Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	30th June & 1st July 2021	**Level(s)**	FY1, FY2, IMT, GP & ST3+
Type of visit	Revisit	**Hospital**	Royal Alexandra Hospital
Specialty(s)	Medicine	**Board**	Greater Glasgow & Clyde

Visit panel	
Dr Reem Al Soufi	Associate Postgraduate Dean – Quality
Dr Fiona Cameron	Associate Postgraduate Dean – Quality
Dr Carol Blair	Training Programme Director - Gastroenterology
Mrs Hazel Stewart	Quality Improvement Manager
Mr Les Scott	Lay Representative
In attendance	
Miss Emma Stewart	Quality Improvement Administrator

Specialty Group Information		
Specialty Group	Medicine	
Lead Dean/Director	Professor Alastair McLellan	
Quality Lead(s)	Dr Reem Al Soufi, Dr Greg Jones, Dr Alan McKenzie	
Quality Improvement Manager(s)	Mr Alex McCulloch, Mrs Hazel Stewart	
Unit/Site Information		
Trainers in attendance	7 including clinical director	
Trainees in attendance	6 x FY1, 3 x FY2, 1 x GPST, 9 x ST (1 unable to stay to end of session)	

Feedback session: Managers in attendance	Chief Executive		DME	✓	ADME		Medical Director		Other	✓

Date report approved by Lead Visitor	25th August 2021

1. Principal issues arising from pre-visit review:

The Royal Alexandra Hospital was on the Deanery radar for several years due to recurring red flags raised following National Training Surveys. These concerns were raised again in the 2020 QRP and therefore a triggered visit was planned for June 2021. In preparation for the visit multiple sources of information were reviewed including the reports from two previous visits (2018 and 2020), pre-visit questionnaire and supporting documents provided by the department ahead of the visit.

The 2018 triggered visit to Medicine at the Royal Alexandra Hospital (RAH) was undertaken in November of that year due to several negative indicators in both the GMC National Training Survey (NTS) and Scottish Training Survey (STS). Following the visit a total of 8 requirements were made under the following headings: induction, handover, feedback, adequate experience, challenging behaviours and patient safety concerns in relation to a locum doctor.

Despite the post-visit action plan being followed up by the Deanery at regular intervals the 2019 quality review panel decided to re-visit The Royal Alexandra Hospital Medicine department as it appeared on the GMC triage list due to poor NTS outcomes. A triggered visit was completed in March 2020 and found that half of the requirements from 2018 had not been met. Additionally, there were 2 patient safety concerns that required immediate action:

1. Handover for downstream wards:
    - The 16:45 handover for downstream wards remained unstructured and attendance was variable.
    - The gap between HAN finishing at 8am and ward doctors starting at 9am posed a further risk to the breakdown in communication around patients in the downstream wards.
2. Procedural Support:
    - Providing central lines, arterial lines and inotropic support for medical patients requiring high dependency unit (HDU) admission during out-of-hours was challenging due to lack of support for ST/CMT2 who were not line-competent, reliable contingency plans were not in place.

In addition to these concerns, the main areas that required to be addressed were:

- workload’s impact on morale and health

- CMT2 trainees acting up without additional support or training
- lack of feedback to FY/CMT/GPSTs
- lack of trainee forum
- educational supervisor development meetings were not provided to all FY doctors
- access to study leave for GPSTs
- reports of undermining behaviour

On review of the information available to the Quality Review Panel (QRP) in September 2020, the majority of the issues raised at the two previous visits continued to present challenges to the department and so the Royal Alexandra Hospital Medicine Department was re-visited for a third time in June 2021, a summary of the visit findings has been compiled in this report 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.

A very helpful and informative presentation was provided by the clinical director prior to the panel meeting with the trainers. This provided an update on what changes and improvements had been made since the 2020 visit and areas where work was still in progress. Information from the presentation has been incorporated into the report below.

Please note that to protect the anonymity of the only GPST doctor who attended the visit the report included information from the GPST pre-visit questionnaire to provide multiple responses. Additionally, the GPST who attended the visit was working on the ST3+ Rota in a "Med Reg" capacity while the rest of the GPST trainees were working on the middle grade rota for FY2/GPSTs. Where appropriate the GPST's responses that were relevant to the ST3+ experience were included in the ST3+ section.

2.1 Induction (R1.13):

Trainers: Trainers reported that there was a generic hospital induction for all trainees. Based on previous feedback, physical tours were offered although uptake by trainees was minimal. An orientation video was recently recorded to show trainees round the key areas of the hospital with the

intention to share this video with trainees starting in August or December 2021. Trainers reported that an induction handbook had been sent to trainees which contained a substantial volume of information. The trainers stated that induction booklet would be issued to future trainees as soon as possible to allow them time to familiarise themselves with the information. Trainers reported that Foundation doctors were given an induction to all departments at the start of their training year and FY1 trainees had the opportunity to undertake shadowing in the hospital prior to commencing their post. Trainers reported that a departmental induction was provided to trainees and they allocated the first set of nights mostly to trainees who had worked previously in RAH. If a trainee was unable to attend induction, it was reported that a catch-up induction was provided.

FY1: Trainees reported that they had received a hospital induction via Microsoft Teams. They felt that their induction was not as extensive due to COVID-19 pandemic and that despite receiving induction for Medicine in general they did not receive a specific induction to the ward they worked in. FY1 trainees reported that they had no senior staff available in Acute Medicine to explain the roles and responsibilities of FY1 doctors when they had started. They found working the night shift particularly challenging and suggested that it would have been useful if Acute Medicine practicalities were covered during the induction, with specific information on their out of hours (OOH) roles and responsibilities. Trainees reported that this would have been particularly useful for foundation doctors starting in surgery, as all FY1s work in medicine at night and those starting in surgery will even be less familiar with the set up within the medicine department. Trainees felt that the handbook, which was created by one of their colleagues, was very useful and would benefit future trainees in the department.

FY2/GP: Trainees reported that they were emailed a handbook prior to starting in post. They reported that they did not receive a medical induction but were given an informal introduction to the ward they were based in. trainees reported that they were not given enough information regarding their roles and responsibilities including how on-call works when they covered areas other than their base-ward. Information from the GP PVQ reported that they had received a departmental induction and could offer no suggestions for improvements to this.

IMT: Trainees reported that they had received hospital induction which was delivered via lectures and presentations from each specialty on the first Friday after commencing in post. The induction included information on where to admit patients as there were different receiving areas, and how to undertake

referrals. During their hospital induction trainees were informed of their role when working during OOH. Trainees were issued a handbook prior to starting in post, which they found useful. However, some of the information were not adequately updated, for example there was no information about the Specialist Assessment and Treatment Area (SATA) unit. With the exception of geriatric medicine, trainees reported that they did not receive specific departmental inductions. Trainees suggested that it would have been more beneficial to have their induction on their first day in post (Wednesday). This was particularly pertinent for trainees starting on-call as they were not given adequate guidance or understood their roles upon starting On-calls on the change-over Wednesday.

ST3+: Most trainees received a comprehensive hospital induction in August, which included information about the rota. However, some trainees were unable to attend due to starting on night shifts. Trainees starting in February felt that their hospital induction was less comprehensive that their colleague's induction in August. Trainees received a handbook in advance of starting their post and felt that this was reasonably comprehensive. Trainees suggested that it would have been useful to know the difference between being first, second and third on-call prior to starting in post. They received a departmental team induction from their supervisors which they found very helpful for understanding their day-to-day duties. However, this induction did not cover on-call roles and responsibilities adequately, which trainees gained through experience and discussion with colleagues.

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

Trainers: Trainers reported the lecture theatre was blocked off to enable foundation trainees to attend their foundation teaching sessions. There had been some issues in providing training due to the pandemic, but this was reinstated virtually in December. Trainers reported that trainees did not carry bleeps, instead there is a board with various mobile contact numbers. Trainers believed that trainees were able to attend their teaching sessions and felt that trainees should take some responsibility by stating to colleagues that they had to leave the ward to attend teaching. During the presentation session, the panel heard how the department was engaging with trainees to encourage them to attend morbidity and mortality meetings by presenting more cases relevant to General Medicine than specialty specific cases. There were also shared links for trainees to join the Greater Glasgow and Clyde grand-round. It was also reported that more simulation training was provided to

trainees, such as central line insertion, which was felt to provide trainees with both the opportunity to participate in or teach during the simulation exercise.

FY1: Trainees reported that they had 1 to 2 hours of teaching per week. This had stopped for a period of time due to COVID-19 pandemic. However, trainees explained that the main barriers to attending teaching were heavy workload on the wards and room availability. Trainees also mentioned they encountered issues with the sound system in the room on several occasions. Trainees reported that all sessions were recorded and available online to watch when they were off duty, which was what they had to do 70 - 80% of the time. Trainees reported that there was weekly local teaching in the medical assessment unit that FY1s could rarely attend due to workload.

FY2/GP: Information from the PVQ reported that GP trainees had weekly or biweekly online teaching sessions as well as bedside teaching, with trainees being able to attend between 30 minutes to 1 hour per week on average. FY2 trainees reported there was a local teaching session via MS Teams every Friday that they could attend depending on their workload which was variable. They reported that Fridays were particularly busy as wards prepared for weekend ahead and workload for ward doctors made it difficult for them to attend the Friday teaching, particularly when staffing levels were low. Trainees indicated that they have only managed to attend approximately 10% of the local teaching sessions. Trainees who were based in Acute Medicine described good departmental teaching that was well attended.

In general, FY2 trainees could attend their Foundation Programme teaching, although there was one instance of a trainee being unable to attend their teaching as staffing levels meant that their study leave request could not be approved.

IMT: Trainees reported that they were able to attend their regional teaching sessions. Where their rota commitments prevented them from attending, such as being on-call, trainees were given study leave to catch up with the recorded session. Most trainees were aware of the local teaching provided on a Friday. However, many reported difficulties in attending these sessions as they were leading or attending the ward round at that time.

ST3+: There was a significant variation amongst trainees' experience; some trainees reported that the volume of clinical activity had prevented them from attending teaching live and that they would

watch the recorded session on a later date. Others found that they could attend teaching unless working on-call.

2.3 Study Leave (R3.12)

Trainers: Trainers reported that service pressures were the only barriers to approving study leave. However, only 3 of 119 study leave requests had been turned down according to trainers.

FY1: Not applicable.

FY2/GP: Foundation trainees reported there had been a lack of clarity if they were allowed to apply for study leave during the COVID-19 pandemic. Although trainees reported that they could get their leave approved by their programme director, there was a risk that the rota manager would decline it, with some departments enabling study leave approval more easily than others. GP trainees reported no issues with obtaining study leave if their rota allowed for it.

IMT: Trainees reported that, unless they were on-call, it was easy to get study leave approved.

ST3+: Trainees reported that it was easy to obtain study leave. However, due to the workload on the ward and shortage of staff, trainees were conscious not take their leave simultaneously as they felt it would be unsafe to leave the ward without adequate senior cover.

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

Trainers: Trainers reported that they were emailed the names of the trainees they had been allocated to supervise alongside their pictures. They felt trainees had to share the responsibility of contacting their educational supervisors (ES) to arrange training meetings. They reported that trainees were notified in advance of who their ES was and their contact details. On occasions some trainees had their ES reallocated due to unforeseen events. Trainers reported that completion of induction report on e-Portfolio was sometimes problematic as not all trainers had access to the trainee’s e-portfolio. Trainers stated they had time in their job plans for their educational role.

FY1: Trainees reported that they were notified who their educational supervisors were prior to starting their post and had agreed personal learning plans with them.

FY2/GP: Trainees and PVQ reported that trainees had met with their ES and had no difficulty accessing them.

IMT: Trainees reported that they all had met with their supervisors. They found them approachable and it was easy to arrange to meet them. Where supervisors were reallocated due to unforeseen events the transition was smooth and well-communicated to trainees.

ST3+: All trainees had met with their supervisor, although one of the trainees stated they had a delay of more than 1 month to have the initial meeting.

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 trainees were informed of whom to contact for advice during induction and at morning handovers. They also reported that during the 4.45pm handover contact details were usually emphasised particularly whom to contact for support in the high dependency unit. They advised that if the senior trainee on-call required support for specific procedural skills the on-call consultant could be contacted. Trainers reported that junior trainees managing very vulnerable patients received support from their colleagues on the senior tier rota. Trainers reported that they ensured a trainee was comfortable to act up before being assigned the role and that additional training was provided to them.

FY1: Trainees reported it was very clear whom to contact for support during out of hours. At times they felt they had to work beyond their competence levels. An example was given of an FY1 feeling that they were acting up by undertaking half of a ward round independently, with an FY2 undertaking the other half with no senior support due to staff shortages. Trainees felt that they were expected to act up on the middle grade rota when gaps appeared for ward cover. Whilst the support of another junior trainee was welcomed, trainees felt that filling middle grade gaps with FY1 doctors added to the pressures on the wards. Trainees reported that when covering a middle grade gap, they were expected to contact a consultant directly for support, which could be challenging for them when

consultants were busy in clinics or other non-ward duties. However, trainees emphasised that senior support was available when needed despite their perception of relative delays.

FY1 Trainees also reported that on occasions there was no reliable escalation plan for the Acute Medical Unit (AMU) during the day. Patients referred from the Emergency Department were admitted to AMU and the acuity of such patients could be high. Ideally 4 FY1 doctors would cover AMU during weekdays yet due to ward shortages 2 FY1s could be pulled away from AMU. Trainees described an incident where the trainee had to physically leave AMU to seek senior support from another ward. Trainees reported that when support was required, senior colleagues were accessible and very approachable once FY1 identified whom to contact.

FY2/GP: Trainees reported that they knew whom to contact for support most of the time. Trainees reported that there was no Registrar cover for geriatrics and so FY2/GPST trainees had to contact consultants directly for support. When a consultant was off duty there was less clarity on whom to contact for their patients.
Trainees reported that when ward staffing was poor, the FY2 could be the most senior person working in the ward. If a patient deteriorated and the consultant was not immediately available a call for support would be put out to all senior staff. For example when a FY2 trainee required assistance while acting up within the medical assessment unit (MAU) more senior support was available to them. Trainees felt they had received great support from very approachable senior colleagues when needed. The PVQ for GPST trainees reported that none had to work beyond their level of competence and that they had received very good support when needed.
The GPST attending the visit stated that he had worked in RAH in a locum post on the ST3+ rota before commencing his GPST post. When he received his GPST rota he found that -unlike the other GPSTs- he was placed on the ST3+. While he welcomed the richness of the experience this senior post had provided, he was disappointed to be paid a different band to his ST3+ colleagues while doing the same job. The panel understood that there was an ongoing debate between Human Resources and the GPST doctor to resolve his concerns.

IMT: Trainees reported that they knew whom to contact for support both during the day and out of hours. Some trainees did feel that they had worked beyond their competence. An example was given where a trainee and consultant disagreed on the management plan of a patient, which in turn made the trainee feel unsupported at the time. This was discussed at a later date and both trainer and

trainee had a better understanding of each other's viewpoints. This incident was highlighted as a one-off occurrence with all trainees reporting that the consultant team were very supportive, and they would have no hesitancy seeking senior support. Half of the trainees at the visit were competent to undertake tasks such as central line insertion. Where a trainee was not competent or confident, they advised that support was available from the intensive care unit (ICU). Trainees reported that support from ICU for central lines was very good while it was more variable from the emergency department (ED) depending on how busy the ED seniors were at the time.

ST3+: Trainees reported that they knew whom to contact for supervision both during the day and out of hours. None had felt left to cope with a situation beyond their competences and described their consultants as supportive and approachable. It was suggested that working within HDU during the day would be beneficial to get in-hours training and improve competence and confidence in undertaking procedures such as central line insertion.

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

Trainers: Royal Alexandra Hospital provided trainees with a rich experience and exposure to a broad spectrum of pathology. However, trainers felt that service pressures might have resulted in educational needs being partially met. Trainers stated that curriculum competences were delivered although meeting the outpatient clinic requirement, for IMT trainees in particular, was challenging. Covid-19 pandemic added extra pressures as consultants were also adapting to new ways of delivering clinics with all the required safety precautions and social distancing. Additionally, building works within RAH OPD had further limited the number of clinic rooms available. However, a clinic rota was developed by the chief resident with the aspiration to allocate trainees to clinics on regular basis. Trainers felt that at times there was a reluctance from trainees to leave the ward to attend clinics due to service pressures, despite trainers encouraging them to attend.

FY1: Trainees reported that they were concerned about meeting their required number of teaching hours due to workload, at times, preventing them from attending teaching. They felt the post easily enabled them to develop their skills in managing acutely unwell patients, however, the staffing shortages also left them feeling quite exposed at times. Trainees felt that up to 80% of their time could be spent on tasks of little or no educational benefit such as providing phlebotomy service. Trainees stated that they were often told the phlebotomists were short-staffed and can only attend to

approximately 10 patients, with trainees having to complete the rest of phlebotomies. Trainees found the presence of an advanced nurse practitioner (ANP) on the ward to significantly help reduced their basic tasks and therefore when an ANP was available they had more time to undertake work of greater benefit to their development as doctors.

FY2/GP: FY2 trainees reported that they were concerned about meeting their required number of teaching hours due to workload at times preventing them from attending teaching. Trainees were encouraged to attend clinics although this time had not been built into the rota yet. Trainees felt that about 50 – 60% of their time was spent undertaking non-educational tasks. They reported that there was ANP support available on the medical assessment unit (MAU) and within the geriatric ward but not on any other medical ward. They too reported that whilst they were supported by phlebotomists, it would be rare that they would complete the full list of patients requiring blood tests.

IMT: Trainees reported that they had received simulation training for procedural skills, such as central lines. However, they felt it would be beneficial to both their training and confidence if they could work within the HDU during the day to gain further supervised practical experience. Trainees reported that it had been challenging to get to clinics with attendance varying from about 2 to 5 clinics per month. Trainees reported that they could go for months without any clinic experience and when well-staffed they could attend a clinic every day for a week. They reported that an ST trainee had recently started a clinic rota to allocate clinics to IMT trainees, and they found this arrangement useful. However, when staffing levels were poor trainees were unable to attend their allocated clinic. Trainees reported that there was less opportunity to develop their skills and competences when working on the wards, in a similar capacity as FY2. However, when working out of hours they experienced a more senior role and could develop their skills further.

ST3+: The more junior trainees reported that it was difficult to get some of their procedural skills, mainly line insertions, signed off if they were working away from the main receiving areas due to paucity of direct supervision. It was also reported that due to the on-call workload within acute internal medicine they found accessing clinics difficult due to workload. Additionally, clinic space was limited with patients being added to lists for trainees to review, yet when turning up they had no room available to review patients. Trainees also reported that ward cover had been problematic at times and trainees felt unable to leave the wards to attend their clinics. However, the higher trainee in rheumatology had reported very good access to out-patient clinics and manageable workload.

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

Trainers: Trainers reported that due to the various admission routes into the hospital, it can be difficult for trainees to complete their ACATs. They reported that they had encouraged trainees to try and achieve this during receiving shifts and on wardrounds. There was a willingness amongst the trainers to complete the eportfolio assessments and to facilitate WPBA when required.

FY1: Not asked due to time constraints but none reported having any issues completing their assessments in the PVQ.

FY2/GP: A trainee described it was difficult to get signed off for competences such as abdominal and PV examination due to senior direct supervision being infrequent. FY2s in general were able to achieve WPBAs required for their portfolios and credited their trainers for being very helpful in completing assessments.

IMT: Trainees reported that it could be difficult to get feedback for their ACATs due to the various receiving areas and different consultants covering these areas. They reported no challenges in completing other forms of assessment and credited their consultants for being very cooperative and welling to complete assessments. All six IMT trainees had passed their PACES exam while in RAH and they all had ARCP outcome 1.

ST3+: Trainees reported that it could be difficult to get their ACATs due to multiple receiving areas covered by different consultants. At least one trainee had to attend hospital on their day off to get their ACATs completed. Trainees reported that when working as first-on in the receiving units, it could be very challenging to complete assessments as they worked independently with only one consultant floating between MAU, AMU and SATA. They also reported that they rarely undertook a joint ward-round with a consultant and therefore faced challenges in completed their assessments. Four out of the nine trainees reported that they had attended on their days off to get assessments completed. However, when working on the ward and HDU, trainees found it much easier to get their assessments completed as a consultant was easily accessible for combined ward rounds.

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

Trainers: Whilst there were no specific multiprofessional teaching sessions, trainers reported there were opportunities for multidisciplinary team learning. They had also run a minor injury nurse specialist course where the focus was on multiprofessional learning and inclusion.

FY1: Trainees reported there was no formal learning with other health professionals.

FY2/GP: Trainees reported that they had a good relationship with the multidisciplinary team and they were encouraged to attend MDT meetings.

IMT: Not asked

ST3+: Not asked

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

Trainers: Trainers reported they had a Quality Improvement Den which supported many ongoing quality improvement projects. They reported that this had been challenging during COVID-19 pandemic. The QI Den was advertised to all trainees and aimed to provide an open and inclusive environment.

FY1: Trainees reported that they felt QI opportunities were dependent on their supervisor. However, they felt the post was too busy to find the time to undertake a QI project.

FY2/GP: Most trainees reported that they were not offered suggestions for QI projects. However, other trainees were encouraged by their supervisor to undertake a QI project and others felt that the pandemic was a likely reason why they were not prompted to be involved in QI work. Trainees based in geriatric wards reported being released from ward duties to undertake QI work while ANPs covered them.

IMT: Not asked

ST3+: Trainees reported that it was easy to get involved in QI projects and that they were encouraged to do so. However, they had no allocated time within their rota to undertake QI work and would use their time off duty to accommodate QI projects.

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: They had a recent presentation session on delivering feedback and overcoming challenges such as, trainees not always recognising that they were given feedback, and how to deliver constructive. One of the trainers also met with trainees who had felt uncomfortable about the way feedback had been given during handover to find out how to improve the delivery of feedback.

FY1: Trainees reported that they had received constructive and meaningful feedback on clinical decision if they actively sought it out.

FY2/GP: Trainees reported that they had received constructive and meaningful feedback. It was felt that senior staff were particularly good at delivering feedback at the right time, with generally supportive and encouraging feedback following tougher shifts. Trainees reported that feedback was also provided during wardrounds with discussion of what went well and what could be improved.

IMT: Trainees reported that ward rounds provided the best opportunity to receive informal feedback. They also found it easy to speak to consultants and receive feedback on their clinical decisions when working overnight. At least one trainee reported they only received feedback when it was sought. Trainees felt that their feedback was constructive and there was no hierarchy, with trainers willing to listen to different opinions.

ST3+: Trainees reported that feedback is not always an automatic process, however, when managing a sick patient, they would be given constructive feedback from the consultants.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: Trainers reported that an anonymised survey was run in the past and that it had provided valuable information on the trainees' experience within RAH, there were plans to re-run the survey in the near future. There were also trainee engagement forums which involved both trainers and

trainees to discuss any concerns related to work and training. The clinical director reported that she was meeting regularly with the chief resident and frequently encouraged trainees to approach her directly as her door was always open to them, trainees were reported to have taken this opportunity to feedback to their CD.

FY1: Trainees reported they had a BMA representative that attended the trainee forum meetings, however that trainee had recently left and no-one had taken over this role yet. Trainees felt that the trainers were very approachable and listened to feedback.

FY2/GP: Trainees reported that they were aware of the trainee forum and the chief resident to feedback on their experience in post and highlight any issues. Trainees reported that they had started to see changes coming into place following discussions at the forum meetings. They felt that a lot of discussion had been about the middle graders' access to clinics and whilst they were happy to raise the issue in relation to accessing formal teaching, they felt it was best to have one issue raised and addressed at a time. Trainees described a situation that had arisen in relation to the MAU location which was swiftly addressed.

IMT: Trainees reported discussing issues they were facing with the clinical director and having follow up meetings. Trainees had a representative who attended the forum meetings. They felt that their suggestions for change or improvements were listened to although not always acted upon.

ST3+: Trainees reported that they had a representative who attended the trainee forum to provide feedback on their experience and any issues they were facing. Trainees felt that their ideas were listened to, although no action appeared to have been taken yet. However, trainees recognised that some of the issues being raised were complex and could not be resolved in a short timeframe, therefore would not expect complete resolution while they were in post.

2.12 Culture & undermining (R3.3)

Trainers: Trainers reported that changes had been made to the evening handover to improve communication and reduce unsupportive behaviour. It was felt that the changes to staffing and leadership were working well, and the department was keeping a close eye on the situation. It was reported that there had been an undermining issue within respiratory by a locum which had been

addressed. Trainers reported that it was made clear that negative behaviours would not be tolerated and that trainees could discuss any concerns with them. The clinical director reported that the department was placing a great importance on looking after and nurturing trainees. Trainers also welcomed a “civility saves lives” presentation which highlighted the benefits of a positive working environment.

FY1: Trainees reported that senior colleagues were very supportive. They did report a negative experience within the respiratory ward with a locum doctor. However, when concerns were raised trainees felt the trainers were very supportive and the issue was resolved.

FY2/GP: Trainees reported that they had a very supportive team. They had not experienced or witnessed any undermining behaviours. They felt that there was no hierarchical system at RAH which encouraged open conversations to take place and trainees felt safe to raise any concerns they might have.

IMT: Trainees reported that there had been some issues with staff within the emergency department. They felt comfortable to discuss the concerns with their colleagues to address them. Overall, trainees felt that their clinical team were very supportive.

ST3+: Trainees reported that their senior colleagues were extremely supportive. However, trainees had significant concerns about the perceived tone of communication with the management team. Trainees described incidents of being pressurised by bed manager to board patients against their clinical judgement in a manner they found undermining. They described being e-mailed by service managers at extremely short notice to alter their shifts to cover gaps without prior discussion, which they felt was lacking in consideration to their own wellbeing.

A trainee described an incident when the on-call service manager contacted them after night shift to criticise their actions and felt that the manager could have handled feedback more sensitively and chosen a better time than after a busy night shift.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: The clinical director reported that having trainees engaged in rota design and delivery was fantastic as it aimed to support their curriculum needs. During the pandemic the CD had regular weekly meetings with trainees to discuss what changes were needed to make improvements. It was felt that this engagement had helped trainees and improved morale although the emotional toll from the pandemic was taking effect. It was acknowledged that there were rota gaps and at times consultants had acted down overnight and at weekends to cover the gaps. It was also felt that at times, trainees might be unaware of the work being done to try and fill rota gaps which was further exasperated when a trainee was moved to cover a gap at Inverclyde Royal Hospital, resulting in a gap at the RAH. It was also reported that the department had engaged with trainees with a short-life working group to discuss rota issues. They had taken on feedback from FY1 trainees in relation to annual leave and made changes to accommodate this. It was also reported that trainees did not engage with rota monitoring which made it challenging for the department to fully evaluate the effect of the rota and workload on their trainees.

FY1: Trainees reported that there were gaps in the rota. They were aware of these gaps when starting in post but felt that these gaps had not been addressed as they would be contacted a week in advance to ask if any are available to cover the shifts.

FY2/GP: Trainees reported that there were gaps in their rota with a reliance on locums who were not always available. Trainees also reported that some of the wards were staffed by locums as there were not enough trainees to fill the posts. Trainees also felt there was a lack of recognition of gaps, where some trainees may be on study leave, annual leave or a rest day resulting in the overall number of trainees in a ward being reduced. They also reported that a ward doctor might be pulled to cover a gap within HDU which would result in further shortage in ward cover. All of these examples resulted in trainees feeling that there was a lack of understanding from management of the stress being put on trainees working in the wards.

IMT: Trainees reported that there were gaps in the rota which relied on long-term locums. However, trainees reported that the locums did not work out-of-hours shifts and therefore the trainees spent disproportionately more time covering out-of-hours gaps. An example was given where a trainee was moved to cover on-call which resulted in them not undertaking any ward work for a whole month.

Trainees reported that there were clinical development fellows who helped to fill the gaps but they were not allocated any night shifts.

ST3+: Trainees reported that there were gaps on their rota. They felt that there was a greater dependence on locums and clinical fellows in comparison to other hospitals they have worked within. Trainees reported various issues with being asked to fill gaps at short notice. They also felt that the rota gaps had impacted on their training as they were unable to attend out-patient clinic while providing support for juniors on the wards. Suggestions were put forward by trainees on possible improvements although progress was felt to be very slow.

2.14 Handover (R1.14)

Trainers: It was reported that the department had to adapt the handover during the pandemic. This was initially in a large group but following feedback from junior trainees it was adjusted and provided in a more structured approach. The clinical director advised that the 4.45pm handover remained a challenge to structure with ad hoc attendance, and that the department continued to recognise it as an area for improvement.

FY1: Trainees reported there were 3 handovers: morning, 4.45pm and 9pm. Trainees advised that at the weekend they could also put out a call for a weekend review and were provided with a list of wards to be covered. Trainees felt that the 4.45 handover worked but noted that if a trainee did not attend that handover, it was assumed that there was nothing to handover for their ward. They felt that verbal communication from middle grade trainees provided safe continuity of care for patients in the downstream wards. However, trainees admitted that if a patient was to become unwell around handover time it could be challenging to obtain information in a timely manner as the 4:45 handover was not structured or documented. Trainees reported that handover could be used informally as a learning opportunity.

FY2/GP: Trainees reported that the morning handover worked well. They had no concerns about any of the handovers. They advised that when a consultant was present at handover they provided some learning opportunities.

IMT: Trainees reported that they only attended the 4.45pm handover if they had a patient to discuss. At least one of the trainees did not feel this handover worked well, with the potential of missing vital information. They confirmed that it would not be known if someone did not attend the 4.45 handover due to workload or if there was nothing to handover. However, they felt that the trainees supported one another and would page to confirm if anything needed to be handed over. Trainees reported that the other handovers work well (9 am and 9 pm).

ST3+: Trainees reported that the 4.45pm handover was less structured than the morning and evening handovers, but still worked well.

2.15 Educational Resources (R1.19)

Trainers: Trainers reported that providing sufficient IT facilities had been challenging due to the need for social distancing as well as room availability. The clinical director reported that the department had managed to source a room in the past few months where trainees could complete admin work.

FY1: Trainees reported that educational facilities were limited as is access to library, due to social distancing requirements.

FY2/GP: Not asked.

IMT: Trainees reported that simulations for procedural skills was useful, although it was felt that it would be beneficial to work within HDU during the day to undertake supervised line insertions to increase their confidence when working out of hours.

ST3+: Trainees described in other sections of the interview the limitations imposed by social distancing and lack of adequate IT facilities and clinic rooms.

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

Trainers: Trainers reported that where support was required for a trainee, this would initially be provided through the clinical and educational supervisor, who would meet with both the trainee and their team to determine how best to support the trainee. Any concerns about a trainee's physical or

mental health would be flagged to the TPD, if they were not already aware, to provide the most appropriate support to the trainee.

FY1: Trainees reported that there was support available to them if they were struggling with the job. An example was given of reasonable adjustments made where a trainee required to shield.

FY2/GP: Trainees had no awareness of what support was available to them if they were struggling personally or professionally. However, they reported that the senior team was very approachable, and they would be happy to discuss any concerns with them.

IMT: Trainees reported that if needed, they would contact their supervisor for support.

ST3+: Support is available to trainees with an example of adjustments made to accommodate a trainee's health issues.

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: Trainers reported that the local ADME met with the team regularly as part of the clinical governance meetings; both medical and sector wide. There were also lunchtimes meeting run by Dr McClure with proactive trainees' involvement.

FY1: Trainees reported that they had an FY1 on the trainee forum to raise issues related to the quality of training. However, communication had been poor since the representative stepped down and no other FY1 had taken up the role.

FY2/GP: See response in section 2.11

IMT: See response in section 2.11

ST3+: See response in section 2.11

2.18 Raising concerns (R1.1, 2.7)

Trainers: Trainers reported that they encouraged trainees to highlight any issue on the noticeboard at the weekly improvement huddles in acute medicine. Any action taken was reviewed to determine if there was an effective change in place. They also felt that they were proactive in talking to colleagues when a Datix incident report was submitted which encouraged discussion at all levels, including trainees. The trainee forum provided trainees with the opportunity to raise concerns about their education and training.

Trainees: See section 2.19

2.19 Patient safety (R1.2)

Trainers: Trainers reported that there were 3 site safety huddles a day, which monitored the safety of patients and could highlight any concerns. They recognised that boarding patients was an undesirable option. They tried to select the most appropriate patients to board in-hours to lessen the additional stress and workload this could have on trainees. Trainers reported that information about boarded patients was updated on a spreadsheet and shared via MS Teams, however, trainers were unclear if all trainees had access to this information. Trainers acknowledged that the spreadsheet were not the most efficient system to use for tracking boarded patients and were looking at what had worked in other hospitals to make improvements to tracking system for boarders.

Trainees: Trainees at all levels reported significant concerns about the boarding of patients at RAH. The concerns related to:

- Lack of clear escalation policy
- FY2 doctors did not have access to the list of boarders on MS Teams
- Inaccurate or outdated list of boarded patients, this had resulted in incidents were patients were not reviewed for several days
- Feeling pressurised by bed managers to board out patients against trainees' clinical judgement
- Boarding of patients by management despite consultant notes stating a patient should not be boarded
- Lack of clear criteria for boarding, with trainees having to make clinical judgements

In addition to the concerns regarding the boarding of patients, FY2, IMT & ST trainees also had concerns regarding the SATA unit.

- Adequacy of medical staffing during out-of-hours:

Trainees described a thinly spread medical workforce with frequent gaps during out-of-hours to cover all 3 receiving units (SATA, AMU and MAU) and down-stream wards. However, SATA was perceived to be most challenging due to level of acuity compared to AMU and MAU.

Trainees reported that SATA was staffed completely during hours by locum doctors, while out of hours it fell under the responsibility of trainees with frequent gaps in their rota due to AL, SL, Zero days and short-term sickness. Some of these gaps were filled by acting up trainees who found it challenging to cover the volume and acuity of patients admitted in SATA.

- Adequacy of clinical space:

Trainees described limited access to rooms suitable for Aerosol Generating Procedures (AGPs) within SATA which they described as very challenging when multiple patients require Non-invasive Ventilation (NIV) or high flow nasal cannula (HFNC) application.

- Consultant review:

Lack of consultant review beyond the post-take ward round for patients who were awaiting transfer to a downstream ward from SATA, which could take several days.

- Boarded patient's notes:

There were also concerns regarding patients' notes being incorrectly filed resulting in delays with patients review and treatment. This was raised with the consultant team and steps were taken to prevent this reoccurring.

- Lack of communication to trainees about service re-design of receiving areas

Trainees were particularly concerned by the lack of communication and the timing of amalgamating AMU and SATA on a Friday. They reported chaotic transition with safety concerns that was reversed shortly to two separate units. The panel understood that there was ongoing work on simplifying front-door arrangements and the senior trainees felt they were not adequately informed of such plans.

All levels of trainees felt that their senior consultant team were extremely supportive and acknowledged the issues being faced. Trainees felt that the majority of their concerns regarding patient safety related to perceived pressures from the management team.

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

Trainers: Adverse incidents are reported through the datix system. Trainers reported they had regular, well-established morbidity and mortality (M&M) meetings where each specialty took responsibility for presenting cases and learning from incidents. These meetings were built into the Friday teaching sessions to enable trainee attendance and participation. Trainers also advised that there were regular improvement huddles to discuss shared learning with the use of route cause analysis tools. The output from these meetings were shared via email with trainees. Support through both the educational supervisor and informal discussion with the clinical director were also provided to trainees if they were involved in a situation where something went wrong with a patient's care.

FY1: Trainees reported that adverse incidents were recorded through the Datix system. Trainees usually received feedback soon after an incident via a team debrief, but this did not always happen. Trainees were aware of the M&M meetings at the teaching sessions. However, some trainees had never managed to attend these sessions due to their workload preventing them from leaving their ward duties.

FY2/GP: Trainees reported that adverse incidents were reported through the datix system. Debriefs were given to the team when working on the ward. Trainees were aware of the M&M meetings and felt that incidents were viewed as opportunities to learn.

IMT: There was a limited awareness from trainees about the M&M meetings. Trainees advised that adverse incident were reported through the datix system. One of the trainees that was involved in an incident reported that they were well supported by the team, highlighting that reviews of incidents were treated as learning events with a no-blame culture.

ST3+: No asked due to time constraints. Pre-visit questionnaire noted that incidents were reported through the Datix system with varied awareness of shared learning.

2.21 Other

Trainees were asked to rate their overall satisfaction with the experience they had during this post ranging from 1 (poorest) to 10 (best).

FY1: Range: 7-8, Average 7.5

FY2: Not asked and none completed the PVQ

GP: Range: 4-7, Average 5.67 (from PVQ)

IMT: Range: 6-8, Average 7

ST: Range 4-5, Average 4.7

3. Summary

Is a revisit required?	**Yes**	**No**	**Highly Likely**	**Highly unlikely**

Throughout the visit all levels of trainees could not emphasise more strongly the approachability and high level of support provided to them from the consultant team. The panel noted the significant efforts made by the department to make improvements, in particular, the provision of simulation training to support trainees in the procedural skills with line insertion. This is further highlighted as all trainees in the department who sat the PACES exam successfully passed it. Nevertheless, the panel has significant concerns in relation to patient safety, the boarding of patients and the slow progress made since the first visit in 2018. This is a department that is clearly working hard to try to provide a good training environment to trainees despite being significantly impeded by staffing shortages and COVID-19 pandemic.

The DME action plan based on the visit findings will be reviewed to assess progress against requirements at six months interval. Progress will be discussed with the Lead Dean Director for Medicine in NHS Education for Scotland to ensure adequate improvements are provided for trainees on the ground. If requirements are not adequately met within the time frame allocated the Royal Alexandra Hospital – Medicine Department will be considered for escalation to Enhanced Monitoring at the six-month review meeting.

Serious Concerns

Patient safety

1. Trainees described **SATA** as unsafe due to the following:
    a. Thinly spread medical workforce with frequent short-term gaps and variable skill mix during out-of-hours. This resulted in more junior trainees having to act up on occasions beyond their ability to cope with volume and/or acuity of patients in SATA.
    b. Lack of consultant review beyond the first post-take round until patient was transferred to a downstream ward, this might take 2-3 days.
    c. Lack of adequate space to accommodate Aerosol-generating procedures (AGP) such as Non-invasive Ventilation

The visit panel recognises this concern to be COVID-19 related as service had to adapt to major changes imposed by the pandemic and create a new clinical area (SATA). This had added extra pressures on an already stretched system.

2. Trainees described **Boarding** practices within RAH to be unsafe due to the following:
    a. Frequent inaccuracies in Boarders' list shared on MST channel and not all trainees having access to the list.
    b. Trainees reported frequent incidents when they felt pressurised by the bed manager to board patients against their clinical judgement, including boarding patients directly from ED to a surgical ward without senior review.
    c. Lack of agreed criteria for selecting patients for Boarding and feeling that trainees' and consultants' clinical judgement was ignored by bed manager during out-of-hours even when documented in notes.

Positive aspects of the visit

1. Supportive, regularly visible and very approachable consultants
2. The culture within the medical wards is highly supportive with multi-professional teams (medical, nursing and pharmacists) working collaboratively to deliver service and support trainees
3. All trainees had met their educational supervisors and described their interactions with them as constructive and educationally valuable

4. The provision of critical care support for trainees working in the High Dependency Unit fully resolved previous concerns around contingency plans for central line insertion during out of hours.
5. Acute Medicine teaching was well perceived by trainees working in AMU and well attended.
6. Handovers in the morning and at 9pm were structured and well attended.

Less positive aspects of the visit

1. **Induction:**
   a. FY1/FY2/GPST/ST3+ all described induction as inadequate for working out of hours. They lacked clarity around roles and responsibilities OOH and were confused by the complexity of receiving areas and the differences between 1st, 2nd and 3rd on-call roles.
   b. Hospital induction in August was structured. Trainees joining in February felt they had a limited version that was less adequate.
   c. Induction took place on a Friday, resulting in some trainees starting on a nightshift on the Wednesday without sufficient guidance.

2. **Access to formal teaching impacted by high workload during the pandemic:**
   a. Formal Deanery teaching: Trainees described high workload and lack of adequate cover to release them from their duties had resulted in poor attendance at formal teaching, both Deanery and departmental Friday teaching.

3. **Access to clinics for ST3+:**
   Recently, Trainees and Trainers have worked together on an excellent initiative to roster clinics for IMT and ST doctors. However, Trainees described significant limitations to attending clinics due to workload in wards and on-call commitments in AMU. Additionally, they described lack of physical space in Out-Patient Department (OPD). In contrast, Rheumatology trainee described excellent access to clinics and support to leaves ward commitments.

4. **Difficulty obtaining WBPA requiring direct supervision by consultants for ST3+:**
   ST3+ described difficulty in completing WPBA requiring direct consultant supervision such as ACAT and DOPs. IMTs described similar difficulties in obtaining ACATs.

5. **Workload and Rota gaps compromising trainees' ability to engage in training opportunities:**

   Workload in receiving units and down-stream wards was described as very intense, this was complicated by frequent requests to fill rota gaps at short notice and trainees acting up to fill more senior gaps, of particular concern is FY1 doctors acting up as FY2s.

6. **Handover at 16:45**

   Improving attendance and structuring Handover at 16:45 remains an outstanding requirement since 2018

7. **Perception of breakdown in communication between management and trainees**

   Trainees described incidents of being pressurised by bed manager to board patients against their clinical judgement, to remove telemetry boxes from patients in wards to facilitate new admissions from ED and being e-mailed by service managers at extremely short notice to alter their shifts to cover gaps without prior discussion. This has resulted in a perception that trainees were not adequately valued by management.

Listed below are the requirements from the 2020 visit. Requirements 7.1, 7.2, 7.11 and 7.12 were the unmet requirements from the 2018 visit.

Ref	Issue	Met?
7.1	4:45pm handover processes of downstream wards must be improved to ensure there is a safe, robust handover of patient care with adequate documentation of patient issues.	Not Met
7.2	Ward handovers in the morning must be formalized and happen consistently in all ward areas to ensure safe handover and continuity of care following nightshift.	Met
7.3	Clinical supervision - trainees must be provided with clearly identified seniors who are providing support for central lines, arterial lines and inotropic support for medical patients requiring high dependency unit (HDU) admission during out-of-hours.	Met
7.4	Educational supervision - initial meetings and development of learning agreements must occur within a month of starting in post.	Met

7.5	Barriers preventing trainees attending their dedicated teaching days must be addressed	Not Met
7.6	Staffing levels in wards must be reviewed to ensure that workload is appropriate and does not prevent access to learning opportunities including outpatient clinics.	Not met
7.7	Support for acting up should be provided and agreed with trainees who are selected for acting up.	Partially met
7.8	General practice trainees must be given allocated time to meet with their educational supervisors who are based in GP practices and given study leave to attend mandatory teaching.	Partially met (GP mandatory teaching not taken during RAH block)
7.9	A trainee forum should be established and supported so trainees can safely raise concerns and provide feedback.	Met
7.10	All staff must behave with respect towards each other and conduct themselves in a manner befitting Good Medical Practice guidelines. Specific example of undermining behaviour noted during the visit will be shared out with this report.	Not met
7.11	Work must be undertaken to ensure that trainees are supported to attend clinics and other scheduled learning opportunities without compromise because of service needs.	Not Met
7.12	Trainees must be able to attend the post receiving ward round in the acute medicine unit and when they do, the feedback they receive must be delivered in a constructive manner.	Not met (feedback for ST3+)

4. Areas of Good Practice

Ref	Item	Action
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	N/A	

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	Measures must be implemented to address the patient safety concerns described in this report in relation to SATA and Boarding patients (page 26)	Immediately	All levels
6.2	There must be robust arrangements in place to ensure the tracking of all boarded patients. In addition, for boarded patients, there needs to be clarity which Consultant and clinical care team are responsible, how often patients are reviewed and what the escalation policy is.	Immediately	All levels
6.3	There must be a policy in place, that trainees are aware of, regarding the selection of patients who are potentially suitable for boarding.	Immediately	All levels
6.4	Trainees must receive adequate induction to all clinical areas they cover particularly out-of-hours, to allow them to begin working safely and confidently.	1st April 2022	All levels
6.5	Doctors in training must not be expected to work beyond their competence.	1st April 2022	FY1
6.6	Alternatives to doctors in training must be explored and employed to address the chronic gaps in the junior rota that are impacting on training, particularly night shift gaps.	1st April 2022	All levels

6.7	4:45pm handover processes to downstream wards must be improved to ensure there is a safe, robust handover of patient care with adequate documentation of patient issues.	1st April 2022	All levels
6.8	Barriers preventing trainees attending their dedicated teaching days must be addressed	1st April 2022	All levels
6.9	Work must be undertaken to ensure that trainees are supported to attend clinics and other scheduled learning opportunities without compromise because of service needs.	1st April 2022	All levels
6.10	WPBA requiring direct supervision such as ACATs and DOPs must be facilitated during the working hours of trainees by their trainers.	1st April 2022	ST3+ and IMTs
6.11	All staff must behave with respect towards each other and conduct themselves in a manner befitting Good Medical Practice guidelines. Perception of breakdown in communication between ST3+ trainees and management, and allegations of undermining behaviour should be investigated by RAH and dealt with appropriately.	1st April 2022	All levels
6.12	Support for acting up should be provided and agreed with trainees who are selected for acting up.	1st April 2022	FY2, GPST
6.13	General practice trainees must be given allocated time to meet with their educational supervisors who are based in GP practices and given study leave to attend mandatory teaching.	1st April 2022	GPST
6.14	Trainees must be able to attend the post receiving ward round in the acute medicine unit and when they do, the feedback they receive must be delivered in a constructive manner.	1st April 2022	ST3+