Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	20th January 2023	**Level(s)**	FY, GPST, ACCS, IMT, ST
Type of visit	Immediate Triggered	**Hospital**	Forth Valley Royal Hospital
Specialty(s)	General Internal Medicine	**Board**	NHS Forth Valley

Visit panel	
Professor Alastair McLellan	Visit Chair - Postgraduate Dean
Dr Marie Mathers	Associate Postgraduate Dean – Quality
Dr Clive Goddard	Associate Postgraduate Dean – Medicine
Dr Ken Lee	Assistant Director for General Practice
Ms Catherine Fallon	Lay Representative
Ms Emma Barron	Trainee Representative
Ms Gillian Carter	Quality Improvement Manager
In attendance	
Ms Patriche McGuire	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 AlSoufi
Quality Improvement Manager(s)	Ms Gillian Carter
Unit/Site Information	
Non-medical staff in attendance	14
Trainers in attendance	18
Trainees in attendance	16 FY; 2 GPST; 1 ACCS; 6 IMT; 9 ST

Feedback session: Managers in attendance	Chief Executive		DME	√	ADME		Medical Director	√	Other: Director of Nursing	√
Date report approved by Lead Visitor	7th February 2023									

1. Principal issues arising from pre-visit review:

Following review and triangulation of available data at the 2021 Deanery Quality Review Panel (QRP), a visit to General Internal Medicine (GIM) including associated GIM specialties at Forth Valley Royal Hospital (FVRH), Larbert, was planned around the following concerns; red flags at All Trainee level for Geriatric Medicine in the National Trainee Survey for adequate experience, regional teaching and rota design; pink flags for curriculum coverage, educational supervision, local teaching, overall satisfaction and supportive environment. A visit was arranged for 17th June 2022, however this was cancelled due to insufficient panel members. An Action Plan Review Meeting took place in lieu of this.

The Deanery later became aware of additional concerns about FVRH as a training environment highlighted by:

- the 2 unannounced visits to assess safety and quality of care by Healthcare Improvement Scotland in 2022,
- the site's escalation to Stage 4 of the Scottish Government's National Performance Framework (for Governance, Leadership and Culture) and
- the resignations of 5 consultant respiratory physicians in Q4 of 2022 & Q1 of 2023.

Accordingly, an immediate triggered visit was arranged to GIM including associated medical specialties at FVRH.

A summary of the discussions has been compiled under the headings in section 2 below. This report is compiled with direct reference to the GMC's Promoting Excellence - Standards for Medical Education and Training. Each section heading below includes numeric reference to specific requirements listed within the standards.

The panel would like to thank Dr Kate Patrick, Director of Medical Education, and other service leads and members of management for meeting with the panel to discuss the current challenges in medicine at FVRH and to share their desired outcomes from the visit.

2.1 Induction (R1.13):

Trainers: Trainers reported that induction seems to equip trainees to start work. The hospital has an educational website which includes induction information and some departments have handbooks to which trainees contribute. Concerns were raised regarding the hospital's multiple IT systems - all of which are essential for patient care, each requiring its own password. There are also systemic issues across NHS Scotland whereby e-mail addresses are changed when trainees move between Health Boards and new e-mail accounts do not become active until the trainee's first day of work, creating a further barrier to accessing IT systems.

FY: All FYs received a hospital induction and noted that there was an online handbook. FYs felt GIM induction was useful, however most did not receive a departmental induction due to pressures on senior staff. FY1s felt they got good support from outgoing FY1s during the shadowing period. Trainees starting out of sync did not receive information in advance of starting and did not receive a GIM induction.

GPST: GPSTs were content with the induction they received which included being shown around the hospital and an introduction to IT systems.

IMT/ACCS: All IMT/ACCS trainees received a hospital induction, however departmental induction was felt to be variable. Trainees felt "front door" induction was good and noted that Acute Medicine had a useful handbook, however "back door" induction was minimal. Infectious Diseases and Respiratory Medicine gave a good induction. Gastroenterology did not offer induction, however they are now re-writing a handbook following feedback. Support from FY1s who had attended shadowing was useful to other new trainees. Trainees who missed induction were given the required information to enable them to start work.

ST: Trainees felt that induction to Gastroenterology did not adequately explain their expected job roles and these expectations often varied amongst consultants. Respiratory Medicine did not offer induction to STs.

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

Trainers: Trainers confirmed that there is weekly FY teaching which is bleep free except for the arrest page and trainees are encouraged to leave the ward for this.

FY: Most Foundation trainees were able to attend most of their regional teaching which is bleep free. Trainees found this teaching to be useful. FY1s are also encouraged to attend regional FY2 teaching where possible to meet their required hours of teaching attendance. FY2 teaching consists of full days of teaching for all FY2s in the West region. Some FYs were able to attend 1 hour of local teaching per week, but obstacles included workload and lack of phlebotomy service. Ward A12 was described as having good teaching. FYs noted that the quantity of local teaching had increased in recent weeks.

GPST: GPSTs were able to attend their regional teaching (around 2 days per 6 months) after applying for study leave. Local teaching was described as mostly peer-led and sporadic. GPSTs felt it was hard to attend local teaching due to workload and lack of staffing, but it was also noted that provision was reinstituted only in recent weeks.

IMT/ACCS: IMT/ACCS trainees reported that local teaching including Grand Rounds have only recently resumed with consultant input and were restored after concerns were shared with the chief resident having only been peer-to-peer for a while.

ST: STs also noted the newly created Grand Rounds as well trainee-led teaching in Geriatric Medicine and Gastroenterology. There is a weekly consultant-led multi-disciplinary team meeting in Rheumatology which is educational. STs noted the quantity of local teaching had increased in recent weeks.

2.3 Study Leave (R3.12) – Not covered

2.4 Formal Supervision (R1.21, 2.15, 2.20, 4.1, 4.2, 4.3, 4.4, 4.6) – Not covered

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: Supervision arrangements are explained to trainees at initial meetings with Educational Supervisors and can be seen on the rota template. The hospital is consultant-led and trainees are encouraged to seek support and not work outside their capabilities. Trainers noted that IMTs may have been expected to carry the “medical registrar page” due to staffing, but felt this was reasonable as a learning opportunity alongside senior support.

FY: FYs knew who to contact for supervision, but felt they sometimes needed to cope with problems beyond their competence in Respiratory Medicine due to lack of consultant presence. Support in the Acute Medical Unit was felt to be good.

GPSTs: Trainees were confident they could always access support. An incident was raised whereby a GPST was asked to perform a lumbar puncture which they had not been trained to perform. The trainee declined and the patient was sent home with an arrangement to re-attend for the procedure as no-one else was available to do this.

IMT/ACCS: In general, IMT/ACCS trainees felt consultants were accessible and provided excellent support when their input was required. Concerns were expressed about the lack of consultant physician oversight and responsibility for Emergency Department (ED) referrals seen by the medical receiving team but who are not seen by a consultant until they access a bed in the Acute Medical Unit (AMU)/Clinical Assessment Unit (CAU); this is a trainee and patient safety issue – see section 2.19 for further details.

IMT1s felt exposed to working beyond competence, and out with their comfort zones, when holding the medical registrar page; there can be a more senior on at “the back of the hospital” but they are fully engaged dealing with their extensive workload and are not well placed to provide support to the IMT1s.

Trainees also reported it was not always clear who to ask for support with boarders. There is a transition point between the consultant handover starting at 8am and the arrival of the consultant of the day at 9am, during which time consultant supervision is not fully understood. Accessing the consultant on for GI haemorrhage was noted to be a challenge on two occasions.

ST: Concerns were expressed again about the lack of consultant physician oversight and responsibility for ED referrals seen by the medical receiving team but who are not seen by a consultant until they access a bed in the AMU/CAU – see section 2.19 for further details.

They had difficulties knowing who to contact for support at the back door out of hours if a patient deteriorated.

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

Trainers: Trainers felt that clinic attendance was an issue for FY2s, GPSTs and IMTs. A clinic rota was trialled but did not work. It has been difficult to plan clinic attendance in advance as consultant rotas are being issued monthly due to staffing concerns. Currently trainees are provided with lists of when clinics are taking place and are encouraged to attend. Attending the Rapid Access Care Unit (RACU) is counted as a clinic and trainees are encouraged to attend when over-staffed at the front door. Trainees based in Acute Medicine can usually attend this once per week.

FY: FYs felt this post allowed them to develop their skills in managing acutely unwell patients and some reported opportunities to get feedback on their decisions. As expected, FY1s did not have access to clinics; 1 FY2 reported having attended a clinic once, for an hour. FYs felt some ward rounds provided learning opportunities, however generally only 1 FY attended the ward round while others were needed for jobs such as phlebotomy. Trainees felt an improved phlebotomy service would improve the educational benefit of their job as they often did not know about phlebotomy gaps in advance and spent a lot of time taking bloods. FYs also felt they would benefit from more advice from their supervisors about how to obtain their competencies including teaching hours. Trainees received little informal feedback on their management of acutely unwell patients and did not present patients at ward rounds.

GPST: GPSTs reported that initially they did not have access to clinics, however after raising with a supervisor access was improved, but only for some. GPSTs sometimes attended ward rounds with a consultant, but often alone on alternate days from consultant ward rounds. For this reason, opportunities to receive feedback from consultants were also limited for GPSTs, although the medical registrars did provide some feedback on their decisions.

IMT/ACCS: IMT/ACCS trainees were concerned about lack of clinic access as workload and clinic space have been obstacles to attending. A few trainees were on target regarding clinic numbers having reached 10 clinics in 6 months by including ambulatory care clinics, but mostly by sitting in and observing. Only 2 trainees reported seeing patients themselves (with a consultant in another room), having done this at just 1 clinic each. Trainees had been informed that a clinic rota had been trialled, but this was not successful due to lack of space and trainees not turning up.

Consultant-led ward rounds took place with FY1s only, generally without more senior trainees, adding to the difficulty IMT/ACCS trainees reported in getting feedback on their management of cases. Trainees estimated 70-80% of their work was not educational and felt this was due to inadequate staffing.

ST: Although there was good exposure to acute general medicine, learning opportunities aligned to this were very limited due to lack of feedback, with no feedback on their management plans being given to inform their learning and development. This was made more difficult by the complexities of how receiving works and by the additional issue that these trainees' input can be to patients referred from ED, but consultant review doesn't happen until these patients access a bed in the AMU/CAU some 24-48 hours later (further details in 2.19). Senior trainees perceived their role to be "fire-fighting" and working at a more junior role rather than having oversight of the overall management of the receiving workload, as they believe they should. Access to consultant ward rounds in downstream wards was very limited too, further limiting opportunities to get feedback on decision-making.

In general, clinic opportunities were limited.

STs generally reported good training experiences in Cardiology, Ageing and Health and Rheumatology.

In Respiratory Medicine there was absence of opportunities in relation to non-invasive ventilation (NIV) and high dependency unit (HDU) and there was insufficient access to clinics. Access to bronchoscopy was adequate.

In Gastroenterology there were difficulties accessing consultant ward rounds, outpatient clinics and, although there was access to upper GI endoscopy, access to colonoscopy was more limited.

Less-Than-Full-Time trainees felt they received a lower percentage of specialist training compared to General Internal Medicine training due to the structure of their rotas.

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

Trainers: Trainers did not experience any issues completing workplace-based assessments for trainees and tried to prompt trainees to send these to them. Tickets were often delayed or not sent due to trainees being busy.

All Trainees: Trainees felt consultants were willing to complete workplace-based assessments for them, but sometimes they needed to chase these up and some felt the feedback received was not constructive. Feedback from Acute Medicine consultants was commended.

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

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

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: Trainers stated that they give informal feedback on ward rounds, in wards and in the receiving unit. They also have an end of block meeting with each trainee to give feedback on the whole block. IMT trainees are given specific advice by trainers regarding completing Acute Care Assessment Tools (ACATs). Trainers recognised that there were challenges in trainees receiving feedback on cases they had managed in the ED as patients can be waiting for up to 2 days without consultant review. Sometimes these patients are reviewed by consultants at trainee request, however this is not the norm.

All Trainees: See section 2.6. There is near absence of feedback from consultants on GPST, IMT and ST trainees' medical management of patients in the context of acute medical receiving and in downstream wards.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: Not covered

All Trainees: Trainees were not aware of any regular schedule of meetings for them to provide feedback about the quality of their training or about the quality of patient care (although the Director of Medical Education (DME) has subsequently advised that trainees are included in a general invitation to an all staff “Clinical Engagement Meeting” that presents a potential opportunity to discuss pressures and concerns), however they noted that an ad hoc meeting had been organised by the DME recently in response to recent adverse press coverage. IMT trainees had also been supported by the chief residents with a recent meeting.

2.12 Culture & undermining (R3.3)

Trainers: Trainers reported that information about reporting bullying or undermining was provided at induction and trainees were encouraged to speak to a senior colleague for support. They were not aware of any instances of bullying or undermining.

FY: Foundation trainees reported concerns about Hospital at Night handovers, noting an unpleasant atmosphere that they perceive is obstructive and discourages them from handing over tasks. Trainees also reported 1 incident of undermining of a trainee.

GPST: Trainees had not experienced any bullying or undermining and would speak to their clinical supervisor if they did.

IMT/ACCS: Trainees felt their trainers were generally very supportive and very helpful; 2 incidents of bullying and undermining of trainees were mentioned, 1 of which had been escalated internally.

ST: ST trainees felt their consultants were approachable and reasonable, but did not always reach out to trainees to offer support. Acute Medicine and Respiratory Medicine were commended as supportive departments. Trainees felt the situation in the ED could be tense or worse and they had seen some IMTs being undermined when holding the medical registrar page.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: The staffing at all levels for the increased workload was noted to be of concern.

All Trainees: All trainees reported concerns about staffing for workload at all levels; this was exacerbated by the creation of “contingency beds”. Foundation trainees were concerned that “known gaps” were not necessarily covered. They also cited a fraught meeting that felt threatening around short notice cover for a rota gap; they had escalated their concerns about the conduct of this meeting. They perceived the rota coordinator role was under-resourced. There is currently no consultant involvement in the rota and trainees felt this was required to provide insight into the different trainee roles.

2.14 Handover (R1.14)

Trainers: Not covered.

All Trainees: Trainees reported that evening medical handover has no agreed team lead and often inadequate attendance. The lack of engagement in handover of those looking after patients in the boarders’ ward A11 was also raised as a potential risk.

2.15 Educational Resources (R1.19) – Not covered

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

2.17 Educational governance (R1.6, 1.19, 2.1, 2.2, 2.4, 2.6, 2.10, 2.11, 2.12, 3.1) – Not covered

2.18 Raising concerns (R1.1, 2.7)

Trainers: Not covered.

Trainees: Trainees stated they would raise concerns by completing an IR1/datix. Trainees noted they had raised the issue of contingency beds with the executive team, but did not feel their concerns had been responded to. Some had received some feedback following submission of concerns via datix.

Some trainees had also provided feedback to their consultants about concerns. The Acute Medicine safety briefing which takes place weekly was described as helpful.

The absence of a routine forum to raise concerns about the quality of training or about the quality and safety of care was noted in section 2.11.

2.19 Patient safety (R1.2)

Trainers & Trainees: Similar potential concerns around the safety and quality of care were identified by trainers and by the different cohorts of doctors in training. These included:

- Lack of consultant physician oversight and responsibility for ED referrals seen by the medical receiving team but who are not seen by a consultant until they access a bed in the AMU/CAU; this is a trainee and patient safety issue.
    - The risk is exacerbated by the lengthy backlog in the flow from ED and the delay of up to 1 to 2 days waiting for a bed in AMU/CAU.
    - The environment in which these patients were waiting was not conducive to proper clinical assessment by the doctors in training in the receiving team (under pressure and in poorly lit corridors).
    - There were concerns also about the quality of care for those awaiting a bed in AMU/CAU - including delays in starting the necessary treatments and interruption of usual treatment during this period.
    - There was lack of clarity around which consultant should be contacted in the event of urgent advice being required.
- Medicine in FVRH is currently substantially over-capacity and workload is reported to be much greater than medical staffing at all levels can manage safely and to the quality of care that staff seek to provide. This is reflected in a) the volume of patients backing up after referral from ED, who are awaiting a bed in AMU/CAU, b) the high level of boarding into ward areas that traditionally are out with medicine and c) the provision of contingency beds – additional beds in existing 4-bed rooms and in other areas not designed for inpatient care.
    - Trainees expressed concern about the quality of care that was able to be provided in contingency beds – noting compromise to the dignity of care in some areas, the absence of call-bells, lack of access to oxygen in some areas – and the practical challenges of resuscitation that were encountered in such areas.

- Concerns were expressed about the AMU being largely covered by Foundation trainees during the day after conclusion of consultant ward rounds, as the medical registrars spent most of their time in the ED.
- Doctors in training of all grades perceive that the workload for the available staffing has the potential to impact adversely on the safety of patient care.
- Concerns were expressed about the level of nursing staff for the patient workload and the potential impact on care.
- Diagnostic specialties experience difficulties in passing on details of concerning lab results for patients to those looking after the patients as ward teams are too busy to answer the phone.
- It was reported that movement amongst patients queuing whilst awaiting a bed was determined by a ward clerk and there was no system for prioritisation based on medical need.

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

Trainers: Not covered.

All Trainees: There were few opportunities for feedback and to learn from incidents and adverse outcomes although we heard that Infectious Diseases, Gastroenterology and Cardiology have either regular meetings to learn from adverse events such as morbidity and mortality meetings or equivalent; most departments don't appear to offer this. While some had received feedback on datix submissions, this was not consistent.

3. Summary

Is a revisit required?	Yes	No	Highly Likely	Highly unlikely

Overall the panel found a department experiencing significant challenges which had given rise to serious concerns in terms of clinical supervision. Nonetheless, the consultant workforce was described as committed and supportive despite the pressure under which they were working. Trainees used descriptors such as “amazing” and “inspirational” reflecting their recognition of the efforts made by trainers to sustain training in the face of potentially overwhelming service and workload pressures.

Positives

- Staff (described as “amazing”) who despite being very stretched by workload and challenging circumstances are striving to do their best.
- Trainees described committed and engaged trainers, referring to “inspirational consultants”, who are endeavouring to deliver high quality training but who are constrained by workload.
- Senior support is accessible, and assistance willingly given when sought.
- The dedicated, protected F1 teaching programme.
- The Acute Medicine safety brief.
- Cardiology, Ageing and Health, Rheumatology and Acute Medicine were regarded as positive training environments.

Negatives

- Lack of consultant physician oversight and responsibility for ED referrals seen by the medical receiving team but who are not seen by a consultant for a day or 2 until they access the AMU; this is a trainee and patient safety issue. **Serious concern requiring immediate action.**
- Patient safety concerns as detailed in the Healthcare Improvement Scotland reports.
- IMT1s have been acting as the medical registrar which is beyond their competence/comfort zone (noting that a more senior trainee may be on concurrently but is fully committed covering the back door).

- Absence of feedback to inform learning around their acute medical management for all grades of trainees.
- Apart from FY1s, trainees reported their inability to get on downstream medical ward rounds with consultants (some exceptions are noted in the report).
- Rota co-ordination, that is perceived to impact on the adequacy of staffing provision, cover for gaps and trainee wellbeing, is reported to be under-resourced (in relation to administrative and senior (medical) support).
- There is a lack of clinic access for IMTs, STs and GPSTs and clinic attendance may involve observation rather than being actively involved in patient management.
- There was no regular, scheduled process for trainees to raise concerns, although recent ad hoc meetings arranged by the DME were acknowledged.
- FY1s reported discouraging handover interactions with the Hospital at Night team, that were a barrier to handing over.
- Departmental inductions were not provided by all departments.
- Phlebotomy support.

4. Areas of Good Practice

Ref	Item	Action
4.1		

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	The rota management arrangements should be reviewed to ensure sufficient resourcing of the rota coordinator role and consultant input. There should also be a shared understanding of how rota gaps (known and established and those that arise at short notice) are managed.	
5.2	There should be rationalisation of the multiple IT systems and/or of the separate password access required to use each of these systems.	
5.3	There should be routine, scheduled departmental and hospital teaching supported by consultants. The duration of any disruption to the schedule should be minimised and explained.	
5.4	Additional phlebotomy support would enable Foundation trainees to access more educational opportunities as some are spending a high proportion of their shifts performing phlebotomy tasks.	
5.5	All trainees should have opportunities to engage in the sharing of lessons to be learned from review of adverse outcomes at morbidity and mortality meetings or equivalent.	

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	Consultant physician oversight and responsibility must be established for ED referrals who have been seen by the medical receiving team but who are awaiting access to the AMU/CAU: this is a trainee and patient safety issue.	As soon as possible	FY, GPST, IMT, ACCS, ST
6.2	Measures must be implemented to address the patient safety concerns described in section 2.19 of this report, that largely reflect the issues identified by Healthcare Improvement Scotland.	20th September 2023	FY, GPST, IMT, ACCS, ST
6.3	Doctors in training must not be expected to work beyond their competence. Specifically, IMT1s should not be expected to work as the medical registrar.	20th September 2023	IMT
6.4	Feedback to all levels of trainees on their management of acute receiving cases must be provided to inform their learning and training (aiming for this in at least 40% of opportunities).	20th September 2023	FY, GPST, IMT, ACCS, ST
6.5	There must be regular consultant ward rounds involving GPST, IMT, ACCS and ST trainees which review trainee decisions and care plans and offer constructive feedback and teaching.	20th September 2023	GPST, IMT, ACCS, ST
6.6	Appropriate outpatient clinic training opportunities must be provided for GPSTs, IMTs and STs in which they are actively involved in patient management and not only observing.	20th September 2023	GPST, IMT, ST
6.7	A formal mechanism for all trainees to be able to feedback to the department on concerns about the quality of training and patient care must be established.	20th September 2023	FY, GPST, IMT, ACCS, ST

6.8	All staff must behave with respect towards each other and conduct themselves in a manner befitting Good Medical Practice guidelines. Specific attention should be given to improving handover interactions between trainees and the Hospital at Night team.	20th September 2023	FY, GPST, IMT, ACCS, ST
6.9	Departmental induction must be provided in all departments which ensures trainees are aware of all of their roles and responsibilities and feel able to provide safe patient care.	20th September 2023	FY, GPST, IMT, ACCS, ST
6.10	The department should ensure that service needs do not prevent trainees from attending scheduled formal local learning opportunities.	20th September 2023	FY, GPST, IMT, ACCS, ST