Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	19th & 20th November 2020	**Level(s)**	FY/GPST/IMT/ST
Type of visit	Virtual – Enhanced Monitoring re-visit	**Hospital**	Inverclyde Royal Hospital
Specialty(s)	General Internal Medicine and Geriatric Medicine	**Board**	NHS Greater Glasgow and Clyde

Visit panel	
Professor Alastair McLellan	Visit Chair - Postgraduate Dean
Mr Robin Benstead	General Medical Council Visits and Monitoring Manager
Mr Tom Drake	Lay Representative
Dr Reem Al-Soufi	Associate Postgraduate Dean for Quality (Medicine)
Mr Alex McCulloch	Quality Improvement Manager
Dr Clive Goddard	Associate Postgraduate Dean for Medicine (South East Scotland)
Dr Ken Lee	Assistant General Practice Director & Associate Post Graduate Dean for Quality
Dr Paul Cadden	Training Programme Director
Dr Marie Mathers	Associate Post Graduate Dean for Quality (Foundation)
Dr Ailie Grzybek	Trainee Associate
In attendance	
Miss Claire Rolfe	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 Greg Jones
Quality Improvement Manager(s)	Mr Alex McCulloch

Unit/Site Information				
Non-medical staff in attendance	N/A			
Trainers in attendance	12			
Trainees in attendance	FY x 11	GPST x 3	IMT x 2 + 1 CDF	ST x 2

Feedback session: Managers in attendance	Chief Executive	X	DME	✓	ADME	✓	Medical Director		Other	Lead Trainer, Clinical Service Managers, Business Managers, Rota Manager, Quality Improvement Managers.

Date report approved by Lead Visitor	 21st December 2020.

1. Principal issues arising from pre-visit review:

In 2017, the General Medical Council (GMC) undertook a national review of medical education and training in Scotland. As part of that review, the GMC visited GIM at IRH on 11 October 2017 and stipulated 2 requirements to be addressed.

In 2018, survey data received by the Deanery confirmed the continued need to visit GIM at the IRH. The triggered Deanery visit on 19 November 2018 resulted in 12 requirements for the site. The 6-month update provided by the IRH to address the requirements reported good progress had been made against all requirements.

In 2019, geriatric medicine at the IRH featured on the GMC's triage list. Geriatric medicine is routinely integrated within GIM visits; however, the visit panel in 2019 was careful to consider specifically both geriatric medicine (the Larkfield Unit) and GIM. At that visit, concerns were raised that trainees felt unsupported in the Larkfield Unit and unable to clarify escalation plans. Further concerns were flagged via a notification of concern that was escalated to the DME resulting in further support to the department, and since then a further 2 consultant geriatricians are supporting trainees working in the Larkfield Unit. In September 2019 the Deanery received a further notification of concern from a trainee on behalf of colleagues raising concerns around the impact of rota gaps on training and trainees' well-being. Relationships between the trainees and the local management team were strained at this time and the trainees continued to raise concerns about the impact of the rota gaps on their training.

A further Deanery revisit on 13 November 2019 resulted in the escalation of both GIM and geriatric medicine at the IRH to the GMC's enhanced monitoring process because of the persistence of concerns around the GMC's standards for education & training not being met. The visit also resulted in 13 requirements to be addressed as listed below.

Ref	Issue
6.1	Those responsible for educational governance must investigate the allegations of undermining and concerning behaviours, and if upheld, put in place an appropriate action plan to address these concerns.
6.2	HDU consultant cover – There must be clarity regarding who is on-site to provide cover and is available to attend patients in the HDU.
6.3	Medical Receiving Unit – Clarity should be provided to trainees around the consultant responsibility and review of patients in the medical receiving unit for patients who stay in the medical receiving unit for longer than 24 hours.
6.4	Tasks that do not support educational and professional development and that compromise access to formal learning opportunities, including teaching, for all cohorts of doctors must be reduced.
6.5	Handover processes in general medicine must be improved to ensure there is a safe, robust handover of patient care with adequate documentation of patient issues, senior leadership and involvement of all trainee groups who would be managing each case.
6.6	Feedback to all levels of trainees on their management of acute receiving cases must be provided to inform their learning and training.
6.7	Trainees must have access to the appropriate procedural opportunities, including pleural procedures, to enable them to meet the requirements of the curriculum and to achieve satisfactory annual review of competence progression outcomes.
6.8	The site must foster a culture of learning that includes doctors in training both in reporting critical incidents but also in the consequent learning that comes from an effective system.
6.9	Cardiology transfer – Escalation pathway needs to be clarified to ensure trainees are supported in escalating patients.
6.10	There must be robust arrangements in place to ensure the tracking of all boarded patients and to support regular review by a consultant.
6.11	There must be an educational governance process that links training delivery in Inverclyde Royal Hospital to the NHS Greater Glasgow and Clyde's Board. Trainees must be aware of this.

6.12	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 may be useful in aiding this process but are not sufficient in isolation.
6.13	There must be active planning of attendance of doctors in training at teaching (including bleep-free attendance) events to ensure that workload does not prevent attendance.

This visit is being undertaken to review progress against previous visit requirements, identify good practice and to identify any current trainee concerns**.** 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.

The panel would like to thank Dr Abby Gunn (Lead Trainer) who delivered a very detailed and informative presentation to the panel, which provided an update regarding progress against the previous visit's requirements, along with supporting evidence/documentation. The panel welcomed this type of approach to reporting on progress from a previous visit and considered it to be an exemplar of how to present improvements in response to the requirements following deanery visits.

2.1 Induction (R1.13):

Trainers: Trainers advised a thorough induction was provided to trainees and advertised in advance. Departmental induction was provided separately and were generally accommodated by supporting documentation that was made available to trainees on a local shared drive, ward tours were also included as part of departmental induction. International Medical Graduates were now supported by a pastoral lead who sent on the induction documentation to them and supported them with a bespoke induction. A separate medical receiving unit induction was now also provided for trainees and ran on 3 separate occasions.

All Trainee Cohorts: Trainees present had received induction to site, and most had received departmental inductions to their specific ward/department; the need to ensure this happens consistently including for those starting outside the main changeover times was noted. Departmental inductions, although informal, were thought to support the trainees' needs. Trainees who had worked

in the High Dependency Unit (HDU) reported a separate HDU induction, which they felt was good. Suggestions to improve induction included requests for more consistent department tours and early provision of door access codes.

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

Trainers: Trainers felt a comprehensive teaching programme was offered to trainees and efforts were made to limit interruptions to their teaching sessions. Teaching attendance was encouraged by all staff and nursing staff would provide ward cover and hold pagers, to allow trainees to get to their teaching. Providing interruption free teaching was acknowledged to be more difficult in some of the smaller departments (due to limited staff numbers), however efforts were still made to ensure trainees could attend sessions as often as possible. Teaching registers were kept by the post graduate medical team, who would follow up on attendance. Teaching now took place at lunchtimes and was conducted virtually via MS Teams, due to the restrictions in place to manage the Covid 19 pandemic. The teaching schedule had resumed in August (following postponement during 1st wave of the pandemic) and the trainers highlighted to us the focus of their teaching, which they tried to ensure was focused on trainee need and included:

- Weekly IRH ‘spotlight’
- Weekly medical department teaching
- Monthly IMT/ST teaching (acute higher level specific to ST grades)
- DOME teaching program
- FY1/2/IMT/ST deanery teaching
- Ward teaching
- Post-board teaching
- Procedures teaching

Foundation Trainees: Trainees reported that excellent teaching was delivered to them on Tuesdays, Wednesdays (local hospital teaching) and Thursday lunchtimes (Foundation specific teaching). Attending the Tuesday and Wednesday sessions could be difficult due to interruptions caused by ward workload, trainees advised the Foundation specific Thursday sessions were more protected. Trainees estimated they got to between 1 - 2 hours teaching per week, which were attended virtually using MS Teams. Trainees reported difficulties regarding the ability to find somewhere quiet to watch the teaching sessions if they were not streamed from the education centre. From the sessions that

were streamed in the education centre, trainees reported the quality of the video link to teaching sessions to be particularly poor. Trainees felt the quality was good and variety of teaching they received was comprehensive, Trainees reported they were able to get to between 50 – 100% of the available Foundation programme teaching although workload could sometimes inhibit their ability to attend.

General Practice Trainees: Trainees reported a lack of any organised GP programme teaching and did not think they had attended any sessions so far. They were able to attend some of the local teaching, but workload significantly affected their ability to attend.

Internal Medicine Trainees: Trainees confirmed weekly teaching sessions and estimated they got to between 1 – 2 hours of local teaching per week. Teaching was considered to be interruption free for the most part and the use of MS teams had made teaching very accessible to trainees.

Specialty Trainees: Trainees reported good weekly local teaching, and some were involved in presenting case-based discussions. Regional teaching took place on a monthly basis, but it could be sometimes difficult to attend due to workload. Trainees felt a good standard of teaching was provided for them but recommended that more General Internal Medicine based sessions be delivered as a potential improvement.

2.3 Study Leave (R3.12)

Not covered, no concerns raised in pre-visit information.

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

Not covered, no concerns raised in pre-visit information.

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

Trainers: Trainers advised that clinical supervision contacts were covered in induction and a clear out of hours rota with contact details of consultant supervisors was available to trainees. Trainers recognised that trainees may feel nervous about contacting them, so they felt they made efforts to be

courteous and supportive of them when they did call them for support. Access to senior support was available 24 hours per day, generally in person up until around 9.00 pm at night and then by on-call consultants after this time. The “Say no to SHO” campaign was run in NHS Greater Glasgow and Clyde, which was supported by posters and colour coded badges; trainers felt they were working hard to eliminate the use of the term SHO but it was a term that was used by some of the short term locum staff, some of whom still referred to themselves as SHO. Trainers had encouraged the use of the term “middle grade” in preference. Trainers were unaware of any recent instances of trainees working beyond their competence, a number of changes had been made to the supervision of trainees in HDU, since the last visit in November 2019 and included the creation of an escalation policy, standard operating procedure, clear out of hours contact lists, creation of a 2.30 pm ward huddle and a specific HDU learning resource folder. Additional procedures training had also been put in place following concerns raised at last year’s visit (in regard to chest drain and central line insertion procedures). Trainees were only encouraged to seek consent from patients for procedures they were trained to carry out.

Foundation Trainees: Trainees were generally aware of who was providing their supervision. Consultants were accessible, easy to contact (contact numbers were readily available) and checked-in with trainees periodically. No concerns were expressed by trainees in relation to their clinical supervision. Trainees said their consultant colleagues were approachable and supportive. As some specialties had no presence in the hospital, it could be difficult to get advice from consultants in specialties such as Infectious Diseases and Neurology that have no presence in the hospital. Trainees in Geriatric Medicine confirmed that a stroke pager had recently been introduced and they were sometimes uncertainty around which consultant was on call for stroke, but this was perceived to be a teething problem. Trainees acknowledged the HDU (High Dependency Unit) had previously been light on supervision cover, but recent changes had been made to provide improved support (including provision of a middle grade trainee to support the FY1 allocated to the ward).

General Practice Trainees: Trainees advised they were aware of who was providing their supervision during the day and out of hours, they were aware of the consultants contact numbers and felt their consultant colleagues would have no issues if they contacted them for support.

Internal Medicine Trainees: Trainees were aware of who was providing their supervision. Some concerns were raised by IMY2 trainees in relation to potentially working beyond their competence

when they started and for the first time were '1st on' for medical receiving as the 'medical registrar'. They felt adequate support was available from the on-call consultant and anaesthetics on site (if required) but described it as a stressful transition. Trainees advised that no specific supervisor appeared to have responsibility for medical patients within the HDU during out of hours and at weekends, however they felt they could get support from the on-call consultant if they required it and they considered the arrangement to be robust. Trainees described their consultant colleagues as approachable when they required their help. Overall, trainees did not raise any concerns in relation to the clinical supervision they were receiving.

Specialty Trainees: Trainees felt well supported by their senior colleagues both during the day and out of hours. They did not feel they had to work beyond their competence and did not report any instances when they were required to do so. Trainees described being nervous about the lack of an Intensive Care Unit at the IRH and of the need to stabilise and transfer very sick patients to the Queen Elizabeth University Hospital. They were aware that work was ongoing to improve supervision in HDU and acknowledged that steady progress was being made.

Other

Trainees reported concern about the potential risk posed by a new start IMG who was new to UK practice who was on call overnight on day1 without assessment of competence and without additional supervision in place.

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

Trainers: Trainers felt the biggest challenge to trainees was accessing clinic experience; access to clinics was limited further due to the current wave of the pandemic. Plans were in place to allow trainees to join clinics virtually via MS Teams. Trying to find space which would facilitate this was proving a challenge. Trainers thought that some other competences trainees may struggle to obtain were in Gastroenterology, as the only Gastroenterologist on site was a locum consultant and patients were often transferred to the Royal Alexandra Hospital. The surgical team were currently helping support the trainees by providing a scoping service for Inflammatory Bowel Disease patients. Trainers confirmed that recent vacancies in the phlebotomy service had been filled over the course of the last few weeks. Nursing staff also assisted the provision of the phlebotomy service.

Foundation Trainees: Most trainees felt they were receiving enough experience to meet their curriculum requirements. They described lots of experience of clerking patients, ward rounds and procedures. Opportunities were felt to be limited in the Acute Receiving Unit if it was busy, in which case their work would revert to non-medical tasks to support the service. Trainees advised there was no phlebotomy service in acute receiving, so it was the role of FY1 to provide this service there. Trainees estimated non-medical tasks took up 80-85% of their workload. Despite this, Foundation trainees were very positive about their learning experience, including access to procedures.

General Practice Trainees: Trainees felt they were receiving a good exposure to experience in the medical wards. Clinic experience was zero to minimal. Trainees estimated non-medical tasks took up around 25% of their current workload.

Internal Medicine Trainees: Trainees felt they could get enough experience through their posts to meet their curriculum requirements with the major exception of outpatient clinic numbers. The trainees confirmed a new Respiratory consultant had been recruited, who was running pleural procedures training. Clinic experience was highlighted as an issue for trainees and they had attended very few clinics so far. Trainees described the balance of non-medical vs medical work as good without an unduly heavy burden of non-medical tasks.

Specialty Trainees: Trainees had no concerns around getting enough experience to meet their curriculum requirements with the exception of outpatient clinic numbers. Clinic access again was highlighted as an issue for many, as was trying to find a suitable room/place to participate in clinics. Trainees seemed unaware of the pleural procedures training opportunities that were available to them and described the balance to training vs non-medical tasks as very good.

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

Not covered, no concerns raised in pre-visit information.

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

Not covered, no concerns raised in pre-visit information.

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

The panel noted the embedding of a culture of quality improvement. The panel heard of the appointment of a doctor in training as a QI lead, and that that role was supported by consultant staff.

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: Trainers provided feedback to trainees after morning huddles, following which trainees were encouraged to complete workplace-based assessments, such as ACATs (Acute Care Assessment Tools) and CBDs (Case Based Discussions) to consolidate their learning. Trainers would come in early the morning following trainee nightshifts to provide feedback on patient cases trainees had seen overnight and were also available working in most of the wards until 8.00 or 9.00 pm where they would provide informal feedback to trainees. Trainers estimated trainees may receive feedback for every 1-3 patients they seen.

Foundation Trainees: Trainees said they received regular informal feedback from middle grade trainees (FY2/GPST/IMT) which was good. Feedback from consultants was felt to be variable depending on the department and consultant.

General Practice Trainees: Trainees felt they received minimal feedback but if they seek it out, they receive it. Feedback was particularly limited on nights and they described receiving no feedback their overnight cases**.** Trainees estimated they got feedback on around 10% of the patient cases they had seen.

Internal Medicine Trainees: Trainees felt they received minimal spontaneous or routine feedback from consultants and often had to seek out. Trainees advised that they didn't get feedback during consultant ward rounds as they were usually doing a round seeing the other half of the patients in the ward while the consultant did a round of the other half with the FY1. They reported minimal feedback on their overnight admissions seen during acute medical receiving.

Specialty Trainees: Trainees felt they did receive some feedback but not regularly, and not routinely. They felt they had to seek it out rather than it being given to them. They tend not to stay for the ward round after their night shifts.

2.11 Feedback from trainees (R1.5, 2.3)

The panel heard of multiple, effective routes for feedback to be gleaned from doctors in training including via the junior doctor forum, via the chief residents.

2.12 Culture & undermining (R3.3)

Trainers: Trainers felt they were making progress in regard to improving culture within IRH. More frequent twice daily meetings were taking place in some departments during the first wave of the Covid 19 pandemic and since the first wave had passed, they had kept these meetings to twice weekly. They described the handover structure as now being more robust with regular informal as well as formal meetings and discussions. Good practice or outstanding work was now recognised during M&M (morbidity& mortality) meetings through Greatix nominations. Work was also ongoing to resolve the previous concerns raised in regard to culture in the HDU, trainers felt steady progress had been made but that it would take time to resolve these issues.

Foundation Trainees: Trainees described the environment with IRH Medicine as friendly, nice, informal and supportive in the wards. They described their consultant colleagues as very supportive.

Trainees said the culture within HDU was improving but they still felt it could still be challenging because of behaviours. No specific incidents of undermining were reported. Trainees were aware of and participated in the junior doctor forum and were also aware of who their local Chief Residents and Specialty Training Committee representatives were.

General Practice Trainees: Trainees felt the environment within IRH was friendly. They found it to be a nice place to work but it could be challenging to balance the heavy workload. Trainees present did not report any undermining incidents and although not aware of the process to report them, felt they would be comfortable enough to ask. Trainees were aware of and participated in the junior doctor forum and were also aware of who their local Chief Residents and Specialty Training Committee representatives were.

Internal Medicine Training: Trainees had no concerns in regard to culture within the Medicine wards and felt the environment to be friendly, noting all consultant were very approachable. Trainees

described a negative culture in the High Dependency Unit (HDU) with potential to impact on referral of patients to HDU. Incidents had been witnessed in the past and reported to senior colleagues.

Specialty Trainees: Trainees described their consultant colleagues as generally very supportive. Exceptions to the generally positive culture were noted including the issue in HDU.

Other

The doctors in trainee the panel met with were very positive in their descriptions of the culture in IRH Medicine & Geriatric Medicine. Words such as 'friendly', 'supportive', 'community' featured frequently. The trainees reflected a culture of 'active interest in training and learning'. The panel noted also, and commend, the empowerment of doctors in training in roles such as 'chief residents', 'QI leads' and the 'M&M lead'.

- Concerns were expressed by some trainees in regard to alleged undermining behaviours the details of which will be shared with the Director of Medical Education out with this report. (see requirement 6.1)

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Trainers felt their current rota was compliant and they tried where possible to roster time in the rota to accommodate learning opportunities, particularly for FY trainees. Challenges were frequent in regard to staffing the rotas and sometimes the changing of rostered long days had to be made to cover short term vacancies, which were acknowledged to be not always popular. Trainers reported 2 vacancies at Foundation level in HDU and Geriatric Medicine.

Foundation Trainees: Trainees were aware of vacancies on their rota and of these not being filled. They also reported late issue of their rota, with one trainee describing an incident of a colleague arriving on a Monday for a shift at 9.00 am, receiving their rota in the morning to find out their shift was not due to start until 11.00 am. They felt approval of annual leave was granted without first checking the availability of cover, which had led to vacancies that required cover which the trainees had to organise themselves. Trainees reported their concerns to their middle grade colleagues, who had raised them with the Rota Co-ordinator. A heavy workload was reported by trainees, trainees advised they were encouraged to take breaks whilst on shift, but it could often be difficult to do so,

due to the number of jobs they were required to do. Trainees advised they were not involved in the design of their rota and some had not received their rota 6 weeks before starting their post.

General Practice Trainees: Trainees were not aware of any gaps on their rota – any were filled with locums. They were aware of vacancies on some of the other rotas, which affected the overall workload. Trainees felt their rota was heavy, with not enough rest days between their long day shifts, they felt their workload and their rota had the potential to affect their health and wellbeing. Trainees confirmed they took their concerns to the junior doctor forum and that they were being listened to and attempts were being made to address the issues.

Internal Medicine Trainees: Trainees advised their rota was a 13-person with 11-people on it. They described the on-call component of their rota as very frequent with few weeks without on-call shifts. Trainees said their rota did not provide them with protected time to attend clinics and had additional concerns in relation to being able to attend clinics due to their heavy workload. They also felt that workload was affecting their health and wellbeing as there was not enough time between long shifts to recover from them. Some trainees commented that they were exhausted. Trainees said they hadn't been involved in the design of their rota, they were aware that their Chief Resident was taking forward their concerns with the newly appointed Rota Manager.

Specialty Trainees: Trainees were aware of 3 vacancies on their rota, which were being covered by long term locums. They described their rota as a 12-person rota with 11 people on it. Trainees described nights as particularly demanding, and felt their workload was very heavy.

2.14 Handover (R1.14)

Trainers: Trainers described the "safe to go" process which had been embedded in the medical receiving unit, to support transfers requiring signing off by medical staff of management plan and ongoing needs to support safe transfer to the downstream wards. Weekend handover was recorded on Trakcare and daily handover during the week was well embedded with the most formal handover taking place in the morning at 9.00 am, which was the most appropriate for trainees to gain learning from.

All Trainee Cohorts: Trainees described handover as taking place 3 times per day, at 9.00 am, 5.00 pm and 9.00 pm. The 9.00 am handover was felt to be the most formal, structured and led by a consultant. Informal handovers took place at 5.00 pm (which was from peer to peer) and the 9.00 pm handover was to the HAN (Hospital at Night) team. Trainees were unaware of any written record of handovers and described handover as functional rather than structured but did support safety of care. Trainees felt that sometimes handover could be of educational value, but it was often dependent on the consultant leading on it and the time available to them that day.

2.15 Educational Resources (R1.19)

Trainers: Not covered.

All Trainee Cohorts: Trainees were aware that a rest room was available somewhere within the hospital but were unsure where it was, and none reported using it. They also advised they had use of doctor's mess but described little opportunity to make use of it.

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

Not covered, no concerns raised in pre-visit information.

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

Not covered, no concerns raised in pre-visit information.

2.18 Raising concerns (R1.1, 2.7)

Trainers: Trainers felt they encouraged trainees to raise concerns and how to report concerns was covered during trainee induction. Efforts were made to address trainees concerns that were fed back to trainers through the trainee forum and chief resident structure. Learning from Datix incidents was discussed at monthly M&M meetings, to which all trainee cohorts were invited.

All Trainee Cohorts: Trainees said they would approach their more senior middle grade trainees, with consultant colleagues, with Senior Nurses or the Clinical Service Manager if they wanted to raise

concerns. They would also use Datix. Trainees also highlighted the junior doctor forum as another avenue for raising concerns. Trainees felt pathways for raising concerns were well embedded. All trainee cohorts were aware of monthly M&M meetings occurring and were invited to them; however, it could sometimes be a challenge attending them due to workload. Trainees were generally confident concerns would be addressed.

2.19 Patient safety (R1.2)

Trainers: Trainers felt there were lots of embedded processes to ensure the safety of patients. Trainees were involved in the reporting of incidents, safety huddles, handover, the safe to move initiative and the monthly M&M meetings where they could present cases for discussion. Trainers were still addressing the issues in regard to boarded patients and described ongoing problems with their boarders' lists.

All Trainee Cohorts: Trainees did not have concerns generally about safety of care in medicine wards. The culture within the HDU was the focus of many concerns; this had potential implications for patient safety Although the HDU is under the oversight of critical care and the surgeons, it is perceived to be run by FY1s, but they reported access to supervision and support from senior physicians is improving. Some concerns were expressed the lack of an ICU on site and having to stabilise and transfer very sick patients to the Queen Elizabeth University Hospital.

Trainees reported concerns around boarding of patients, in particular because of the inconsistency of availability of the list of boarded patients, but also the unreliability of its content, as patients who have been boarded out were not reliably documented on this list. It was not unusual that notification to trainees that they had patients under their care and boarded out elsewhere came late in the day. Review of boarded patients by consultants was said to be intermittent.

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

Trainers: Trainers felt they had introduced improvements to involving trainees in learning from adverse incidents and imbedding awareness of Duty of Candour. Trainees were invited to and would attend and participate in monthly M&M meetings. Chief Residents were now involved in the medical division meetings to bring trainee concerns to them for discussion and a 'spotlight of the week' on

Duty of Candour had been led by Dr Gunn. Discussions had also taken place with the hospital governance group to improve feedback to trainees on Datix cases they were involved in.

All Trainee Cohorts: Most trainees highlighted Datix as the method for reporting adverse incidents, the trainees present had not been involved in Datix incidents and as such had not received feedback on them. The FY trainees seemed less familiar with Datix reporting than the other cohorts of trainee. Trainees confirmed that learning took place from Datix incidents at monthly M&M meetings and most trainees could attend these.

3. Summary

Is a revisit required?	Yes	No	Highly Likely	Highly unlikely

Overall this was a positive visit to Inverclyde Royal Hospital, and significantly more so than when we visited in November 2019. The Deanery Team was impressed at the local leadership and commitment to drive the transformation of the culture around education, training and safety. We commend, in particular, the personal contribution of Dr Abigail Gunn recognising also the engagement of colleagues whose support is integral to this transformation. The trainees' experience of education and training has improved, and this was evident in the relatively high overall satisfaction scores given by each cohort of trainee. Despite the overall trajectory of improvement, there remains some work to be done relating to the previous visit's requirements, and these will be reflected in the requirements from this visit and in the DME's action plan.

Overall Satisfaction scores from trainees:

FY trainees scored between 6 -8 out of 10, with an average score of 7.2 out of 10.
GPST trainees scored between 6 – 7 out of 10, with an average score of 6.6 out of 10.
IMT trainees scored between 5 – 7 out of 10, with an average score of 6 out of 10.
ST trainees scored between 6 – 6.5 out of 10, with an average score of 6 out of 10.

The positive aspects of the visit were:

- The local leadership and commitment to drive the transformation of the culture around education, training and safety. We commend the personal contribution of Dr Abigail Gunn but recognise also the engagement of colleagues to support this transformation.
- Culture of active interest in training and learning.
- Supportive, friendly and readily accessible consultants providing good clinical supervision that ensures trainees are generally not feeling exposed to working beyond competence.
- Empowerment of doctors in training through leadership roles and trainee representation including as 'chief residents', 'QI leads' leads and through the junior doctor forum.
- FY1 doctors in training report a very positive experiential learning experience – that includes opportunities for practical procedures.
- The embedding of and support for a quality improvement ethos.
- The support on the days of the visit of Michael McCrossan and Pamela McCamley who acted as enablers and facilitators.

The less positive aspects of the visit were:

- Relationships in HDU between nursing staff and doctors in training. We acknowledge work is in progress to achieve harmonious relationships, but this is a potential safety issue as the current atmosphere is reported to discourage trainees from referring patients for admission to the HDU (see requirement 6.1).
- Concerns were expressed by some trainees in regard to alleged undermining behaviours the details of which will be shared with the Director of Medical Education out with this report. (see requirement 6.1).
- New start, new-to-UK, International Medical Graduates going straight on to on-call rota on 1st shift without ascertaining competence and confidence and without support is a potential patient safety issue (see requirement 6.2 and 6.6).
- The 'safe to go' process is working consistently well; however, delays in these patients' management can be incurred as doctors in training in the destination wards are not always advised when these transfers arrive (see area of improvement 5.1)
- Lack of clinic access is an issue for IMTs, ST3+ & GPSTs (but has been is exacerbated by COVID-19) (see requirement 6.3).

- Lack of feedback to doctors in training on their management of acute cases, especially after night shifts (see requirement 6.4).
- While there is recognition of the issue of the lack of robustness in tracking of 'boarders' – we heard concerns both around the availability of, and the completeness of, the 'boarders' list' (see requirement 6.5)
- Induction – whilst at the August changeover inductions were provided consistently, we heard that arrangements for those arriving 'out of synch' were less robust (see requirement 6.6).
- Handover is good in AMRU but less good evening to overnight (see area of improvement 5.2).

Review of previous visit requirements from 2019:

	Visit requirements from 2019	**Progress in 2020 visit**
6.1	Those responsible for educational governance must investigate the allegations of undermining and concerning behaviours, and if upheld, put in place an appropriate action plan to address these concerns.	Instance noted in 2019 addressed, however, but an ongoing theme. See new requirement 6.1.
6.2	HDU consultant cover – There must be clarity regarding who is on-site to provide cover and is available to attend patients in the HDU.	Addressed
6.3	Medical Receiving Unit – Clarity should be provided to trainees around the consultant responsibility and review of patients in the medical receiving unit for patients who stay in the medical receiving unit for longer than 24 hours.	Addressed
6.4	Tasks that do not support educational and professional development and that compromise access to formal learning opportunities, including teaching, for all cohorts of doctors must be reduced.	Progress being made. See new requirement 6.7

6.5	Handover processes in general medicine must be improved to ensure there is a safe, robust handover of patient care with adequate documentation of patient issues, senior leadership and involvement of all trainee groups who would be managing each case.	Ongoing, see Areas for Improvement 5.2
6.6	Feedback to all levels of trainees on their management of acute receiving cases must be provided to inform their learning and training.	Ongoing, see new requirement 6.4
6.7	Trainees must have access to the appropriate procedural opportunities, including pleural procedures, to enable them to meet the requirements of the curriculum and to achieve satisfactory annual review of competence progression outcomes.	Addressed
6.8	The site must foster a culture of learning that includes doctors in training both in reporting critical incidents but also in the consequent learning that comes from an effective system.	Addressed
6.9	Cardiology transfer – Escalation pathway needs to be clarified to ensure trainees are supported in escalating patients.	Addressed
6.10	There must be robust arrangements in place to ensure the tracking of all boarded patients and to support regular review by a consultant.	Ongoing, see new requirement 6.5
6.11	There must be an educational governance process that links training delivery in Inverclyde Royal Hospital to the NHS Greater Glasgow and Clyde's Board. Trainees must be aware of this.	Addressed

6.12	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 may be useful in aiding this process but are not sufficient in isolation.	Progress being made, see new requirement 6.6
6.13	There must be active planning of attendance of doctors in training at teaching (including bleep-free attendance) events to ensure that workload does not prevent attendance.	Largely addressed

Areas of Good Practice

Ref	Item	Action
4.1	The local leadership and investment of commitment to drive the transformation of the culture around education, training and safety.	None required
4.2	Empowerment of doctors in training through leadership roles and trainee representation including as ‘chief residents’, ‘QI leads’ and ‘M&M leads.	None required
4.3	Culture of active interest in training and learning.	None required

5. Areas for Improvement

Areas for Improvement are not explicitly linked to GMC standards but are shared to encourage ongoing improvement and excellence within the training environment. The Deanery do not require any further information in regard to these items.

	Item	Action
5.1	Transfers of patient care	Trainees in destination wards, receiving patients who have been through the ‘safe to go’ process in medical receiving, should be notified of the arrivals of these patients in the destination ward to minimise delays in the ongoing management of these patients.
5.2	Handover	Handover is less robust at 5.00 pm and 9.00 pm, these handovers could be more robust if registrar led.

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	All staff must behave with respect towards each other and conduct themselves in a manner befitting Good Medical Practice guidelines.	20th August 2021	FY/GPST/IMT/ ST
6.2	Trainees' responsibilities for patient care must be appropriate for their stage of education and training. Supervisors must determine a learner's level of competence, confidence and experience and provide an induction that meets their needs and appropriately graded level of clinical supervision	20th August 2021	FY/GPST/IMT/ ST
6.3	Appropriate outpatient clinic training opportunities must be provided for Internal Medicine and General Practice Trainees. Clinic experience must be active participation (rather than merely observing) as is appropriate to the level of trainee.	20th August 2021	IMT/GPST
6.4	Feedback to all levels of trainees on their management of acute receiving cases must be provided to inform their learning and training.	20th August 2021	FY/GPST/IMT/ ST
6.5	There must be robust arrangements in place to ensure the tracking of all boarded patients and to support regular review by a consultant.	20th August 2021	FY/GPST/IMT/ ST
6.6	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 - including for those who miss the main changeovers.	20th August 2021	FY/GPST/IMT/ ST
Requirements from November 2019, that have not yet been fully addressed			

6.7	Tasks that do not support educational and professional development and that compromise access to formal learning opportunities, including teaching, for all cohorts of doctors must be reduced.	20th August 2021	FY/GPST/IMT/ ST