexpected adverse incident requires review in greater detail, a significant clinical incident review is undertaken and feedback is given directly to all involved and trainees are encouraged to submit a reflective statement. Lessons learned from these reviews are shared with the whole multi-professional team through department M&M meetings.

Foundation: Trainees reported that adverse incidents are recorded through the datix system. They were not aware any shared learning outcomes following review of an adverse incidents.

GP: Trainees reported that adverse incidents are recorded through the datix system. Those that had submitted a datix reported that they had not received feedback afterwards. Some trainees reported that they did have an initial debrief following an incident they had involvement with. Some trainees were aware of the risk management meetings but did not know when these took place and had never been invited to attend these meetings.

ST: Trainees reported that adverse incidents are recorded through the datix system. Some trainees reported that they had not received feedback on their datix submissions. All levels trainees reported that they are encouraged to attend the risk management meetings and the senior trainees are also encouraged to attend the significant clinical incident meetings.

Non-Medical Staff: Staff reported that adverse incidents are recorded through the datix system, reviewed and then discussed at clinical risk meetings. Where there has been a major incident, staff advised that a debrief is undertaken with all involved. Staff reported that following a risk review meetings, learning summaries are emailed to the lead clinician who shares this with the trainees.

2.20 Duty of candour (R1.4)

Trainers: Trainers reported that they encourage all staff to be open with patients.

Foundation: Trainees reported that they do not know how they would be supported if they were involved in an incident where something went wrong.

GP: Not asked.

ST: Trainees reported that they would be supported by the senior consultant team if they were involved in an incident when something went wrong.

2.21 Culture & undermining (R3.3)

Trainers: Trainers reported that the introduction of the positive culture group and organising some social events is helping to develop more of a teach culture which trainers felt can be difficult due to the size of the department. They also felt that the greatix board, where they can leave positive comments for trainees, helped to share positive communication. Trainers reported that they inform trainees at induction about how to report any bullying or undermining concerns and they encourage trainees to raise any issues with the clinic lead or college tutors. Trainers reported that they were aware of instances where behaviours towards some trainees had not been appropriate and were taking steps to address this.

Foundation: Trainees reported that they felt they worked within a supportive team. None of the trainees interviewed had experienced or witnessed any bullying or undermining behaviours but would raise this with the positive culture consultant if they did.

GP: Trainees reported that most of the senior colleagues were supportive. However, some of the trainees interviewed reported they have felt disrespected by some staff working within the unit. Some trainees also felt that had experienced unwanted behaviours from some staff when working within the labour and post-natal wards. Trainees reported that they have raised their concerns with the positive culture consultant who is looking into the issues.

ST: Trainees reported that the majority of consultants are supportive, providing a positive experience. However, a number of trainees reported that they had witnessed or experienced behaviours from some staff which were less positive. Trainees felt that some consultants were quick to comment on others performance in a non-constructive way. Some also felt that discussions during handover were more judgemental than constructive, with a lack of appreciation of the intensity of workload during the night. Some trainees perceived the labour ward to have a highly critical culture in front of other colleagues and peers. Another trainee reported of a negative and upsetting interaction with midwifery staff. This was reported to the positive culture consultant, and although no incidents have happened since, trainees did report a lack of feedback and closure when they do raise concerns, resulting in trainees having no awareness of what action has been taken or changes that may have been put in place. However, some trainees did feel that genuine changes are underway within the department to improve the team culture.

Non-Medical Staff: Staff reported that the promoting positive culture was developing a culture or respect throughout the team. They highlighted that handover as an opportunity for all staff to highlight 'what matters to them' to further support a good team environment. Staff reported that there is a clear escalation policy in place to report any issues relating to bullying or undermining behaviours. It was reported that a member of staff had been subjected to inappropriate behaviour from a consultant and this was being addressed.

2.22 Other

Trainees were asked to rate their overall satisfaction experience of working within the department from a range of 0 (very poor) to 10 (excellent). The scores are listed below:

- Foundation – Range: 5 – 7, Average 6.25 out of 10
- GP – Range: 4 – 8, Average: 5.67 out of 10
- ST - Range: 6 – 8.5, Average: 7.14 out of 10

3. Summary

Following the survey data in 2018, the department has clearly taken steps to improve the trainee experience and the culture within the department. However, a number of these initiatives are still in their infancy and require further development and support. Due to the number of concerns,

particularly in relation to the culture and potential patient safety issues, the panel recommend that the department should have a revisit within 12 months' time.

Positive aspects of the visit

- Clinical supervision is rated highly by all groups of trainees and the level of consultant presence is to be commended.
- Good access to study leave.
- A lot of work, by some of the consultants, has been undertaken to make improvements to the induction program and handbook, although there is still some work to further improve induction to meet the specific needs of the GPST doctors.
- There is a robust handover in place with consultant presence which offers the opportunity for staff to identify the different levels of trainee and enables trainees to highlight specific learning needs ('what matters to them').
- The 'Promoting positive culture' initiative is to be commended. The workplace behaviour champion plays an important role within this and should be supported in further developing this role.

Less positive aspects of the visit

- Significant patient safety concerns in relation to immediate discharge letters where all trainee cohorts reported that these in some cases are not being completed until 3 months after a patient has been discharged. This is resulting in patients being sent home with medication but without any information to pass to their GP to confirm what medication they are on and the reasons for this. This issue seems to be a particular problem on the post-natal wards.
- It is acknowledged this is a very busy unit with a high workload. However, some areas particularly the post-natal ward lacks senior input and the significantly high workload at weekends, which requires to be addressed.
- The panel are aware that a consultant is working hard to deliver and improve local teaching and CTG training is working well. However, trainees have difficulty accessing teaching due to workload and teaching is not bleep free. There is also a lack of communication about local teaching to FY2 and GP trainees and lack of relevant teaching for FY2 and GP trainees.
- Although trainees have no issues raising concerns and these concerns are taken seriously, both GP and Paediatrics Specialty trainees reported experience of, or witnessing, negative and

unwanted behaviours from some staff within the department. There is also a lack of feedback to trainees to inform them what action has been taken and the final outcome.

Is a revisit required?	Yes	No	Highly Likely	Highly unlikely

4. Areas of Good Practice

Ref	Item	Action
4.1	Handover is well structured and enables trainees to highlight learning needs.	
4.2	Introduction of the positive culture champion to improve the team culture.	
4.3	The Greatix Board enables positive feedback to be shared with trainees. Although it was indicated that this is now hidden behind a door.	

5. Areas for Improvement

Ref	Item	Action
5.1	Induction	Learning modules for IT systems, such as immediate discharge letters, should be signposted to trainees.
5.2	Induction	Trainees should be given a tour of the main hospital to ensure they are familiar with the location of areas they may require to access when working out of hours.
5.3	Induction	The department should have a plan in place to deliver the newly revised junior rota induction regardless of the availability of the junior rota consultant.
5.4	Feedback	The role of the chief resident within the department and how to contact them should be highlighted to Foundation and GP trainees.
5.5	Adverse Incident	All levels of trainee should be provided with the shared learning outcomes following the risk review meetings.

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	Measures must be implemented to address the patient safety concerns associated with the lengthy delays between patients being discharged from the post-natal ward and completion of the immediate discharge letter.	Immediately	FY2, GP
6.2	Initial meetings and development of learning agreements must occur within a month of starting in post.	3rd February 2020 (9 months)	FY2, GP
6.3	Ensure that service needs do not prevent trainees from attending clinics and other scheduled learning opportunities	3rd February 2020 (9 months)	FY2, GP
6.4	Lack of access to clinics for Foundation trainees and for GP trainees must be addressed to improve the training opportunities for these cohorts.	3rd February 2020 (9 months)	FY2, GP
6.5	Trainees must not be expected or requested to seek consent for a procedure they are not competent to do and not undertaking.	3rd February 2020 (9 months)	GP
6.6	There must be a clear escalation policy where there is a medical concern about a patient, which is understood and followed by all involved.	3rd February 2020 (9 months)	All Cohorts
6.7	A regular programme of formal teaching should be introduced appropriate to the curriculum requirements for FY2 and GP trainees.	3rd February 2020 (9 months)	FY2, GP
6.8	All staff must behave with respect towards each other and conduct themselves in a manner befitting Good Medical Practice guidelines.	3rd February 2020 (9 months)	ALL

6.9	Feedback to trainees on their input to the management of cases must be constructive and meaningful, not critical, particularly during handover.	3rd February 2020 (9 months)	ST
6.10	The department must ensure that there are clear systems in place to provide supervision, support and feedback to trainees working within the post-natal ward.	3rd February 2020 (9 months)	FY2, GP
6.11	Trainees must know who to contact for support at all times, especially within the post-natal ward	3rd February 2020 (9 months)	FY2, GP
6.12	There must be a process that ensures trainees understand, and are able to articulate, arrangements regarding Educational Governance at both site and board level.	3rd February 2020 (9 months)	FY2, GP
6.13	Trainees must receive feedback on incidents or concerns that they raise.	3rd February 2020 (9 months)	All cohorts