Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	23 November 2022	**Level(s)**	Foundation, GP
Type of visit	Triggered	**Hospital**	Lorn and Islands General Hospital
Specialty(s)	General Medicine and General Surgery	**Board**	NHS Highland

Visit Panel	
Professor Alastair McLellan	Visit Chair – Postgraduate Dean
Dr Marie Mathers	Associate Postgraduate Dean – Quality
Dr Ruth Isherwood	Training Programme Director
Dr Emma Wilson	GP Training Programme Director
Dr Chetana Patil	Foundation Training Programme Director
Dr Katherine Quiohilag	Trainee Associate
Mr Eddie Kelly	Lay Representative
Ms Jill Murray	Senior Quality Improvement Manager
In Attendance	
Ms Claire Rolfe	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 and Dr Alan McKenzie
Quality Improvement Manager(s)	Ms Gillian Carter
Unit/Site Information	
Trainers in attendance	3
Trainees in attendance	Medicine – 4, Surgery - 3

Feedback session: Managers in attendance	Chief Executive	1	DME	1	ADME	-	Medical Director	1	Other	6
Date report approved by Lead Visitor			20/12/22							

1. Principal issues arising from pre-visit review:

Background information

Previous fact-finding meeting: 17th May 2022

The Deanery re-visited General Medicine at Lorn and Islands Hospital to evaluate the progress made by the department in addressing the requirements from the previous fact-finding meeting. Due to concerns raised in the GMC's National Training Survey the department of General Surgery was included in the visit. The previous requirements for the fact-finding meeting are detailed in the summary later in this report along with the visit panel's determination of the progress made. The visit team was also keen to identify any good practice within the department that could be shared widely across Scotland.

Department Presentation

The visit commenced with Dr Maggie Brooks delivering a detailed presentation to the panel which provided an update regarding progress against the previous fact-finding meeting requirements. The team have been supported by NHS Highland with funding for additional doctors to support the junior rota and a number of appointments have been made to Clinical Development Fellow posts. A specialty doctor has been appointed to Emergency Medicine on a locum basis and the team have embarked upon a strategy to employ a cohort of Rural Emergency Physicians (REPs), typically from backgrounds in primary care, to provide additional support to the 'front door'; 5 REPs have been recruited and are due to take up their posts in the coming months. There are still recruitment challenges to be faced but the situation is improving.

2.1 Induction (R1.13)

Trainers in Medicine and Surgery: Induction is run 3 times a year and is comprehensive. Topics covered include trainee logins, passwords, discharge letter training, the radiology service, talks from the infection control team and pharmacy. There is an introduction to the specialist nurses and the team in the Emergency Department. The Emergency Department team cover how the triage system runs, how the patients are assessed and clerked. Anyone unable to attend receives their induction on a more ad-hoc basis.

Trainees in Medicine and Surgery: Trainees attend a good full day induction that covers everything they need to know about working in the hospital and each of the departments. Induction included the opportunity to meet with staff. Shadowing had also worked well for FY1s.

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

Trainers in Medicine and Surgery: Trainees contact the associate specialist who manages the rota to request time to attend their teaching and it is accommodated. Taster weeks for FY2 trainees are also accommodated. There is a dedicated room in medicine and an office within surgery for trainees to use to access their training via teams. Within the site there is hospital wide teaching on a Wednesday which trainees can attend. There is also teaching on a Tuesday organised by the Clinical Development Fellow, the trainees suggest the topics and the appropriate person leads the session.

Trainees in Medicine and Surgery: Trainees can typically access ~2hours per week of formal local teaching. This includes a one hour clinical meeting on a Wednesday with varied content, that includes a monthly M&M meeting. A further hour of teaching for Foundation trainees, that is organised by a Clinical Development Fellow, runs on some Tuesdays (and would benefit from regular scheduling). The teaching is of good quality and although trainees have to take their bleep with them they are rarely called. The appointment of a locum Specialty Doctor in A&E in particular, but also the availability of a REP have enabled trainees to attend local learning opportunities. FY2s and GPSTs are able to attend their regional teaching sessions.

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

Trainers in Medicine and Surgery: Educational Supervision for medicine trainees is provided by a consultant radiologist with clinical supervision sitting with 3 other colleagues within medicine. Trainees in surgery are all supervised by one consultant surgeon. Whilst there is time in their job plan for the role it is challenging to find all the relevant information associated with supervision and they have received no training to undertake the role.

Trainees in Medicine and Surgery: All trainees have a named Educational Supervisor who they have met with. Some trainees reported limited interaction with their supervisor due to annual leave and the way their rotas have worked. Time is allocated to the GP trainees to attend their placement with their GP Educational Supervisor in practice.

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 in Medicine and Surgery: It was noted Foundation trainees have been removed the OOH rota and at no time are on-site without seniors also being on-site. Clinical Supervision is always available, the receiving rota which is issued on a daily basis has a note of the consultant to be contacted if support is needed. There is a handover every morning which trainees attend and know who is available that day. There have been no

reported issues of trainees being unable to access support when required. There is time in the job plans for supervision.

Trainees in Medicine: Trainees reported that there is always access to clinical supervision when needed; there is also willingness to come into the hospital, if called when off-site. There is also more pro-active presence of supervisors including in A&E around 5pm without the need to call them. The available clinical supervision supports the safe delivery of care for medical patients.

There is a lack of robust clinical supervision of doctors in training in medicine who are asked to see children or patients with obstetric and gynaecological issues or with mental health presentations; at times those providing the clinical supervision are unwilling to provide input and support. An OOH on-call GP who happened to be in the hospital at the time offered support on one occasion. The backstop is that trainees engage remotely with specialist teams in Glasgow hospitals for advice. The potential availability of REPs may offer a future solution to this problem.

The morning medical handover presents an opportunity to discuss all patients who were managed overnight to ensure plans are in place for all, including those who were not admitted.

Trainees in Surgery: Trainees all know who to contact including for medical queries on the surgical ward. None of the trainees work beyond their competence as someone is always available to help.

There is lack of robust supervision when trainees are asked to see patients with Trauma & Orthopaedic problems. The backstop is that trainees have to engage remotely with specialist teams in Glasgow hospitals for advice. The trainees had submitted a Datix about the challenges experienced around the management of a recent case that involved the Royal Alexandra Hospital in Paisley. Trainees suggested the need to update ‘how to refer guidance’ that is held on a shared drive.

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

Trainers in Medicine and Surgery: Trainees have been allocated time in their rota to attend clinics and theatre and they are free to choose what they wish to attend in their allocated time. For some trainees gaining exposure to practical procedures such as chest drains may be limited. Within surgery theatre lists always tend to have a trainee in theatre which is a better experience than they might get in a larger hospital.

Trainees in Medicine: Trainees were given time in their rota to attend clinic or theatre at the beginning of their post but this has not happened latterly. More senior trainees are able to choose the clinics relevant to their training; however even the more senior trainees are merely sitting in (like medical students) as observers rather than assessing patients and proposing management plans under the supervision of seniors. The post offers good exposure to opportunities to manage acutely unwell patients. Trainees stated they felt that they had developed their skills better in this placement because they have been able to carry out procedures that they would not have had the opportunity to do in a larger hospital, for example, to thrombolyse stroke patients. The GPST was also able to access their GP practice keeping in touch days.

Trainees in Surgery: Trainees reported a dearth of surgical cases, with a predominant caseload of elective day case surgical cases. Acute surgical presentations are infrequent (around once per 1-2 weeks) and there is limited exposure to 'the deteriorating patient'. However, for trainees interested in pursuing a surgical career there is potential benefit as there is potential to be in theatre every day; this would not have been experienced elsewhere. There is potential to attend pre-operative and ophthalmology clinics.

Trainees reported, however, that their potential training opportunities in A&E more than make up for the deficiencies in relation to access to surgical cases. It was noted that the training opportunities in the A&E unit have been enhanced by the appointment of those providing supervision including the Specialty Doctor.

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

Trainers in Medicine and Surgery: There are no issues with the completion of assessments in surgery. In medicine the situation has improved since the summer with a more stable staff cohort who are happy to complete assessments when requested.

Trainees in Medicine: Trainees are able to have their assessments completed easily. While it can be more challenging for those who need assessments signed off more senior members of the team this can be done, although may involve locum consultants.

Trainees in Surgery: Trainees have no issues having their assessments completed.

2.8 Feedback to trainees (R1.15, 3.13)

Trainers in Medicine and Surgery: Trainees receive feedback from colleagues in medicine based on their patient management plans. The more senior trainees covering the hospital at night receive feedback on their

management of patients during the morning handover. There is a briefing every day in surgery where trainees are given feedback regarding their patient care.

Trainees in Medicine: For trainees covering the hospital at night there is a handover discussion including all patients who were seen, whether admitted or not; this ensures that those discharged have ongoing plans where necessary. Trainees can seek feedback on patients whom they have admitted, but on the job feedback on their patient management plans is variable, often not happening.

Trainees in Surgery: Trainees do not receive any feedback in surgery as there is little decision-making required. Feedback on their decision-making is available in the Emergency Department; the locum Specialty Doctor discusses every patient trainees see and provides feedback on the clinical decisions they have made.

2.10 Feedback from trainees (R1.5, 2.3)

Trainers in Medicine and Surgery: Feedback is sought following teaching and the relationship between the senior team and the trainees is good and they do highlight issues when they arise. There is a trainee rep who attends the senior team meetings where there is an opportunity to provide trainee feedback or raise any issues that trainees are concerned about.

Trainees in Medicine: Trainees have not been asked to provide feedback and there is no forum for them to do so. A trainee does attend the senior team meeting but they were unaware, until recently, that they were the trainee rep.

Trainees in Surgery: Trainees advised that there is no formal way to give feedback as a group but they reported that relationships with the senior team are very positive, and the senior team are very approachable trainees feel empowered to raise concerns and feel safe doing so. They would have no concerns about providing feedback.

2.11 Culture & undermining (R3.3)

Trainers in Medicine and Surgery: Trainees are supported when a swap on their rota is required to facilitate attendance at teaching, previously they would have had to arrange this themselves. There are anti-bullying policies on the intranet and posters on the wall across the hospital. At induction trainees are all told to speak to their Educational Supervisor if they have any concerns. Generally a more supportive culture is being promoted across the hospital.

Trainees in Medicine and Surgery: No issues, everyone in the hospital is supportive.

2.12 Workload/ Rota (1.7, 1.12, 2.19)

Trainers in Medicine and Surgery: Foundation trainees have been removed from the night shift rota with GP trainees or a Clinical Development Fellow covering the hospital overnight alongside a hospital at night advanced nurse practitioner.

Trainees in Medicine: Trainees are allocated across 3 wards, Ward A is the surgical ward but has recently been used for medical boarders, Ward I is the longer stay rehab ward with a Covid unit there as well and Ward B is HDU and acute admissions. There is usually one person covering Ward A, one covering Ward I and 2 in Ward B but on occasion the trainee on Ward I has to cover Ward A as well. There is a lot of variation on the wards with some days 2 trainees on and other days 5 trainees. There is also one trainee who is based in Emergency Department. Foundation trainees do not cover the hospital out of hours. The GP trainee and Clinical Fellow cover the hospital at night and it can be challenging, there have been times when a consultant has come in to help. There is also a trainee in the Emergency Department until 10pm which helps.

Trainees in Surgery: During the day the rota has one FY1 and 2 FY2 trainees covering the ward and one FY2 assigned to the Emergency Department on a long day, there are currently 4 surgical patients on the ward. The trainees do not work out of hours.

2.13 Handover (R1.14)

Trainers in Medicine and Surgery: Handovers are safe for continuity of care as all patients are discussed at each handover. At the morning handover all patients who are to be discharged or have investigations pending are discussed and everyone on shift for the day attends the handovers. The handover is always face to face and there are handover sheets that are run though. The night handover at 9pm is between the advanced nurse practitioner and the dayshift medical and surgical junior trainees. Each handover is considered a learning opportunity as patients are discussed and trainees are given feedback on their management plans.

Trainees in Medicine: There is a very comprehensive morning handover that is attended by all medical consultants, all junior trainees and medical students. There is a thorough night handover at 9pm which the Emergency Medicine associate specialist attends to ensure the hospital at night team is aware of all patients that might need reviewed overnight. There is a 5pm evening handover but that is not always well attended and could be improved. However, all handovers ensure safety patient care.

Trainees in Surgery: The trainee on the hospital at night team attends handover at 8.45am to handover to the day team which includes the consultant for the day. The day team then handover to the wider multi-disciplinary team at 9am. There is also a FY2-to-FY2 handover at 5pm followed by a hospital at night handover at 9pm where the FY2 hands over to the nurse practitioner for the night. The trainees believe all handovers are safe for patient care.

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

Trainers in Medicine and Surgery: Trainees are encouraged to speak to their Educational Supervisor if they require support but there is also peer support available to them as they work closely with each other.

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

Trainers in Medicine and Surgery: There is a senior medical team representative who would identify any issues or concerns. There is the Director of Medical Education and their team and also a local FY2 co-ordinator who can provide help and advice.

2.16 Raising concerns (R1.1, 2.7)

Trainers in Medicine and Surgery: Trainees are happy to raise issues directly with the management team and their supervisors. There are monthly M&M meetings and trainees present at these meetings.

Trainees in Medicine: Trainees would raise a concern with members of the senior management team as all are approachable.

Trainees in Surgery: Trainees would raise issues with seniors or through the Datix system and hospital management if required. An example was given of raising a concern with the management team and that a satisfactory outcome was achieved.

2.17 Patient safety (R1.2)

Trainers in Medicine and Surgery: There were no concerns regarding patient safety raised, the trainers believe the environment is safe for patients.

Trainees in Medicine: Trainees reported that there is discontinuity of senior, consult-level decision-making because of the turnover of locum consultants; this can result in reversal of patients' management plans from

one locum to the next. This impacts negatively on training and has potential to impact negatively on care. Trainees have no concerns otherwise regarding safety of patient care in medicine.

Trainees in medicine perceive that trainees on surgical wards are relatively unsupported when looking after patients on the wards, as seniors can be tied up in theatre.

Trainees in Surgery: A trainee raised concerns regarding the decision-making of a locum doctor with a member of the senior team and appropriate action was taken. There have been no other patient safety concerns.

2.18 Adverse Incidents and Duty of Candour (R1.3)

Trainers in Medicine and Surgery: Any incidents would be discussed at M&M meetings followed by a review of the incident and any feedback or learning shared widely across the hospital teams.

Trainees in Medicine: Trainees attend M&M meetings where any incidents would be discussed.

Trainees in Surgery: None of the trainees present had attended an M&M meeting nor have they experienced an adverse incident.

Overall Satisfaction Scores
Trainees in Medicine – range 5.5 to 8.5 with an average of 6.8
Trainees in Surgery – range 6.5 to 8 with an average 7.6

3. Summary

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

Overall the panel felt the visit was positive with many creative solutions enacted to deal with the challenges faced by the hospital. There is still some work to be done by the team but the panel agreed that the site is on the right track with a good and committed group of trainers.

Positive aspects of the visit:

- Good experiential learning opportunities for FY trainees in theatre and clinics.
- We commend creative solutions to deal with staffing solutions, eg, Rural Emergency Practitioners. This will also help with the lack of supervision/support for Paediatrics, Obstetrics & Gynaecology, Mental Health and Trauma & Orthopaedic cases.
- The appointment of an Emergency Medicine Associate Specialist is a real asset to supporting training in the Emergency Department.
- The culture on site is very positive with senior colleagues accessible, approachable and supportive.
- The morning handover provides an opportunity to review the management plans for patients admitted and for those who have been discharged.
- The quality of local teaching is very good and trainees are all able to attend this teaching.
- The support for 'softer landing' of IMG doctors appointed to Lorn and Islands Hospital by providing them with an introduction to working in NHS Scotland while based initially for 6months in Raigmore Hospital.
- Incorporating the opportunity to attend clinics in the medicine trainee rota is very positive.

Less positive aspects of the visit:

- There remains a fragility of senior cover and a heavy dependence upon locum consultants. The discontinuity of patients' management plans (at times reversing these) with successive locums is a concern. However, should there be concerns about the appropriateness of decision-making all trainees feel empowered to escalate concerns to senior staff and feel supported when doing so.
- The scheduling of clinic attendance into the rota is undoubtedly a good thing as it does enable attendance, but further development of these opportunities is necessary to ensure trainees move from having an observer role to having a more active decision-making role appropriate to their level of training.
- The value of the post for training and exposure to surgery is limited because of the low volume and limited surgical caseload, but the appointment of the associate specialist in the ED has provided supervised learning opportunities around ED presentations that were valued by the trainees. If the supervised ED training opportunities continue it may be beneficial to re-label the surgical Foundation posts to reflect the available training opportunities.
- There has been an improvement in the feedback opportunities for trainees in medicine however this requires further development particularly with regard to feedback that informs the learning around trainees' decision-making.

- There remains a current lack of robust on-site support and willingness to provide supervision for trainees having to deal with Paediatrics, Obstetrics & Gynaecology, Mental Health and Trauma & Orthopaedic cases. There is a potential future solution when the appointed cohort of Rural Emergency Practitioners (REPs) takes up posts over the next several months.
- Whilst the local teaching has been transformed with a Clinical Development Fellow taking the lead developing this programme, senior support is required to ensure it continues to develop and becomes fully established.

Requirements from May 2022 Fact Finding Meeting

Ref	Issue	Progress Noted
5.1	**Clinical supervision** Onsite supervision arrangements for Foundation trainees out of hours must meet the standards set by the GMC in requirement 1.8 in Promoting Excellence.	Met
5.2	**Clinical supervision** There must be sufficient substantive senior staff /consultants in medicine to provide appropriate supervision of doctors in training by GMC-approved named clinical supervisors and to support training and **the safe care of patients**.	Partially met
5.3	**Clinical supervision** There must be robust, clear, and effective arrangements to access on-call, out of hours senior support when required.	Met
5.4	**Staffing for workload** There must be sufficient junior and middle grade staffing for the workload and **to ensure safe care** and to ensure that trainees have access to quality training by day.	Met
5.5	**Feedback** A process for providing feedback to Foundation trainees and GPSTs on their input to the management of cases including those who are acutely unwell must be established to inform their training and development.	Partially Met
5.6	**Formal teaching** Barriers preventing trainees attending their formal hospital and regional teaching sessions must be addressed. Some of this time must be protected.	Met
5.7	**Adequacy of experience** GPSTs and also FY2s must be able to attend clinics without compromise because of service needs.	Partially Met

5.8	**Formal assessments** WPBAs as required by trainees must be provided by seniors and consultant during the working week.	Met
5.9	**Handover** A structured handover system must be established to ensure safe handover of the care of patients, with documentation.	Met
5.10	**Learning from adverse events** Trainees must be able to access learning from adverse events – for example by attending Morbidity & Mortality meetings or equivalent processes of reflection.	Met

4. Areas of Good Practice

Ref	Item	Action

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	**Surgery** The educational opportunities of the 'surgical posts' really lie mainly in the supervised learning available in the A&E unit, because of the low volume and limited nature of the surgical caseload. Trainees should be clearer about what training opportunities are being provided.	
5.2	**Medicine & Surgery** Senior support is required to ensure the teaching programme being developed by the Clinical Development Fellow continues to develop and become fully established as a routinely scheduled event.	
5.3	**Medicine** The scheduling of clinic attendance into the rota has benefitted potential access to training opportunities in an outpatient setting. These opportunities should be realised and in particular for more senior trainees these should not merely to be present as an observer but offer opportunities to see patients and initiate management plans under supervision (within their competence).	

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	**Clinical supervision (Medicine)** There must be sufficient substantive consultant trainers to support the supervision and training of the doctors in training in General Medicine.	23 August 2023	
6.2	**Clinical supervision (Medicine & Surgery)** There must be robust local arrangements to ensure support and supervision for trainees having to deal with Paediatrics, Obstetrics & Gynaecology, Mental Health and Trauma & Orthopaedic cases.	23 August 2023	All Levels
6.3	**Feedback (Medicine)** A process for providing feedback to Foundation trainees and GPSTs on their input to the management of cases including those who are acutely unwell must be established to inform their training and development.	23 August 2023	FY & GP