Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	4th May 2022	**Level(s)**	FY1/FY2/GPST/IMT/ST
Type of visit	Re-visit	**Hospital**	Dumfries & Galloway Royal Infirmary
Specialty(s)	General Internal Medicine	**Board**	NHS Dumfries and Galloway

Visit panel	
Dr Alan McKenzie	Visit Chair – Associate Post Graduate Dean - Quality
Dr Fiona Ewing	Associate Postgraduate Dean – Quality
Dr Brian Scott	General Practice Representative
Les Scott	Lay Representative
Dr Jessica McGinn	Trainee Associate
Alex McCulloch	Quality Improvement Manager
In attendance	
Alison Ruddock	Quality Improvement Administrator

Specialty Group Information						
Specialty Group	Medicine					
Lead Dean/Director	Professor Alastair McLellan					
Quality Lead(s)	Dr Alan McKenzie Dr Greg Jones Dr Reem Al- Soufi					
Quality Improvement Manager(s)	Alex McCulloch					
Unit/Site Information						
Non-medical staff in attendance	0					
Trainers in attendance	12					
Trainees in attendance	FY1 - 8	FY2 – 3	GPST - 5	BBT – 1	IMT - 5	ST - 0

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

Date report approved by Lead Visitor	Dr Alan McKenzie 13th June 2022

1. Principal issues arising from pre-visit review:

The deanery last visited DGRI General Internal Medicine on 12th May 2021 and it has been on a re-visit cycle with the deanery since 2018. Requirements were put in place at the 2021 visit, some of which were highlighted in the 2018 visit:

- Doctors in training must be adequately supported to ensure that they are not working beyond their competence overnight.
- Handover of care of patients transferred from Emergency Department to the Clinical Assessment Unit must be introduced to support safe continuity of care to ensure unwell patients are identified and prioritised.
- 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 (carry forward from requirement 1, 2018 visit).
- All trainees must have timely access to IT passwords and system training through their induction programme. (carry forward from requirement 2, 2018 visit)
- Solutions must be found to address non-compliant Foundation trainee rota which may have non-intended consequences such as patient and trainee safety risks.
- Appropriate outpatient clinic training opportunities must be provided for IMT, BBT and GP Trainees. Clinic experience must be active participation (rather than merely observing) as is appropriate to the level of trainee (carry forward from requirement 4, 2018 visit).
- 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.
- There must be a policy in place, that trainees are aware of, regarding the selection of patients who are potentially suitable for boarding.
- The site must develop an effective system of safe selection, tracking and managing boarded patients and ensuring appropriate clinical ownership & oversight of patient care.
- All Consultants, who are trainers, must have time within their job plans for their roles to meet GMC Recognition of Trainers requirements.
- Morning handovers within Medicine must become more structured and more robust also with written or electronic documentation (carry forward from requirement 3, 2018 visit).

At the 2021 Medicine QRPs, MQMG felt that a re-visit to site should be conducted to review progress against the previous visit requirements.

The visit panel would like to thank Dr Peter Armstrong (Director of Medical Education) for the informative presentation delivered in the visit's management session, that gave an overview of progress since the last deanery visit in 2018.

2.1 Induction (R1.13):

Trainers: Trainers described induction as working well and felt they were explicit in what is expected of trainees both in the downstream wards and in the Acute Receiving department. Departmental induction consisted of a 2-hour presentation, question and answer session and departmental tours. For those trainees that missed the initial induction, trainers advised they provided them with 1 hour catch up sessions. Trainers described a detailed and robust online induction pack that was provided for trainees.

All Trainee Cohorts: Trainees felt they received adequate site induction which was supported by an online handbook. A trainee who missed the initial induction due to Covid related sick leave reported not receiving a catch-up induction. Departmental induction was described as more informal, and most trainees felt they had not received adequate departmental induction and described a lack of a formal induction to the wards. Trainees described difficulties obtaining usernames and passwords for IT systems but described the issue as being resolved quickly by the local IT team and Post Graduate office.

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

Trainers: Trainers advised the panel the FY1 teaching was protected and interruption free, with the post graduate office holding the trainee's pagers when they attended a session. For other cohorts of trainees teaching was less protected, although efforts were made to reduce the impact of interruptions for trainees. Trainers described sessions being delivered both virtually through MS Teams and in person in the lecture theatre, with most sessions taking place at lunchtime.

Foundation Trainees: Trainees estimated they got to around 1 hour of teaching on a weekly basis but estimated that around 50% of the pre organised sessions were cancelled with little notice given. Trainees reported that time was not provided in their rota to watch pre-recorded sessions. Consultant led teaching was described as sporadic, with most sessions being led by trainees themselves. Simulation sessions for F2s were described as good and F2s reported they were able to attend.

General Practice Trainees: Trainees felt access to teaching could be dependent on the ward they were based on, and they could struggle to get to it due to the workload on the ward. Day release for regional teaching was described as very difficult to get, especially for 3-hour sessions as it was difficult to arrange ward cover.

Internal Medicine Trainees: Trainees described grand rounds taking place on Monday's which are consultant led and peer led teaching sessions taking place on Wednesdays on a weekly basis. The peer led sessions could often be cancelled at the last minute. Trainees highlighted the PACES teaching they had received as excellent. Attendance at teaching was described as difficult due to ward workload and limited staffing to provide cover.

2.3 Study Leave (R3.12)

Not asked in FY session.

General Practice Trainees: Trainees had access to study leave and could request it for sessions that were 1 day or longer, they struggled however to get time off the wards to attend shorter ½ day sessions.

Internal Medicine Trainees: Trainees reported some difficulties getting access to study leave, a trainee had difficulty getting study leave signed off for an Advanced Life Support course (ALS) although this was acknowledged to be due to a lack of cover because of Covid pressures. Another trainee had applied twice so far and been declined on both occasions. Trainees advised the rota was created so far in advance it was often difficult to get study leave signed off.

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

Trainers: Trainers advised that they tried to match trainees' educational supervisors with the ward areas they were working in, and they were generally allocated to trainees around 1 month before they started their posts. Trainers had allocated time in their job plans for education but felt it could be difficult to fit it in because of the workload demands, but trainers highlighted the support of their Director of Medical Education in supporting them to provide education.

All Trainee Cohorts: Trainees confirmed they had all been allocated educational supervisors before starting their posts and were able to meet with them both formally and informally on a regular basis.

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 confirmed a coloured badge system was in place with different colours allocated to different grades of trainee, this was supported by posters describing trainees' level of experience and capabilities for their grade. Trainers advised that trainees were provided with information at induction with regard to escalation policies and a list of consultants contact numbers was posted on the wall in the Acute Medical Unit (AMU) and in the wards. Trainers felt that trainees may sometimes feel exposed whilst working in the out of hours period but due to sickness and rota gaps, providing support could sometimes be difficult.

Foundation Trainees: Trainees felt supported during the day, however highlighted concerns in regard to getting support whilst working out of hours and trainees reported an occasion where they had difficulty getting in touch with an on-call consultant and another of a consultant refusing to come into the hospital when called. FY2 trainees described being rostered first and second on and being required to deal with very sick patients. They described covering High Dependency Unit (HDU), the Combined Assessment Unit (CAU) and the cardiac arrest team overnight. Trainees felt this created an issue as FY2s were limited in their ability to make decisions and were unable to request CT scans and left them feeling exposed with minimal support with no immediate senior on-site person to escalate concerns to.

General Practice Trainees: Trainees did not raise any concerns in regard to clinical supervision and could access it both during the day and whilst working out of hours. Trainees reported they could contact the switchboard and be put through to the available consultant and their mobile numbers were posted on the wall in the wards.

Internal Medicine Trainees: Trainees felt they could get support when they required it during the day but confirmed it could be more difficult whilst working out of hours due to a lack of a resident consultant. Trainees described their consultant colleagues as approachable and supportive.

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

Trainers: Trainees were provided with a clinic list during their induction and the contact numbers of the people they would need to contact to arrange attendance at the clinics. Trainers felt it was important that trainees were self-directed in arranging their clinic access. Trainers confirmed high uptake of clinics in Geriatric Medicine.

All Trainee Cohorts: Clinic access appeared to be prioritised for IMT trainees due to their curriculum requirements and they felt they could attend clinics without issue. Most other trainees reported difficulties with attending clinics and learning opportunities due to workload pressures. Experience of some procedures was highlighted as difficult (such as chest drains) due to the small size of the hospital. Trainees reported lots of experience and opportunities to develop their skills in managing acutely unwell patients.

2.7 Adequate Experience (assessment) (R1.18, 5.9, 5.10, 5.11) – Not asked. No issues identified from the PVQ

2.8 Adequate Experience (multi-professional learning) (R1.17) – Not asked.

2.9 Adequate Experience (quality improvement) (R1.22) – Not asked.

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: Trainers advised that trainees get feedback post night shift during morning handover whilst working in Acute Medical Receiving and this was thought to be a good opportunity for them to discuss the cases they had been involved in overnight with a consultant. Trainers confirmed they worked closely with the trainees on a daily basis on the wards and that they provided informal feedback to the trainees on a regular basis. Trainers also described weekly ward feedback meetings where they would review things that had went well that week and also areas for improvement.

All Trainee Cohorts: Trainees felt they did receive feedback from consultants on a regular basis on the post nights morning ward round in Acute Medical Receiving, however informal feedback was ward dependent, and most trainees had to ask for feedback. Trainees also received formalised feedback through Workplace Based Assessments.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: Trainers advised they reviewed the results of the GMC national training survey and the Scottish Training Survey, from this they tried to focus on the negative outlier areas that require improvement. Trainers highlighted Ward D8's meetings, where trainers involved trainees in decision making in regard to cases, where they could receive feedback from trainees, and all could learn from it, other wards were in the process of trying to emulate these meetings. Trainers also confirmed the existence of a trainee forum and chief resident, both avenues for raising any concerns they had about their training.

All Trainee Cohorts: Trainees were aware of the trainee forum and of who their chief resident was and felt they could raise concerns about their training through them. Some trainees confirmed they had raised concerns before which they felt had been resolved adequately. Trainees were aware of the trainee surveys**.**

2.12 Culture & undermining (R3.3)

Trainers: Trainers advised they tried to lead by example by demonstrating positive behaviours and by being open and approachable to trainees. If any undermining or bullying behaviours were raised, trainers felt they acted on them quickly. Trainers felt they had a supportive education centre, which operated in a pastural role for trainees. Trainers told us about a group that was set up by one of them to support ethnic minority doctors in settling into their roles. Education sessions were run as part of this to help junior doctors recognise what could be considered undermining behaviours. Trainers highlighted that bullying & harassment and whistle blowing policies were highlighted to trainees at induction.

All Trainee Cohorts: Trainees felt their consultant colleagues were open and approachable. A couple of isolated incidents that were considered to be of an undermining nature were highlighted by trainees, but they felt they had been raised and appropriately resolved to their satisfaction. Trainees were aware of the process for reporting undermining concerns.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Trainers described weekly rota management as very intense. There were gaps in the current rota which were discussed at weekly rota management meetings. Trainers confirmed providing cover for some trainee level gaps themselves, trainers advised that some IMT3 trainees were removed from initial allocations this year by the deanery which left gaps in the rota. Trainers advised the rotas were reviewed on an annual basis.

Foundation Trainees: Trainees had significant concerns about their rota and both FY1 & FY2 trainees described their rotas as heavy. Some concerns were raised by FY2 trainee about 3-week periods of back-to-back on call long days in the rota while working in the CAU with little breaks in between, which they felt were very challenging. Trainees described receiving daily e-mails requesting cover for rota gaps, the gaps were considered to be mostly due to short term Covid related absences. Trainees advised workload affected their ability to get to learning opportunities and the short notice cancellation of teaching.

General Practice Trainees: Trainees highlighted the 3-week period of long days working on call in CAU as very tiring and felt it could sometimes affect their decision making.

Internal Medicine Trainees: Trainees were aware of previous gaps in their rota but confirmed the shifts were covered mostly by a large locum bank. Trainees were unaware of learning opportunities (including clinics) being planned into their rotas and could sometimes struggle to get too mandatory IMT teaching as a result of time off not being planned into the rota in advance. Trainees did not have any concerns in relation to the periods of 3 week long day shift patterns they worked on.

2.14 Handover (R1.14)

Trainers: Trainers felt a structured and robust handover was in place and had improved in the last few years. Trainers confirmed handover took place twice daily formally at 9.00 am and 9.00 pm, with a more informal handover taking place at 5.00 pm. Trainers confirmed the portal electronic system was used for weekend handover but not during the week. Trainers highlighted morning handover in CAU as a learning opportunity for trainees.

All Trainee Cohorts: Trainees were aware of the handover times and could attend handover and described as working well overall. FY1 trainees felt they sometimes struggled to find someone to handover to due to a gap between overlapping shift patterns between 8.00 am – 9.00 am. Trainees described using handover lists and were aware of the portal system in use at the weekend. There was noted to be consultant presence at the evening and weekend handovers, and the weekend handovers also made use of the portal system to record information. The trainees' views on whether handover was a learning opportunity or not, were variable.

2.15 Educational Resources (R1.19) – Not asked - good feedback was obtained on Educational Resources from the pre-visit questionnaire and via the National Training Survey.

2.16 Support (R2.16, 2.17, 3.2, 3.4, 3.5, 3.10, 3.11, 3.13, 3.16, 5.12) – Not asked.

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 described a quarterly Educational Committee meeting for which each department sent a representative and training issues were discussed at them and for trainees there was the trainee forum and Chief Resident.

All Trainee Cohorts: All Trainees appeared aware of the trainee forum and of their Chief Resident.

2.18 Raising concerns (R1.1, 2.7)

Trainers: Tra**i**ners described ward huddles as a way of raising informal concerns, formal patient safety concerns would be raised through the Datix system. Learning from adverse incidents was also discussed at regular Morbidity & Mortality (M&M) meetings, where learning outcomes were captured and distributed by e-mail.

All Trainee Cohorts: The trainees advised that they would raise informal concerns with their clinical supervisor, for more formalised concerns they would use the Datix system. Some of the trainee's present had submitted Datix reports but had variable experiences of receiving feedback on them, with some receiving it and others not receiving it. Trainees also raised their concerns over a situation where 2 FY2 colleagues worked the on-call rota on a night shift as the most senior doctors available in the hospital, with limited access to support. Trainees had escalated this concern to consultants but appreciated it was difficult to address because of staffing shortages.

2.19 Patient safety (R1.2)

Trainers: Trainers said a lack of specialty trainees put pressure on the more junior trainees, but they felt they worked hard to alleviate the pressure. Trainers felt there were significant numbers of trainees who were struggling in their role and who required additional support which also put extra pressure on the service. Trainers advised they had a boarding policy which was published on the board intranet site and was covered in the trainee's induction programme. Boarding was also discussed in handovers where patients who were unsuitable for boarding where identified.

Foundation Trainees: Trainees had some concerns in regard to patient safety, but these were related to the fragility of the out of hours rota and in particular the lack of seniority on the on-call rota which has left the FY2 trainees feeling exposed. Although they felt there was potential for patient safety incidents to occur, they hadn't encountered any as yet and did not report any specific patient safety incidents.

General Practice Trainees: Trainees had no concerns about patient safety, they felt any potential areas of concern were picked up at an early stage and trainees were aware of the local boarding policy.

Internal Medicine Trainees: Trainees did not have any specific concerns about patient safety, although Cardiology was highlighted as a department that had a high number of patients and staffing issues. Trainees were aware of the boarding system for patients and had no concerns about the management of boarded patients.

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

Trainers: Trainers reported that adverse incidents were reported through the Datix system. Any Datix's would be reviewed, and a trainee's clinical supervisor would be informed if there is any further debriefing that would be useful for their learning. Trainers described informal meetings where there was an opportunity here for consultants to share own mistakes with trainees and also what they would have done differently. Trainers advised that formal learning from adverse incidents were discussed at regular M&M meetings.

All Trainee Cohorts: All trainees felt if they were involved in an adverse incident then they would be adequately supported. Trainees were aware of M&M meetings and were able to attend them.

3. Summary

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

The visit panel found a mostly positive training experience was being provided for trainees in Dumfries and Galloway Royal Infirmary and this is reflected in the positive overall satisfaction scores the trainees provided after each session and which are shown below. The panel observed a committed and supportive cohort of consultant trainers but had some concerns around the fragility of staffing, particularly the exposure of FY2 trainees whilst working on the out of hours rota and trainees lack of access to teaching because of the heavy workload and lack of staffing. The panel acknowledge that the Covid 19 pandemic continues to have a significant impact on staff absences and workload. Discussion will now take place with the Lead Dean Director with regard to whether these concerns would require a re-visit to the site in the next training year.

Overall Satisfaction Scores:

Foundation Trainees: 6 – 9 out of 10 (with an average score of 7.7)
General Practice Trainees: 5 – 8 out of 10 (with an average score of 6.8)
Internal Medicine Trainees: 6 – 8 out of 10 (with an average score of 7.2)

The positive and less positive aspects of the visit are captured below as well as a review of the 2021 visit requirements which are categorised into **Addressed, Progress Noted and Little progress noted:**

Requirements from 2021 visit	Status
Doctors in training must be adequately supported to ensure that they are not working beyond their competence overnight.	Little progress noted – concern is related to FY2 exposure on the out of hours rota, however we appreciate that this is difficult to resolve due to staffing pressures.
Handover of care of patients transferred from Emergency Department to the Clinical Assessment Unit must be introduced to support safe continuity of care to ensure unwell patients are identified and prioritized.	Addressed.
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 (carry forward from requirement 1, 2018 visit).	Progress noted. Work to be done to improve departmental/ ward-based inductions.
All trainees must have timely access to IT passwords and system training through their induction programme. (carry forward from requirement 2, 2018 visit)	Progress noted. Still ongoing concerns raised by trainees, but we acknowledged the speed with which concerns were addressed when raised.
Solutions must be found to address non-compliant Foundation trainee rota which may have non-intended consequences such as patient and trainee safety risks.	Little progress noted. Monitored Acute block F1 rota non-compliant due to inadequate rest breaks (F1 General Medicine Compliant from monitoring provided)
Appropriate outpatient clinic training opportunities must be provided for IMT, BBT and GP Trainees. Clinic experience must be active participation (rather than merely observing) as is	Progress noted for IMT trainees. Still work to be done for GPST & BBT trainees.

appropriate to the level of trainee (carry forward from requirement 4, 2018 visit).	
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.	Addressed.
There must be a policy in place, that trainees are aware of, regarding the selection of patients who are potentially suitable for boarding.	Addressed.
The site must develop an effective system of safe selection, tracking and managing boarded patients and ensuring appropriate clinical ownership & oversight of patient care.	Addressed.
All Consultants, who are trainers, must have time within their job plans for their roles to meet GMC Recognition of Trainers requirements.	Addressed.
Morning handovers within Medicine must become more structured and more robust also with written or electronic documentation (carry forward from requirement 3, 2018 visit).	Progress noted. Still an issue with regard to FY1 morning handover between 2 shift patterns

Positive aspects of the visit:

- Engaged group of approachable and supportive consultants
- Facilities and education centre were highlighted as excellent by trainees (including Wi-Fi)
- Educational Supervisors allocated ahead of trainees arriving; trainees were all aware of who they were and could easily access them
- Handover – weekend handover works particularly well with consultant involvement & has a defined structure with an electronic record on portal.
- Simulation training and PACES training were valued by trainees and highlighted

- Educational and pastoral support by Anne Marie Coxon; trainees value her and her team's support
- Clinical feedback post take nights – very good educational experience, however informal ward feedback could be improved.
- Opportunities to feedback through trainee forum and Chief Residents – trainees aware of and can raise issues through the forum and their Chief Resident

Less positive aspects of the visit:

- Working beyond competence - FY2 exposure whilst working out of hours. We heard of 2 FY2s being the most senior trainees on call for Medicine overnight with no immediate on-site senior person to escalate concerns. In hours support was considered good.
- Departmental induction – Although emailed induction documents, most trainees talked about a lack of a physical ward induction; 1 trainee didn't get a catch-up induction after coming back from sick leave.
- Formal Teaching – difficulty getting away from wards. Teaching frequently cancelled at short notice – Foundation trainees estimated around 50% sessions were cancelled at the last minute.
- IMT teaching not built into rota, trainees sometimes struggle to get to attend.
- Workload/rotas – For F2 / GPSTs periods of 3 weeks of long days/ nights was commented on as heavy.
- IT password provision still a bit tricky, work in progress and still needs to be addressed.
- Handover at 9.00 am for FY1s – not as formal as other handover's and lacking senior presence.
- Informal ward feedback could be improved

4. Areas of Good Practice

Ref	Item	Action
4.1	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	All trainees must have timely access to IT passwords and system training through their induction programme. (carry forward from requirement 2, 2018 visit)	Acknowledge the progress made in regard to this former requirement. Further work required to address.
5.3	Informal ward feedback could be improved	Trainees felt it lacked in detail and could be improved.

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	Doctors in training must be adequately supported to ensure that they are not working beyond their competence overnight. (now specifically in relation to FY2 trainees working out of hours)	Immediately	FY2
6.2	Departmental/ward induction must be provided which ensures trainees are aware of all of their roles and responsibilities and feel able to provide safe patient care. Handbooks or online equivalent may be useful in aiding this process but are not sufficient in isolation.	6th January 2023	FY/GPST/IMT/ST
6.3	Solutions must be found to address non-compliant Foundation trainee rota which may have non-intended consequences such as patient and trainee safety risks. Specifically ensuring adequate rest breaks on the Acute Block rota.	6th January 2023	FY1

6.4	Appropriate outpatient clinic training opportunities must be provided for BBT and GP Trainees. Clinic experience must be active participation (rather than merely observing) as is appropriate to the level of trainee	6th January 2023	BBT & GPST
6.5	There must be active planning of attendance of doctors in training at teaching events to ensure that workload does not prevent attendance. This includes bleep-free teaching attendance.	6th January 2023	FY/GPST/IMT
6.6	Morning handovers within Medicine must become more structured and more robust also with written or electronic documentation (carry forward from requirement 3, 2018 visit).	6th January 2023	FY/GPST/IMT