Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	22nd October 2019	**Level(s)**	FY1
Type of visit	Enhanced Monitoring Re-visit	**Hospital**	Vale of Leven Hospital
Specialty(s)	FY1 only	**Board**	NHS Greater Glasgow and Clyde

Visit panel	
Professor Alastair McLellan	Visit Chair - Postgraduate Dean
Robin Benstead	GMC Visits & Monitoring Manager
Marion Macleod	Lay Representative
Dr Alan McKenzie	Associate Postgraduate Dean – Quality
Alex McCulloch	Quality Improvement Manager
Dr Aravind Punnuswamy	College Representative
Dr Surinder Panpher	Foundation Representative
In attendance	
Patriche McGuire	Quality Improvement Administrator

Specialty Group Information	
Specialty Group	Medicine
Lead Dean/Director	Professor Alastair McLellan
Quality Lead(s)	Dr Alan McKenzie Dr Reem Al-Soufi Dr Stephen Glen
Quality Improvement Manager(s)	Alex McCulloch Heather Stronach

Unit/Site Information		
Non-medical staff in attendance	5 (including Senior Charge Nurses, Frailty Practitioner and Pharmacists).	
Trainers in attendance	8 (including Director of Medical Education, Associate Director of Medical Education and Clinical Services Manager)	

Trainees in attendance	5 FY1								
Feedback session: Managers in attendance	Chief Executive	X	DME	✓	ADME	✓	Associate Medical Director	✓	Other (Chief of Medicine for Clyde Sector)

Date report approved by Lead Visitor	 7th November 2019

1. Principal issues arising from pre-visit review:

In early 2015, training at the Vale of Leven Hospital (VoL) was escalated to the GMC enhanced monitoring process following a deanery visit in December 2014. This escalation was due to concerns of trainee exposure and working without adequate supervision & support, which predominately affected the General Practice trainees experience and Foundation trainees to a lesser extent.

Due to the disestablishment of the 4-year General Practice training posts in August 2018, the only cohort of trainees who rotate through the site currently are FY1 trainees on 6-week Medicine/Surgery rotations from the Royal Alexandra Hospital (RAH) in Paisley. These trainees are predominately from the W7 & W8 Foundation Programmes which are based in the 3 Clyde Hospitals in NHS Greater Glasgow and Clyde. Following the conclusion of their 6-week rotation the trainees move back to the RAH for the remainder of their FY1 year. Each FY1 spends 3 weeks in 2 of 3 ward areas (AMRU, Lomond Ward and Wards 14+15).

There are 3 FY1s that are based in the Vale of Leven at any time and this visit will include discussions with the 3 current FY1s in post and the previous 3 that completed the rotation from (Aug – Sept 2019).

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.

Before the trainers' session, the visit panel were given an overview of training at the Vale of Leven that was led by the local Clinical Services Manager.

2.1 Induction (R1.13):

Trainers: Trainers advised that trainees are e-mailed a link to the NHS Greater Glasgow and Clyde induction website page which contained information relevant to their role. A comprehensive Vale of Leven Handbook was also sent to them, along with relevant I.T and systems passwords (the same passwords for RAH & VoL). Trainers advised the Clinical Service Manager would meet briefly with the trainees in her office on arrival at the hospital before their first shift. At that point an informal chat would take place where the trainees could ask any questions regarding the hospital and they would then make their way to their allocated wards to be met by a Senior Nurse to start their post. The trainers had not received any negative feedback regarding local induction to the hospital and felt it worked well. As part of the shadowing week conducted at the Royal Alexandra Hospital (RAH), the trainees could spend some of that time at the VoL in order to shadow a current trainee.

Trainees: Trainees told us they had received an informal local induction on arrival at the site. This was followed by an introduction to the Charge Nurse on the ward. A more formal induction took place at the RAH but the trainees felt it contained minimal information in relation to the VoL. During their shadowing period at the RAH, only one of the trainees' present had attended the VoL for an afternoon to shadow a current FY1 that was there at the time. This was confirmed to be in the trainee's own time rather than during the time set aside for shadowing. All the trainees had received the VoL handbook but only 3 of the 5 trainees present had read it prior to starting. To improve induction, trainees felt it would have been helpful to have met with the locum middle-grade trainees and be provided with information as to what services / specialties were present at the site and what were the expectations regarding their roles and responsibilities.

Nursing and Non-medical staff: The nursing and non-medical staff felt induction was effective in preparing trainees of the MDT.

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

Trainers: The trainers described the local teaching programme that was provided for trainees. Local teaching was delivered at the VOL on Thursdays, which were usually 45 mins – 60 mins long. Usually and delivered by the local consultant Physician of the week. Non-medical staff (including Pharmacists and Resuscitation Officers) also delivered teaching sessions on various topics. A video link was provided for trainees to conference into regional Foundation teaching that took place at the RAH on Tuesdays.

Trainees: Trainees confirmed that they could access regional Foundation teaching on a Tuesday, through a video link to the RAH and were able to attend the local teaching sessions at VoL on a Thursday. The sessions conducted at the beginning of the training year between (August – September) took place less frequently than they did currently, with some sessions being cancelled earlier in this training year. The current cohort of trainees had not experienced this and had attended sessions each week of their rotation so far. Teaching was described as interruption free on most occasions, although a trainee had raised a concern around being told to leave a teaching session by a member of the nursing staff on their ward, in which they felt they had been spoken to in an inappropriate manner.

Nursing and Non-Medical Staff: Nursing and non-medical staff felt they had done their best to support the trainees by providing cover for their ward duties to allow them to attend teaching on Tuesdays and Thursdays. There had been occasions in the past where they had to interrupt them, but these were described as rare.

2.3 Study Leave (R3.12)

Not applicable to FY1 trainees.

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

Trainers: Trainers advised that Educational and Clinical Supervisors were allocated to trainees at the beginning of the training year by the Rota Co-ordinator and one of the trainers based at the RAH. Usually the Educational and Clinical Supervisors for FY1 trainees were the same and remained their supervisors for the full training year. The physician of the week acts as the clinical supervisor of the trainees during their week at the VoL.

Trainees: Most trainees advised their allocated Educational Supervisors were based at the RAH. A couple of the trainees' present had not met with their Educational Supervisors in the RAH because they were based at the VoL. This meant the initial meetings for some trainees took place 6 – 8 weeks beyond starting their post.

Nursing and Non-Medical Staff: No concerns

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

Trainers: Trainers advised there were two consultants based at the VoL on a permanent basis in wards 14 and 15 (who were supervisors), the others would rotate in each week from the RAH, they were all Educational / Clinical Supervisors for Foundation trainees and understood their curriculum requirements. Foundation Yr1 trainees did not attend clinics but were offered lots of exposure to complex medicine and time to complete Workplace Based Assessments using the experience gained. The trainers felt a good balance of training was offered at the VoL and much of it was offered on a 1-2-1 basis.

Trainees: Trainees felt they received good experience during their time at the VoL – with good exposure to a range of acute general medicine and geriatric medicine. They were able to access ward rounds in the 3 ward areas, could attend MDTs and achieve core procedures. Their percentage of time spent providing service provision was very favourable, with most of their time spent carrying out duties and tasks that were of educational benefit to them.

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

Trainers: Trainers felt the trainees had the time and opportunity to complete Workplace Based Assessments. All the trainers were Educational and Clinical Supervisors and had received the appropriate training to undertake Workplace Based Assessments.

Trainees: Trainees described good access to most Workplace Based Assessments, although DOPs (Direct Observation of Procedures) could be more difficult to get than others.

Nursing and Non-medical staff: Staff completed tickets for Workplace Based Assessments and supported trainees with their learning of core procedures.

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

Trainers: Trainers described multi-professional learning opportunities that were available to trainees. As it was a small site, the multi-disciplinary team worked closely together and as a result, multi-professional learning happened both formally (through Pharmacy and Nurse led teaching sessions) and informally through day to day ward work with Nursing, AHP staff, including a Frailty Practitioner.

Trainees: Trainees described good opportunities to learn with other health professionals and noted the teaching delivered by Pharmacists and the (newly appointed) Frailty Practitioner as very good. Most of the learning was informal due to the small size of the hospital and the MDTs worked closely together as a result of this.

Nursing and Non-medical staff: Staff described ward rounds, MDT meetings and 1-2-1 peer to peer meetings as opportunities for shared learning with the trainees.

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

Trainers: Trainers felt there was opportunities for quality improvement projects and audits, however as the trainees were only there for 6 weeks, they were not able to complete them during that time. Trainers were also looking into developing Morbidity and Mortality meetings, but plans were in the early stages of discussion.

Trainees: Trainees felt that although there were opportunities to become involved in audit or quality improvement projects, it was often difficult to conclude them as they were not at the site long enough to do so.

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: The trainers' perception of Clinical Supervision was that trainees should never have to cope with issues beyond their competence without support from a senior colleague. As the trainees worked 9.00 am – 5.00 pm and did not work out of hours or weekends at the hospital, their supervision was generally provided by either a consultant (who they would be working with each day) or a specialty doctor / locum. Trainers advised that no procedures take place at the hospital, so trainees would not be required to seek consent from patients for any.

Trainees: Trainees were very clear around who they would contact for supervision during the day (and any out of hours working took place at the RAH). Trainees felt they received good support from the locum middle-grade colleagues. A trainee described a brief period of a consultant being on on sick leave from one of the wards and the absence of cover arrangements as there appeared not to be a contingency arrangement. The trainee required senior input regarding care of an ill-patient and described having to search the hospital to find that help; the trainee however acknowledged this to be an unusual situation.

Nursing and non-medical staff: Staff were unaware of any instances when trainees had to work beyond their competence.

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: Trainers felt feedback was provided to trainees on a regular basis and was similar in each area of the hospital they worked in. Lomond ward feedback would be similar to in the Acute Medical Receiving unit (AMRU), with lots of face to face contact and ward round experience. The trainee in Care of the Elderly Wards 14 & 15 could access twice weekly ward rounds with consultants and receive feedback during these.

Trainees: Trainees reported that in all 3 clinical areas they had access to useful and meaningful feedback from consultants and from the middle-grade locums when available. This included feedback on management plans that they formulated in the AMRU.

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

Trainers: Trainers would ask trainees for feedback directly on an informal basis. There was no trainee forum gathering feedback on experiences at this site.

Trainees: The trainees advised they had been sent an online questionnaire to provide feedback on their training, some had completed it, but others had not. The trainees were not aware of a trainee forum either at the VoL or the RAH.

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

Trainers: Trainers advised there were no gaps in the current rota. The rota co-ordinator based at the RAH provided support to the FY1s and was felt to be helpful and approachable. There was some concern around the rota gap caused by the weekend cover the trainees were required to provide at the RAH. If they were working at the weekend in the RAH, then they were given the Monday off, which caused difficulty in providing ward cover for whichever area of the VoL was affected.

Trainees: Trainees advised there were no gaps on their current rota. They felt however that the temporary gap that was created by a trainee being off on a Monday, following working the weekend at the RAH was not managed pro-actively and cover arrangements should be in place for this recurring issue. Trainees felt this issue had caused delays in patients discharges on a Monday. Trainees also thought the system of pre-allocating them their annual leave all in one go was unfair. Some of the trainees had been allocated 2 weeks off soon after starting their training, which meant it then felt like starting their post all over again when they came back to work.

Nursing and Non-medical Staff: Staff had no concerns around rotas and workload, although it was acknowledged that the AMRU can be busy at times.

2.13. Handover (R1.14)

Trainers: Trainers advised that handovers took place twice daily at 8.00 am in the morning and at 4.00 pm in the afternoon. Trainees were not in attendance at the morning handover or huddles due to their shift not starting until 9.00am and were often not at afternoon handover, which was mostly attended by locum middle-grade doctors. Handover at the weekend was recorded in a written format on a Friday, which would be provided by the FY1 and or locum doctor and added to the local shared drive. The CSM receives a report from the morning handover which would then feed into the ward huddles, where trainees could find out what had been discussed.

Trainees: Trainees confirmed that handovers took place daily at 8.00am and late afternoon. Handover at the weekend was confirmed as consisting of a list of jobs that would be created by the middle-grade locum doctors, which the FY1s contributed too; this was then stuck to a white board in the doctors' room.

Nursing and non-medical staff: Staff felt handovers were effective. They advised that although trainees were not present at morning handover or huddles that took place before 9.00am, the nursing staff would update them on what was discussed at the start of their shift. Weekend handover consisted of a list of patient updates, added to a large white board in the doctors' room.

Educational Resources (R1.19)

Trainers: Trainers advised a small on-site library was available to trainees and they had no concerns around facilities or resources available to support the trainees learning.

Trainees: Trainees had access to a small library and computer room and felt the available facilities to be adequate.

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

Trainees: The trainees present had not had to seek any support. They felt it would be available to them through the Clinical Services Manager if they required it.

Nursing and non-medical staff: Staff would raise any concerns they had around the performance of a trainee with one of the consultants or the local CSM.

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

Trainees: Trainees were aware of who their Director of Medical Education was and what they were responsible for. They were not aware of a local trainee forum either at the VoL or at the RAH. Trainees were part of a WhatsApp group, which they used to communicate with one another and to share learning.

2.17 Raising concerns (R1.1, 2.7)

Trainers: Trainers confirmed trainees are encouraged to raise any concerns about patient safety through their main RAH/GGC induction and their local induction at the VoL. Any concerns they had, could be raised with a consultant or Lead Nurse on the wards.

Trainees: Trainees would raise any concerns they had about patient safety with the local consultants, staff nurses or specialty locums they worked with. They had no concerns about patient safety at the site.

Nursing and Non-medical staff: Staff would raise any concerns about patient safety through Datix. Senior Nursing staff would review Datix incidents and discuss any concerns with consultants and CSM. If a trainee was involved in a Datix incident, then a consultant would become involved in the follow up discussions and feedback around the case.

2.18 Patient safety (R1.2)

Trainers: No concerns were raised by trainers around the safety of the environment for patients at the VoL. As patients were selected admissions, they were often stable and non-complex admissions. Any complex patient cases were transferred directly to the RAH. As the FY1s were not working at the front door of Acute Receiving, they would not often encounter the more complex cases that would be transferred to the RAH. Patient boarding was also in-frequent at the hospital, although it had happened on a couple of occasions recently, when 1 or 2 patients had been boarded in the Care of Elderly ward. Routine systems to monitor patient safety were confirmed as morning safety huddles and monthly transfer MDT meetings. Trainees were not included in morning safety huddles as they took place before their shift started.

Trainees: A trainee described an instance of them providing a detailed handover note for 3 patients that required input over the weekend, including blood tests to be done to monitor known abnormalities; on return to work the following week, the trainee found that the patients hadn't been seen and the bloods hadn't been taken. Trainees advised that Trakcare functionality (which could be used to record handovers and requirement for tasks to be done) was not used at the Vol but was used at RAH.
Most of the trainees' present would not have any concerns about patient safety if their friend or relative was admitted to the hospital. Most areas of the hospital such as the AMRU and the other wards were felt to be safe, although a trainee reported concerns at times around nursing staffing levels on ward 14.

Nursing and Non-medical staff: No concerns around patient safety were raised. Boarding was felt to happen infrequently and on the odd occasion. Routine systems in place to monitor the safety of patients were huddles and safety briefings.

2.19 Adverse incidents (R1.3)

Trainers: Trainers confirmed Datix as the main tool for recording adverse incidents. Datix incidents were reviewed by the ward Senior Charge Nurse and generally did not include FY1s.

Trainees: The trainees present didn't have an awareness of the policy for using Datix and were unsure of how to use it. None present had used it so far but felt they could find out how to use it, if they had to.

2.20 Duty of candour (R1.4)

Trainers: Trainers described the VoL as a friendly, open environment to work in. They felt trainees were supported by lots of multi-disciplinary staff and were involved in conversations with patients' families on a regular basis.

Trainees: A trainee present had been involved in a Datix incident recently were something had gone wrong with a patient's care. They described being spoken to by a charge nurse about it and had also received feedback from the Director of Medical Education, this made them feel supported throughout the process.

2.21 Culture & undermining (R3.3)

Trainers: Trainers were not aware of any instances of bullying or undermining behaviours and described the hospital as a close unit. Trainees who had any concerns could raise them informally with the CSM or with their Educational/Clinical Supervisor.

Trainees: Trainees felt their interactions with their consultant colleagues could sometimes be less enthusiastic, depending on which consultant was physician of the week. Trainees raised some concerns around interactions with Nursing staff and had raised their concerns with the DME and Educational Supervisors. Trainees were satisfied that attempts to reach a resolution, were now being investigated by their senior colleagues.

Nursing and Non-medical staff: Staff described the environment at the VoL as a close team, who worked together. They described the team as open, engaged and friendly. They were unaware of any incidents of undermining or bullying.

3. Summary

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

The visit panel found that trainees received an improved and mostly positive training experience at Vale of Leven Hospital, since the last deanery visit in 2016. The recommendation of the visit panel would be to propose the de-escalation of Vale of Leven Hospital from Enhanced Monitoring and to continue to monitor the site through usual Deanery quality management processes by the Medicine Quality Management Group. Formal discussion about the de-escalation from Enhanced Monitoring will take place between the Deanery and GMC and will follow completion of the visit report. Trainees scored their overall satisfaction between 6 – 8 out of 10, with an average score of 7.

Positive aspects of the visit:

- Access to learning opportunities - formal teaching, experiential learning and assessment - was very good.
- Supportive, positive multi-disciplinary team and associated team learning environment.
- Clinical supervision and feedback arrangements in AMRU were good.
- Junior doctor handbook was comprehensive and distributed to all trainees before they started their post.

Less positive aspects of the visit:

- Trainees do not have clear understanding of their roles and responsibilities upon starting, despite provision of the Vale of Leven Hospital Clinical Handbook.
- Lack of clarity around cover arrangements and provision of cover for gaps arising from time off at Vale of Leven Hospital after weekend shifts at Royal Alexandra Hospital.
- Lack of robust handover of tasks and actions required at weekends.
- Lack of formal process for gathering feedback on trainees' experiences at the Vale of Leven Hospital (informal opportunities exist).
- Reference was made to a couple of challenging interactions between nursing staff and doctors in training.
- Lack of familiarity with the Datix system.
- Delay in the first meeting with Educational Supervisors to beyond 6 weeks after starting for some trainees whose initial post was in the Vale of Leven Hospital but whose Educational Supervisors are in the Royal Alexandra Hospital.
- Lack of consistent access to shadowing experience of the Vale of Leven Hospital within shadowing period for those starting here.

4. Areas of Good Practice

Ref	Item	Action
4.1		

5. Areas for Improvement

Ref	Item	Action
5.1	FY1 Shadowing at the VoL	Ensure that some of the FY1 shadowing week is spent at the VoL, in order that the trainees can familiarise themselves with the layout and workings of the hospital.
5.2	Formalised departmental induction – In relation to requirement 6.1	Trainees suggested including signposting to or information in relation to what specialties and services are available or are provided within Medicine.
5.3	Cover arrangements for gaps on Mondays after weekend shifts	Arrangements to provide cover for gaps arising from time off at Vale of Leven Hospital after weekend shifts at Royal Alexandra Hospital should be defined.
5.4	Feedback from doctors in training regarding their training at VoL	In addition to gathering informal feedback from trainees about their experiences of training in the VoL, there should be a more formal mechanism such as a trainee forum (possibly as part of feedback gathering processes at RAH)

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	Departmental induction must be provided which ensures trainees are aware of all of 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	5th August 2020	FY1
6.2	During times of Consultant leave there must be robust arrangements for both ongoing senior review of these patients' care and ongoing supervision of the contributions to these patients' care of the trainees who look after these patients.	5th August 2020	FY1
6.3	Handover processes must be improved to ensure there is safe, robust handover of patient care including at weekends.	5th August 2020	FY1
6.4	Ensure trainees engage in use of the Datix system and highlight the importance of utilising this reporting mechanism.	5th August 2020	FY1
6.5	Initial meetings with Educational Supervisors and development of learning agreements must occur within a month of starting.	5th August 2020	FY1
6.6	All staff must behave with respect towards each other.	5th August 2020	FY1