Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	5th May 2021	**Level(s)**	F1, IMT, GP and Specialty
Type of visit	Revisit	**Hospital**	Victoria Hospital
Specialty(s)	General Internal Medicine	**Board**	NHS Fife

Visit panel	
Dr Marie Mathers	Visit Chair – Associate Postgraduate Dean (Quality)
Dr Geraldine Brennan	Associate Postgraduate Dean (Quality) (Observing)
Dr Alistair Douglas	Training Programme Director
Dr Robert Laing	Foundation Programme Director
Dr Kate Hamlett	Trainee Associate
Mr Stuart Holmes	Lay Representative
Mrs Jennifer Duncan	Quality Improvement Manager
In attendance	
Mrs Gaynor Macfarlane	Quality Improvement Administrator

Specialty Group Information	
Specialty Group	Foundation
Lead Dean/Director	Professor Clare McKenzie
Quality Lead(s)	Dr Geraldine Brennan & Dr Marie Mathers
Quality Improvement Manager(s)	Mrs Jennifer Duncan
Unit/Site Information	
Trainers in attendance	F1 – 8, F2 – 1, IMT – 6, GP – 2, ST - 6
Trainees in attendance	12

Feedback session: Managers in attendance	Chief Executive	0	DME	1	ADME	2	Medical Director	1	Other	16

Date report approved by Lead Visitor	27/08/2021 Dr Marie Mathers 27/08/2021 Professor Clare McKenzie

1. Principal issues arising from pre-visit review:

Following a Deanery visit in March 2019 a number of concerns were raised regarding Foundation training across General Medicine at the Victoria Hospital. The department was revisited in November 2019 and it was evident the department were focused on making improvements. Whilst the visit team were impressed with the improvements made for the Foundation trainees there were concerns expressed about the sustainability of these changes and therefore the panel agreed a further revisit would be required. This decision was upheld at the Quality Review Panel which took place in August 2020.

Recommendations from previous visit:

- The site must continue to develop the boarding policy, tracking and manging boarded patients and ensuring appropriate clinical ownership and oversight of patient care.
- Weekend and evening handover processes must be improved to ensure there is a safe, documented, robust handover of patient care with senior leadership and involvement of all trainee groups.
- Educational supervisors must understand curriculum and portfolio requirements for their trainee group.
- Appropriate outpatient clinic training opportunities must be provided for General Practice, IMT and Specialty trainees.
- Speciality trainees must have regular opportunity for work of educational value suitable for their grade and not be routinely used for work more suitable for a junior trainee.
- All trainees must be able to access Study Leave with a system put in place to allow for cover when trainees are away and must not be dependent on trainees arranging their own service cover.
- Higher trainees must similarly receive feedback on their out of hours work.
- All references to “SHOs” and “SHO Rotas” must cease.

NTS Data 2019:

F1 – Red Flags – Curriculum Coverage, Induction, Workload.

F2 – Green Flag – Teamwork.

Core – Green Flags – Adequate Experience, Curriculum Coverage, Supportive Environment, Teamwork.

Core – Pink Flag – Handover.

GP – Red Flags – Study Leave, Workload.

STS Data 2020:

Foundation – Triple Red flag – Handover

Foundation – White Flags – Clinical Supervision, Educational Environment, Induction, Teaching, Team Culture, Workload.

CMT – Red Flags – Handover, Workload.

CMT – White Flags – Clinical Supervision, Educational Environment, Induction, Workload.

IMT – Red Flag – Handover.

IMT – White Flags - Clinical Supervision, Educational Environment, Induction, Teaching, Team Culture, Workload.

GP – All Grey Flags.

ST – Lime Flag – Clinical Supervision.

ST – White Flags – Educational Environment, Induction, Teaching, Team Culture, Workload.

ST – Red Flag – Handover.

At the pre-visit teleconference the visit panel agreed that the focus of the visit should be around the areas highlighted in the previous visit report recommendations.

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.

Department Presentation:

The visit commenced with Dr Rob Cargill, Associate Medical Director delivering an informative presentation to the panel which provided an update regarding the progress against the previous visit requirements and the impact of COVID-19 on working arrangements within the department.

2.1 Induction (R1.13):

Trainers: Trainers reported taking an active role in hospital and department inductions which all trainees are invited and encouraged to attend. Ward based inductions have been well received and future sessions will be adapted based on feedback received. Trainees also receive the acute medical handbook which covers all training grades and is regularly updated.

F1 Trainees: Trainees reported receiving both hospital and general internal medicine inductions which were of good quality. For those who missed induction a PowerPoint presentation was sent which was reasonable. There are no specific ward-based inductions which was considered vital to allow an understanding of the different wards' trainees are expected to cover and ease transition.

F2/GP/IMT Trainees: Trainees reported receiving a general induction to medicine however this did not cover where to go or admissions pathways. Trainees received an acute medicine handbook however it is 42 pages. Comments received were that a one-page document with key information for each ward would be more useful.

IMT/ST Trainees: Trainees reported receiving a comprehensive induction to general internal medicine and acute medicine however this did not include all medicine specialties. Trainees stated that the base ward rota between the on-call blocks rotates every 8 weeks however no inductions were provided for these base wards. Trainees suggested that ward inductions, details of clinic responsibilities and one page covering general responsibilities for each ward by grade would be very useful to include in future inductions.

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

Trainers: Trainers reported that trainees attend both hospital wide teaching and departmental teaching. During Covid teaching has moved to a virtual platform which has been well received. Great efforts are made to ensure teaching at all levels is protected.

F1/F2/GP/IMT/ST Trainees: Trainees reported no concerns in attending local or regional teaching and confirm the move to a virtual platform has worked well.

2.3 Study Leave (R3.12)

Trainers: Trainers reported the creation of a flexible rota including float doctors has allowed all training grades better opportunities for taking study leave. This however can be at the expense of ward continuity for middle grade trainees. The e-rostering system although not new is being utilised more by all training grades and consultants.

F1 Trainees: Not applicable.

F2/GP/IMT Trainees: Trainees reported no concerns in requesting or taking study leave. One issue was discussed where a trainee prior to commencing in post had study leave approved and cancelled at short notice due to no cover. This was resolved however communication was very poor and the situation caused a lot of stress.

IMT/ST Trainees: Trainees reported no concerns in requesting or taking study leave.

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

Trainers: Trainers reported being very well supported in their roles as trainers. They commented on an enthusiastic and positive culture which is seen at all levels. The education department are fantastic and proactive. They run a very successful clinical educator programme which involves regular continued professional development (CPD) workshops, these have been greatly missed due to Covid. The director of medical education Professor Morwenna Wood is easy to engage with, a fantastic support and is fiercely passionate and trainee driven.

F1/F2/GP/IMT Trainees: Trainees confirmed having a designated educational supervisor who they have met and discussed and agreed learning objectives for the post. Trainees find supervisors approachable and supportive.

IMT/ST Trainees: 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 reported that different coloured name badge casings are used to differentiate between the training grades of doctors and that SHO is not a term they hear used. Trainers commented that trainees are always aware of who to contact on call with some of the medical specialty teams having a 24/7 rota. Consultants are on site until 10pm and there is also overlap between night and out of hours shifts. The tool referral finder can also be used to find contact details and routes trainees should take. Trainees are encouraged to contact the consultant team should they feel they are struggling or working beyond their competencies. If trainers are approached for support, they encourage reflection in training portfolios to ensure it is a learning experience.

F1 Trainees: Trainees confirmed knowing who to contact for supervision both during the day and out of hours. They are not expected to work beyond their level of competence. Comments were made that when escalating a concern, trainees are doing so to a very busy senior and it can be difficult to get the appropriate support.

F2/GP/IMT/ST Trainees: Trainees reported no concerns with clinical supervision provided. They are aware who to contact for support during the day and OOH and are not expected to work beyond their competence.

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

Trainers: Trainers reported that they now have a system where they only supervise one grade of trainee and have found this has made a great difference. Trainers commented that trainees are given sessions in the ambulatory clinic where they can gain a wide range of supervised learning events. Trainees also have the use of the simulation room and can book into the skills lab for pleural procedure training.

F1 Trainees: Trainees reported no particular concerns in achieving curriculum competence. It was noted that a large proportion of time is spent undertaking duties such as discharge letters, cannulas, bloods which they recognise as being part of the job however due to the volume are not able to develop their own skills. Support from phlebotomists is excellent however varied and can be for only one day per week, often notes are left to state there will be no service. Support from clinical fellows (CFs) and advanced nurse practitioners (ANPs) is also variable and dependant on whether they are around on the ward. Trainees commented that often their post is geared more towards service provision than training.

F2/GP/IMT Trainees: IMT trainees reported difficulties when in the high dependency unit (HDU) to get exposure to palliative care. They are allocated an afternoon per week but have no cover and due to workload, it can be very difficult to leave the unit. Suggestion was made to have a full day in palliative care embedded within the rota with adequate cover provided. IMT trainees commented that clinic attendance is variable depending on what ward you are allocated to. Due to Covid clinics have been reduced significantly and those still taking place are conducted virtually. All trainees commented that ambulatory clinics are a good way of increasing attendance percentages however they can lack the specialty specific element. All trainees agreed there were no concerns in the balance between work, training and education.

IMT/ST Trainees: Trainees reported difficulties in accessing pleural line and chest drains due to Covid. These concerns were addressed with the consultant team who helped arrange designated sessions in the skills lab. Trainees reported difficulties for grades ST3 and above attending clinics due to workload on wards, again this has been raised with supervisors. The chief registrar commented that clinics have always been a challenge and have been hugely affected by Covid. There has been a change to the rota to include one week of ECAS for all trainees. This provides trainees with 10 clinic opportunities however due to staffing issues and workload these can be difficult to attend. Trainees also stated that 50% of their time is spent carrying out duties such as discharge letters, cannulas, clerking and rewriting kardexes which are of little or no benefit to their education or development.

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

Trainers: Trainers stated they are not aware of any issues with trainees being able to achieve minimum portfolio assessment requirements. They commented that knee aspirations can be difficult

to achieve for senior trainee grades however this is a Scotland wide area of concern. Trainees also have access to simulated procedures and skills lab training.

F1/F2/IMT/ST Trainees: Trainees reported no concerns in completing minimum assessment requirements for workplace-based assessments.

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

Trainers: Not covered. No concerns raised in pre-visit information.

F1/F2/IMT/ST Trainees: Not covered. No concerns raised in pre-visit information.

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

Trainers: Not covered. No concerns raised in pre-visit information.

F1/F2/IMT/ST Trainees: Not covered. No concerns raised in pre-visit information.

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: Trainers reported that feedback at the front door is provided in real time. However, feedback overnight was highlighted as an area of improvement. It was suggested that instead of multiple consultants and designated supervisors being involved when an issue is raised that having one responsible person to take the issue forward with the trainee would be more beneficial. If a critical event were to take place peer support is available. Also, hot and cold debriefs have been introduced which are supportive and provide feedback.

F1 Trainees: Trainees reported difficulties in receiving feedback on nights and weekends due to covering multiple wards. During the day no feedback is provided and there is no review of decision making at consultant lead ward rounds. Trainees commented that feedback is only provided if they actively seek it or return to the ward and check patient notes for comments. Feedback can be provided over the phone by the registrar if you contact for support.

F2/GP/IMT Trainees: GP trainees reported a positive experience in receiving feedback on clinical decisions. The on-call rota is now staffed with 2 foundation trainees, 2 middle grade trainees and 2 senior trainees and the on-call consultant who provides regular feedback. IMT trainees stated they do not receive specific feedback on patient management as consultants do not see patients who have already been reviewed. Some trainees were unable to comment as they had only been in post a few weeks at the time of the visit.

IMT/ST Trainees: Trainees reported no formal process for receiving feedback on clinical decisions during the day and out of hours. Feedback is very much consultant dependant and trainees must be proactive and pursue this.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: In addition to comments in section 2.10 trainers commented that during the pandemic senior trainees organised themselves into groups and invited consultants to attend wellbeing meetings to discuss issues and difficulties they were having. This was a very useful and proactive thing for them to arrange and continued for 2-3 months. Additional recreational space was also provided in portacabins to assist in compliance with government guidance on social distancing.

F1 Trainees: Trainees reported being aware of but have never used the trainee forum used to provide feedback to trainers with regards to the quality of their training.

F2/GP/IMT Trainees: Trainee confirmed no issues in providing feedback to trainers. They described an online on-call group with consultant input that meets regularly. These are also a good opportunity to discuss quality improvement projects.

IMT/ST Trainees: Trainees reported that it is made very clear that any feedback on trainers, the management team or the quality of training should be e-mailed directly to the DME. Trainees commented that both the DME and consultants are approachable and receptive to feedback.

2.12 Culture & undermining (R3.3)

Trainers: Trainers reported that due to Covid teams were restructured and a big focus placed on team-based working which they are extremely committed to continuing with. It was felt that this had provided more structure and camaraderie. Rotas have undergone major redesign and are being monitored. The on-call rota is now staffed with 2 foundation trainees, 2 middle grade trainees and 2 senior trainees which is working well. Challenges are around ensuring continuity of ward placement which can be heavily affected by study leave and with no longer having fixed annual leave as part of the rota. However, this has been a positive for trainees providing a better work and life balance. These new rotas will continue to be monitored and adjusted when required.

F1 Trainees: Trainees confirmed they had not experienced or witnessed behaviour that has undermined confidence, performance or self-esteem.

F2/GP/IMT Trainees: Trainees reported no major concerns with bully and undermining. One trainee described a difficult situation with a consultant where communication lines broke down and another consultant had step in to help resolve the situation. Although this was a stressful experience excellent support was provided by the TPD.

IMT/ST Trainees: Trainees confirmed they had not experienced or witnessed behaviour that has undermined confidence, performance or self-esteem.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Trainers reported they are very aware of the need for trainees to attend clinics and consider the rota aims to support this. Due to Covid clinics are not functioning as normal however it is hoped this will improve in the very near future. Trainers are not aware of any aspects of the post that are compromising trainee's wellbeing. As previously described in section 2.11 trainee groups were meeting with consultant support and some of these groups plan to continue.

F1 Trainees: Trainees reported that there are aspects of the rota that can compromise well-being. They provided an example on one ward where there should be 2 F1s but due to annual leave or the trainee being moved for the past 4 weeks there has only been 1 F1. This increased workload can be

overwhelming. Trainees are often at very short notice and with no discussion relocated to another ward which can cause additional pressures. Trainees commented that some wards are very well staffed, and thoughts were that the rebalance of staffing across the medical floor could prevent this.

F2/GP/IMT Trainees: Trainees reported that the rota design generally accommodates specific learning opportunities. IMT trainees previously raised issues with regards to difficulties in leaving HDU to attend half days in palliative care. All trainees agreed that ward work at weekends can compromise trainee wellbeing. Over weekends trainees are not allocated specific wards they cover all wards which can be very busy and stressful. It was suggested that moving the long day shift to another day in the week would be more beneficial to trainee wellbeing. Trainees also stated that the rota requires 3 doctors but randomly there may only be 2 on shift. This is not viable or safe and can cause trainees to work beyond rostered hours. This was noted as becoming a frequent issue. Finally, comments were made around the lack of continuity due to frequent and sometimes at short notice changes to ward locations for individual shifts.

IMT/ST Trainees: Trainees reported that although there has been a lot of work put into the rota it remains a problem due to staffing. Due to the shortage in staff any movement in the rota can be of detriment to another trainee, and trainees perceive this to cause patient safety concerns. Most trainees have an even spread of covering Covid areas and if you are allocated to a respiratory post for example instead of a generic general medicine post then you are guaranteed to be placed for some time in that respiratory post. Trainees stated that there are aspects of the rota that compromise their wellbeing. They consider the move from fixed annual leave in the rota as positive.

2.14 Handover (R1.14)

Trainers: Trainers reported they are aware that there remain challenges with providing safe and effective handovers and work is underway to try and resolve this. A 2-week pilot of a new track system is due to take place in the very near future which the chief registrar has been heavily involved with. All trainee grades will be asked for feedback as part of the evaluation process. Handover and acute admissions handover will now be included as part of induction.

F1 Trainees: Trainees reported 4.30pm handover during the week and 8am handover from the HAN (Hospital at Night) team as working well. Evening and weekend handovers are a concern. At the

weekend there is a shared folder that contains a handover from the HAN team and all wards which when printed can be up to 9 pages. It is not easy to find, it has no set format, it does not contain enough information and is often not updated. Evening handover was also highlighted as inefficient and not a good use of time. Often it involves sitting in a room for 40 minutes hoping people will turn up or call. A mixed response was received from trainees regarding the learning opportunities available at handover. Some commented on a good experience while others stated learning at handover was opportunity based with no formal process and is very much dependant on how proactive individual trainees are.

F2/GP/IMT Trainees: Trainees reported that during the week there is no agreed structure to handover. This has been raised with consultants and trainees are aware of a new system that is due to be piloted soon. Trainees described the use of a word document to handover all wards at the weekend. However, it is not well maintained. Weekends are considered to be unsafe when patients are moving up to wards from acute admissions. All trainees agreed that handover is not used as a learning opportunity.

IMT/ST Trainees: Trainees reported that handover is a huge area of concern. There is no agreed structure and no written or electronic handover kept. They stated that informal on-call registrar to registrar face to face handover works well. They are also aware of a word document used at weekends by junior trainees however STs do not review it. Trainees consider handover arrangements for new admissions to be effective however for downstream medical wards concerns were raised with regards to safe continuity of care. Trainees do not consider handover in general as a good learning opportunity however if in assessment areas with consultants this can provide learning opportunities.

2.15 Educational Resources (R1.19)

Trainers: Not covered. No concerns raised in pre-visit information.

F1/F2/IMT/ST Trainees: Not covered. No concerns raised in pre-visit information.

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

Trainers: Not covered. No concerns raised in pre-visit information.

F1/F2/IMT/ST Trainees: 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)

Trainers: Not covered. No concerns raised in pre-visit information.

F1/F2/GP/IMT Trainees: Trainees commented they would raise any concerns with the quality of the training received with supervisors. They consider the consultant team to be accessible and approachable.

IMT/ST Trainees: Trainees reported receiving a lot of questionnaires in which they can raise concerns with regards to the quality of training in post. Trainees stated that they are however mindful of raising concerns as they are worried trainees would be removed from the department and the effect this could then have on other trainee groups.

2.18 Raising concerns (R1.1, 2.7)

Trainers: Trainers reported that the consultant team are approachable and try to be accessible to trainees. They encourage trainees to raise any concerns they may have regarding patient safety. Medical boarders were highlighted as a concern at the previous visit and evidence was shared with the visit team showing a significant reduction in medical boarders over the last year. Due to reconfigurations the front door has a heavier trainee presence and now takes over half of the acute surgical unit. This is to the expense of other areas however the department recognise this and have tried to recruit additional clinical fellows to help rebalance trainee ward allocations.

F1 Trainees: Trainees reported they had no patient safety concerns and if they did these would be raised with educational or clinical supervisors.

F2/GP/IMT Trainees: Trainees reported no major patient safety concerns. Any concerns would be raised with supervisors. An example was provided of a trainee working alone on a weekend where they were extremely busy with patients and discharge letters. As they had raised the same concern in the previous weekend, they were confident of the process and once raised within an hour help was received.

IMT/ST Trainees: Trainees reported that when on-call any patient safety concerns would be raised with the on-call consultant and during the day with the ward consultant. They are confident that concerns would be heard and addressed promptly.

2.19 Patient safety (R1.2)

Trainers: Trainers reported a safe environment for both trainees and patients. Trainers stated that after restructuring due to Covid the medical footprint has increased. The front door is a lot bigger and the department have also taken over acute admissions and additional ward space. There is therefore a heavy trainee presence at the front door which can be challenging when balancing ward continuity and training needs. The department have recruited clinical fellows to help with rebalancing this area and hope to maintain these however there are challenges with regards to sustainability.

F1 Trainees: Trainees reported no concerns with patient safety and would be comfortable for a friend or relative to be admitted to the department. The only concerns raised were around boarding and how far away one of the wards is.

F2/GP/IMT Trainees: Trainees reported they would not feel comfortable if a friend or relative were to be admitted to the department. This is due to staffing gaps filled by locum consultants with noted concerns against them. Also due to the size of the hospital it is very rare during the night that a patient would be seen by anyone above ST3 grade. Trainees raised concerns with regards to responsibilities for medical boarders some of whom can be placed in wards some distance from other medical wards.

IMT/ST Trainees: Trainees commented that they would not feel comfortable with a friend of family member being admitted to certain areas. They consider some wards to have many patients with very junior trainee cover and no adequate handover arrangements. Trainees commented that patients are often transferred from the admissions unit without medical staff being aware that a patient has arrived. There is no process in place in downstream wards to track patients it is by chance that they are found which is a particular risk over weekends.

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

Trainers: Trainers stated that the datix system is used to report adverse incidents and consider these good learning experiences. In the event of an incident the system triggers e-mails to managers in the directorate along with the clinical director. A request is made to the trainee to submit a statement regarding the incident for which the trainee is well supported. They are also encouraged to complete a piece of reflection and upload to their training portfolio. Each department hold their own morbidity and mortality meetings (M&M meetings) and the ambulatory medicine unit discuss incidents at the end of every day which are considered a good learning opportunity. Clinical supervisors are also e-mailed and requested to provide written feedback on trainees on a rolling basis at the end of each placement.

F1 Trainees: Trainees reported they are aware of the datix system for reporting adverse incidents however were unsure how the outcome would be feedback to them.

F2/GP/IMT Trainees: Trainees reported they are aware of the datix system for reporting adverse incidents. They commented on good mechanisms being in place for escalation. Those who have been involved in adverse incidents commented on a positive experience with good guidance and support.

IMT/ST Trainees: Trainees reported being aware of the datix system for reporting adverse incidents however most rarely use because of time pressures and lack of feedback and would only make an entry if it was very serious. One trainee commented on a very good experience in the event of a patient dying. They were very well supported and received feedback.

2.21 Other

Overall Satisfaction Scores:

No scores provided by trainees in attendance at visit.

3. Summary

Is a revisit required?	Yes	No	Highly Likely	Highly unlikely

The visit panel recognised the huge effort and focus put in by the department and DME team and commend progress on continuing to make improvements against the previous action plan during the pandemic. Progress was noted with some requirements from the previous visit action plan and these remain a focus of the group. The key areas of concern remain as before and relate to handover, staffing, induction, feedback, boarding, tracking of patients, educational value of tasks and clinic attendance. The panel were pleased to note a pilot date of August for the new handover system which we look forward to receiving feedback on. Efforts made during peak periods of Covid to ensure trainee wellbeing and safe social areas are commended. There remains a willingness, commitment and enthusiasm to improve training. The visit panel plan to revisit within the next year to ensure progress is achieved in a reasonable and realistic timescale.

Positive aspects of the visit:

- Approachable, enthusiastic and supportive supervisors.
- Good quality educational and clinical supervision.
- Positive team-based approach to workload. The restructure to ensure on-call is staffed with 2 Foundation trainees, 2 middle grade trainees and 2 senior trainees is working well.
- Introduction of trainee wellbeing sessions with consultant support.
- Involvement of chief registrar in discussions and pilot of new electronic handover system.
- Move to virtual platform for teaching has been well received.
- Highly motivated and supportive DME team.
- Comprehensive site induction.
- Changes to rotas to include clinic time however recognise these have been fewer due to Covid.
- Realignment of recognised trainers to supervise one specific group of trainees, to ensure better knowledge of training needs for that specific curriculum.
- Scheduled time for IMT/ST for ambulatory clinics.

Less positive aspects of the visit:

- The visit team recognise the work that has already put into improving handover and are aware that a new electronic system is about to be piloted. However, at present, trainees continue to express concerns with regards to evening and weekend handovers.
- Continued pressures around staffing on some wards and the impact this has on trainee's training and education.
- Most trainees did not receive specific ward induction and suggested a one-page quick reference resource to aid transition and cross cover of multiple specialty wards.
- Trainees reported an ongoing lack of feedback on decision making, particularly when on-call and overnight.
- Recognise the significant progress that has been made regarding boarding of medical patients; however junior staff report that boarding has re-emerged as an issue recently (although with a small number of patients to date) and has caused some concern around lines of responsibility for routine tasks when caring for patients located far from their base wards.
- Concerns were also expressed around the tracking of patients moving out of the Admissions Unit, particularly in the approach to weekends, with possible safety consequences. The visit lead will contact site leads to discuss a specific example.
- Recognise efforts made with the introduction of trainee wellbeing sessions and the use of portacabins to provide extra recreational space, however one trainee was unaware of this space.
- Concerns raised by ST trainees with regards to amount to time assisting junior trainees with ward tasks which is of detriment to their training and education.
- IMT/ST trainees commented on a lack of scheduled specialty specific clinics. Recognise this will have been heavily impacted by Covid.

DME Action Plan: Revisit 20th November 2019

(Carry forward to new action plan not met/partially met)

Ref	Issue	Owner	Update March 2020	Update December 2020	Requirement: Met, partially met, not met
8.1	The site must continue to develop the boarding policy, tracking and managing boarded patients and ensuring appropriate clinical ownership and oversight of patient care.	**AMD, COO, CD, GM**	The boarding SOP has been updated and now implemented. The tracking and monitoring of boarded patients remains the responsibility of the hospital capacity management team and clearly identifies consultant clinical ownership. The division recognises the impact of boarding on clinical quality and on trainee doctor workload and continues to work on reducing the number of patients boarding. Current actions to reduce avoidable admissions will form part of ongoing work	There have been many changes to the medical footprint as a result of the COVID-19 pandemic. • Specifically with respect to boarding patients, we have had no boarding patients from march to November 2020. From November 2020 we have had more of a bed capacity issue and surge capacity has opened in Wards 6 and intermittently in the Surgical Short Stay (SSS) unit. These areas are supervised by a locum junior doctor supervised by a consultant. The trainee doctors in medicine have therefore not had to	Carry forward. The visit panel note significant efforts to reduce boarders however over recent months these seem to be re-emerging.

			to transform urgent care delivery in partnership with other acute and community care providers. Process improvement within the acute hospital and collaboration with HSCP will also reduce unnecessary acute length of stay. Finally the number and location of beds allocated to specialty groups will be reviewed to seek best fit for current specialty demand within the VHK footprint	look after patients beyond the medicine beds apart from the odd boarder in surgical beds recently. • Medicine has increased its overall bed capacity by: 1. Ward 53 (ex-surgical ward) is now a medical ward for proven or suspected COVID-19 patients. This ward is fully staffed and lead by the Endocrinology team. 2. Ward 9 is an additional ward under the care of the Medicine of the Elderly team and forms part of a new development to facilitate rapid discharges. This ward is staffed by a locum junior doctor and trainees are not expected to cover there.	

				• There is now a need for RED and AMBER medical wards and a split red/amber admission ward. NHS Fife have funded 6 new senior clinical fellows to recognize the extra work from the increased bed capacity in ward 53 and the split admission ward. • Medical boarders to Ward 6, SSS or other areas are selected based on the updated boarding SOP. • Dedicated medical teams for these areas has improved patient safety and reduced workload for junior doctors.	
8.2	Weekend and evening handover processes must be improved to ensure there is a	**Dr J Woods and Dougie Main**	We agree that handover processes need further improvements: a. purchase of suitable IT system	a. Several IT systems have been reviewed to help facilitate the handover process and a final decision will be made shortly.	Carry forward. Recognise work to date and pilot of new system in August 2021.

	safe, robust handover of patient care, senior leadership and involvement of all trainee groups.		which will aid safer handover of patients with pertinent details of their care b. significant improvement still required for handover of patients from AU1 at weekends as the current list contains only names and no clinical information owner: c. ongoing senior leadership (Dr Pickles) with involvement of all tiers of trainee doctors (representatives)	b. There is active Quality improvement work ongoing with involvement of junior and senior trainees to help co-design more effective handover processes for both weekday evening and weekend handovers. c. There is ongoing senior leadership at consultant level (Dr Woods) and Trainee level (Chief Registrars)	
8.3	Educational supervisors must understand curriculum and portfolio requirements for their trainee group.	**Dr M Clark, DR K Baker**	Named educational and clinical supervisors are allocated to one type of trainee only except in exceptional circumstances. The ADME (Dr Clark) is developing a super-condensed	All our Educational and Clinical Supervisors are recognised officially through the NES RoT process and as such must have training on areas such as this. It is essential that they understand the training requirements for the grades of trainees they supervise and this is the	Met

			curriculum for Higher medical training and IMT (in conjunction with the local TPD, Dr Baker) to share with the supervisors. The GPST curriculum already has a super-condensed curriculum and Dr Clark will reduce the document to contain only the medicine and elderly medicine parts. These documents will be shared with named supervisors by april 2020.	basis for the increased monitoring of RoT. None of the supervisors are assigned trainees until they can provide evidence they have undertaken the appropriate training. A document prepared by ADME Dr Clark has been circulated to supervisors in NHS Fife and this document will be updated and circulated at regular intervals.	

8.4	Appropriate outpatient clinic training opportunities must be provided for General Practice, Core Medical and Specialty trainees.	**DME, E Hood, CRs, AW**	DME and Chief Registrars are working on a more timetabled version of the OP clinic experience required for trainees (GP, IMT and ST). Wards will have a weekly timetable on display, clearly stating that the trainee is to be off the ward for one afternoon per week to attend clinic. This timetable will be agreed upon by the wards to ensure a full uptake. A portion of each clinic's patient list will be allocated to the respective Registrar to ensure they attend; at first this will be patients taken from the Consultant list and in time the secretaries will book	The Chief Registrars in medicine 2019-20 did much work towards ensuring better clinic attendance. Unfortunately that work was just getting embedded when covid hit and we have had to pick that up again in August 2020. Additionally many clinics have changed in time/place/person. The audit attached shows clinic attendance and shows that ST3+ - managing to get to clinics from wards, but IMT's attendance is not as good as ST3+. We have therefore made a further change to ward cover and from December have provided as many IMT's as possible with a week block in ECAS (8-10 clinics). ECAS is the ambulatory urgent out patient medicine service. Additionally we are still encouraging people to get	Carry forward. Recognise constraints due to Covid.

			a separate clinic list for the Registrar.	away to clinic from wards. One of our ST4s has developed a timetable of clinic availability which trainees can attend in addition to linking a ward with a clinic as follows: **Cardiology** - clinics run twice weekly (trainee list) **Respiratory** – dermatology clinic **Moe-** has a Tuesday clinic, TIA & PD clinics **GI**- run a clinic on a Thursday (pm) **Renal-** Wednesday pm clinic Data from the recent audit on clinic attendance:	
8.5	Speciality trainees must have regular opportunity for work of educational value suitable for their grade and not be routinely used for work	**CD, DME**	We have already taken action on some wards to ensure STs are working at their grade and experience, with STs taking referrals in renal, cardiology and respiratory (the	We continue to encourage registrars to undertake work at a level suitable for their stage of training on all medical wards. We have attached a recently written document describing the role of IMT2+ on each ward. This document was created by trainees and	Carry forward.

	more suitable for a junior trainee.		latter for a trial period). We will ask wards to change practice and no longer divide up patients by area and allocate to individual doctors. We will stipulate that registrars will work as leaders on the ward of the junior medical team. This will be instituted by end of February 2020. Chief Registrars will feedback to Clinical leads, CD and DME as to its implementation.	sanctioned by the clinical leads.	
8.6	All trainees must be able to access Study Leave with a system put in place to allow for cover when trainees are away and must not be dependent on	**E Hood, AW**	All trainees access study leave. We are liaising with the Rota administrator so that e-rostering can be used to allocate cover (or not) when trainees are on agreed leave and we agree that this is not the responsibility	All training requests are submitted through the rotamasters, study leave will be granted provided there is sufficient cover within the ward.	Met

	trainees arranging their own service cover.		of the trainees themselves.		
8.7	Higher trainees must similarly receive feedback on their out of hours work	**CD, DME, EH**	The General Medical department plans to adopt a system used in our A&E department whereby trainees book times with consultants to do any WPBAs. We will extend this to include times on wed/Thursdays following the weekend on call where there is an automatic slot with one of the consultants they have worked with over the weekend in order to achieve some quality feedback on their OOH work.	During the Covid-19 peak, the medical education team organised feedback for all medicine trainees. We are currently re-introducing the system started early 2020 which was working well before covid peak. This received good feedback at the time from trainees.	Carry forward.
8.8	All references to “SHOs” and “SHO Rotas” must cease.	**DME, CD**	Fife are at the forefront of working to exclude the SHO terminology and	This matter has been dealt with as far as possible locally, the DME and team have exhausted	Met

			piloted and adopted the use of different colour badge holders to delineate different levels of trainees according to the colour code suggested by the Postgraduate Dean Claire McKenzie. The medical education team constantly and repetitively remind doctors of all levels that the SHO terminology is unacceptable to the GMC and it has been removed from all written forms from rotas, hospital phones and any other areas where it once was used. We also intend to distribute posters to all wards that indicate clearly that the term should no longer be used. At induction the DME	all avenues with regards to this topic and can do nothing further to change the trainees vernacular use of the term SHO.	

			mentions the use of SHO terminology and makes it clear it is not acceptable. The DME would appreciate any suggestions or input that NES can provide to assist with this problem as it is a joint priority for the Deanery and the Board.		
	Additional information: Workload and Natural Breaks		Currently there is a review of the out-of-hours working currently being undertaken by the IMPACT team. This was commissioned by the Medical Director after the Deanery Visit to General Medicine and covers all Directorates in the Acute Services Division. This will help management to assess out-of-hours workforce	The impact of CV19 and the restriction on areas suitable for breaks has made the issue of Natural Breaks even more sensitive, major initiatives were introduced to encourage break taking for all levels of trainees but these have been hampered by lack of alternative venues for trainees when the assigned areas are at capacity. This is an issue that is currently being reviewed and the Board is doing everything in their power to ensure that trainees have facilities in	

			requirements and plan for the future. The DME and Clinical Director for Emergency Care have both contributed to this work.	which to take their breaks, however, as you can probably understand at this time there are other major factors in play that make this very difficult. Portacabins are currently being considered for use by Gold Command.	

4. Areas of Good Practice

Ref	Item	Action
4.1	Introduction of trainee wellbeing sessions with consultant support.	n/a
4..2	Approachable, enthusiastic and supportive supervisors.	n/a
4.3	Highly motivated and supportive DME team.	n/a

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.

Ref	Item	Action
5.1	2.1 Induction	Trainees suggested that ward inductions, details of clinic responsibilities and one page covering general responsibilities for each ward by grade would be very useful to include in future inductions.

6. Requirements - Issues to be Addressed

* Items 6.1 – 6.5 carried forward from previous visit report action plan.

Ref	Issue	By when	Trainee cohorts in scope
6.1	The site must continue to develop the boarding policy, tracking and managing boarded patients and ensuring appropriate clinical ownership and oversight of patient care.	28/02/2022	ALL
6.2	Weekend and evening handover processes must be improved to ensure there is a safe, robust handover of patient care, senior leadership and involvement of all trainee groups.	28/02/2022	ALL
6.3	Appropriate outpatient clinic training opportunities must be provided for General Practice, IMT and Specialty trainees.	28/02/2022	IMT/ST
6.4	Speciality trainees must have regular opportunity for work of educational value suitable for their grade and not be routinely used for work more suitable for a junior trainee.	28/02/2022	ST
6.5	A process for providing feedback to all training grades on their input to the management of acute cases during the day and out of hours must be established. Higher trainees must similarly receive feedback on their out of hours work.	28/02/2022	ALL
6.6	There must be induction of doctors in training to all roles and responsibilities, including induction to roles in downstream wards and induction for OOH or weekend roles. The induction booklet or online equivalent should be sent to all grades of trainees before commencing in post.	28/02/2022	ALL
6.7	Tasks that do not support educational and professional development and that compromise access to formal	28/02/2022	ALL

	learning opportunities for all cohorts of doctors should be reduced.		
6.8	Ensure that service needs do not prevent trainees from attending clinics and other scheduled learning opportunities	28/02/2022	IMT/ST
6.9	Staffing levels in wards must be reviewed to ensure that workload is appropriate and does not prevent access to learning opportunities including outpatient clinics.	28/02/2022	ALL
6.10	Handover processes 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. Development of a written/electronic handover system to support the morning and evening handover meetings.	28/02/2022	ALL
6.11	Ensure trainees engage in use of the Datix system and highlight the importance of utilising this reporting mechanism. Provide feedback on Datix cases logged and ensure trainees are aware of this feedback to ensure the system is seen as responsive and a learning opportunity.	28/02/2022	ST