

Scotland Deanery Quality Management Visit Report

Date of visit	22 February 2019	Level(s)	FY, CMT, GPST, ST
Type of visit	Enhanced Monitoring Re-visit	Hospital	Queen Elizabeth University Hospital
Specialty(s)	Medicine	Board	NHS Greater Glasgow and Clyde

Visit panel	
Professor Alastair McLellan	Visit Chair - Postgraduate Dean
Dr Stephen Glen	Associate Post Graduate Dean for Quality
Professor Moya Kelly	Lead Dean Director & Director of General Practice Training
Dr Marie Mathers	Training Programme Director
Professor Chris Summerton	College Representative
Dr Euan Harris	Trainee Associate
Robin Benstead	GMC Visits & Monitoring Manager
Tom Carey	Lay Representative
Heather Stronach	Quality Improvement Manager
In attendance	
Claire Rolfe	Quality Improvement Administrator

Specialty Group Information	
Specialty Group	<u>Medicine</u>
Lead Dean/Director	<u>Professor Alastair McLellan</u>

Quality Lead(s)	<u>Dr Stephen Glen</u> <u>Dr Reem Al-Soufi</u> <u>Dr Alan McKenzie</u>					
Quality Improvement Manager(s)	<u>Alex McCulloch and Heather Stronach</u>					
Unit/Site Information						
Non-medical staff in attendance	7, including Senior Charge Nurses, General Managers and Rota Managers.					
Trainers in attendance	22					
Trainees in attendance	FY1 x 17	FY2 x 4	GPST x 7	CMT x 10	ST x 6	
Feedback session: Managers in attendance	11 including the Associate Director of Medical Education, the Clinical Director and Medical Directors.					

Date report approved by Lead Visitor	 17 th April 2019
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1. Principal issues arising from pre-visit review:

The Queen Elizabeth University Hospital is one of the largest acute hospital sites in the UK, with 14 floors and over 1000 beds. The site is home to a range of specialist services and is integrated with the children's hospital which is located on the same campus.

General internal medicine at the Queen Elizabeth University Hospital has been visited on several occasions as listed below:

- 27 October 2015 (new site visit)
- 13 May 2016 (triggered revisit)
- 02 December 2016 (enhanced monitoring visit)
- 21 February 2018 (enhanced monitoring revisit).

The last visit to general internal medicine on 21 February 2018 demonstrated that improvements had been made to the training environment since the previous Deanery visits. However, 16 requirements, that is aspects where GMC's standards were not being met, were identified as needing to be addressed:

- 7.1 The general lack of a culture supporting education and training in relation to most (but not all) units within 'medicine' must be addressed as a matter of urgency.
- 7.2 Access to educational opportunities and training must be improved.
- 7.3 Levels of medical staffing at junior and middle-grade levels, plus appropriate levels of clinical support workers, must be provided at weekends.
- 7.4 All cohorts of doctors in training, including Foundation, GPSTs and CMTs, must be assigned to the same base ward for several weeks and, ideally, for most of the duration of their post.
- 7.5 Consultant-led ward rounds must be vehicles for feedback to doctors in training on their input to the management of their patients and for learning. Consultants must conduct ward rounds with their trainees and not in parallel to them.
- 7.6 FY1 trainees must not work beyond their competence. They must have oversight of their ward rounds and receive feedback on patient care plans.
- 7.7 On the job feedback to trainees from consultants needs to be formalised and embedded on a daily basis.

- 7.8 Core medicine trainees must be enabled to achieve their curriculum competencies.
- 7.9 Access to clinic opportunities for doctors in training must be increased.
- 7.10 Opportunities for trainees to complete workplace-based assessments and have them signed off should be improved.
- 7.11 Escalation pathways when senior medical staff are offsite must be clarified to ensure that doctors in training can escalate concerns at all times.
- 7.12 The practice of boarding overnight from front door to ARU5 must be reviewed to ensure patient safety.
- 7.13 Clarity should be provided to trainees around the consultant responsibility for high dependency unit patients out of hours and at weekends to allow escalation to the right seniors.
- 7.14 Immediate Assessment Unit (IAU): Measures must be implemented to address the patient safety concerns associated with the lengthy delays between arrival and definitive assessment of general practice referrals.
- 7.15 Work must be done to eradicate the use of Senior House Officer (SHO) terminology by trainees. Consideration should be given to implementing the “SaynoSHO” campaign.
- 7.16 The allegations of undermining of junior trainees must be investigated and if confirmed, must be addressed.

2. Introduction

There are approximately 226 trainees in medical specialties at the Queen Elizabeth University Hospital and the Deanery re-visit specifically considered the training experience of those in medical specialties which include general internal medicine and contribute to acute admissions/ out of hours (OOH) care.

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

The panel met with trainers and non-medical staff as well as the following groups: foundation year (FY) trainees, core medicine trainees (CMT), GP specialty trainees (GPSTs) and specialty training registrars (STs) working in general internal medicine.

3.1 Induction (R1.13)

Trainers: Trainers told the visiting panel that there is a hospital wide induction that takes place in August and at changeover in February. The rota team is responsible for organising induction and they help to prepare the programme. Induction includes a mixture of presentations, PDF information with clinical guidelines and on the job experience. Attendance is recorded on sign in sheets. The board has an online module on topics related to patient safety, such as antibiotic prescribing.

Trainers noted that it could be difficult contacting trainees before induction because of issues with email addresses (approximately fifty percent of email addresses were incorrect or for old accounts). Hospital induction is repeated a second time with the aim of capturing the trainees who missed induction the first time.

Trainers said individual medical departments ran their own inductions. A hospital app called 'Dr Toolbox' is being continually developed as an additional form of media where trainees can find relevant information. Trainers felt it is challenging managing how to impart such volumes of information to trainees. They noted that the gastroenterology and respiratory medicine departments have their own information available on the intranet.

FY1: Most of the trainees they panel met with had received hospital induction. Trainees based at Gartnavel General Hospital on a temporary basis suggested that hospital induction to Queen Elizabeth University Hospital could have been offered by videoconference to allow them to attend (they received a ward induction only).

Trainees commended the online gastroenterology webpage. For the acute receiving unit (ARU), some trainees received induction materials by email whereas others did not.

FY2: All trainees present had attended hospital induction except for those who had started on nights. Catch-up induction was offered too close to the first induction and some were not able to attend.

FY2 trainees particularly praised the Dr Toolbox app and felt it helps to clarify what they need. Trainees gave mixed responses about whether they had received a department induction. The cardiology department was noted to offer a good department induction. Some trainees described having met with their educational supervisor who had provided some form of departmental induction on the wards they work in. Trainees who had started on call said their induction clarified their on call duties and also provided good information on the receiving unit: these trainees therefore felt well prepared to start work.

CMT: Most CMT trainees had attended hospital induction (except for those on call). Of these trainees who started who were on call at night, some were aware that a catch-up induction was offered but the scheduling was not conducive to the attendance of all those who needed it.

CMT trainees commended the cardiology department who had provided induction materials by email. It included timetables, information on how the department works, information about clinics, and escalation procedures. Trainees said it was 'good to refer back to.' Respiratory medicine was noted to have a sit down lunchtime meeting with some materials also sent by email. Neurology was noted to have a full day of induction. Most departments appeared to provide some form of induction.

GPST: GPST trainees had received hospital and departmental inductions that generally prepared them well- providing good understanding of expectations of them and of their roles and responsibilities. They suggested that induction to cardiology would benefit from covering the intricacies of the different aspects including cardiology wards and the coronary care unit.

STs: All trainees had received both hospital and departmental inductions and they were happy that these had prepared them for their roles and responsibilities.

Nursing and Non-Medical Staff: Non-medical staff said that induction was effective in preparing doctors to work. They were not aware of any feedback from doctors saying they felt

underprepared. Non-medical staff said there is variable engagement from trainees in attending induction, but that they do support doctors and induct them to their units.

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

Trainers: Trainers advised that there is a wide variety of hospital teaching including:

- FY1 teaching on Tuesdays and Thursdays (repeated content).
- Wednesday lunchtime medicine and medicine for the elderly combined meeting (this session is for all cohorts of trainee but trainers report that trainee attendance is poor).
- FY2 mandatory teaching days throughout the year (these sessions are bleep free with bleeps held by the postgraduate administration office).
- Friday lunchtime grand rounds.
- Practical Assessment of Clinical Examination Skills –(PACES) teaching.

In addition to hospital wide teaching, trainers described a variety of specialty-based teaching available including:

Infectious diseases - Monday lunchtime teaching which is well attended.

Endocrinology and diabetes mellitus – Monday lunchtime.

Cardiology – 2nd Friday of the month echo meeting and 4th Friday of the month afternoon general teaching.

Gastroenterology - Friday lunchtime, followed by handover for the weekend.

Rheumatology - Friday lunchtime xray meetings.

Respiratory medicine - weekly teaching and weekly radiology meetings.

Monthly regional Core Medicine Education Programme (CoMEP) teaching for CMTs. Content is available online and trainers see this as a positive for trainees. Trainers are aware that workload can often impede a CMTs' ability to attend CoMEP teaching in person and having it online means that trainees can access this teaching at a time that suits them.

Other regional teaching is available for STs: Infectious diseases - Wednesday morning national programme teaching coordinated by NHS Lothian (trainees attend via videoconference); Cardiology – 1st Friday of the month there is a continuing medical education meeting at the

Golden Jubilee National Hospital. Gastroenterology - STs have five regional teaching days per year; Rheumatology – regular programme of Royal College of Physicians Edinburgh (RCPEd) meetings.

FY1: Trainees confirmed FY Tuesday and Thursday teaching sessions with repeated content. They said they managed to attend teaching ‘most of the time’ but that pressures of work on the wards can sometimes impede their ability to attend teaching. By comparison, the impact of workload on teaching attendance was perceived to be worse when working on the receiving unit. Trainees appreciate that some learning is online so that they can access teaching in their own time.

Trainees who are temporarily based at Gartnavel General Hospital reported having to get taxis to attend the twice weekly lunchtime teachings at the Queen Elizabeth University Hospital. They said it would be preferable if they could attend the teaching by videoconference to allow them to remain on the wards and complete their ward tasks (rather than spending time travelling back and forth in taxis to attend teaching).

FY2: FY2s also described the range of teaching available listed above. They said mandatory ‘bleep free’ teaching days take place once every 4 months and run on three different days to ensure maximum attendance. Trainees were confident that they would be able to attend these teaching sessions. SIM teaching is provided over 1 day each year for FY2s.

CMT: CMT trainees noted they could attend:

- the monthly regional CoMEP
- hospital grand rounds on a Friday
- medicine/medicine for the elderly meetings on a Wednesday.

Of the trainees the visiting panel spoke with, only one had managed to attend the grand round on a Friday lunchtime. However, they said it was ‘very good.’

Overall attendance at local teaching by CMTs averaged at about 1hr/week, with some managing 3hrs/week (in Neurology). Attendance at CoMEP is affected by workload and staffing levels (attendance thus far was reported to range between 0 to 100% of sessions). CMT

trainees said it would be ideal if the rota masters could build these sessions into the rota as study leave to allow them to attend. CMTs acknowledged that most departments have educational meetings weekly or monthly; however, teaching is difficult to attend due to workload pressures. Friday afternoons are perceived to be the busiest time of week and it was suggested that teaching sessions scheduled to take place at this time (for example, respiratory medicine) could be scheduled to a different time of the week.

GPST: GPSTs had only been in post since 6 February 2019. On average, they had attended zero to two local teaching sessions so far. GPSTs were aware of the grand rounds on Friday and said it was well publicised. They were also aware of the Wednesday lunchtime medicine education/governance meetings but said that more could be done to publicise this meeting.

ST: STs felt able to attend general internal medicine (GIM) regional teaching days. They also said that their workload limited their attendance at local teaching. STs estimated they received on average about 1 hour per week with some not managing to attend any locally delivered, formal education.

Nursing and Non-Medical Staff: Nursing staff said it was embedded in their practice to support their medical colleagues to attend formal teaching and most trainees can get to teaching. They said this was not always the case when trainees are working in the acute receiving unit.

3.3 Study Leave (R3.12)

Trainers: Trainers said all reasonable requests for study leave were approved provided that appropriate notice is given. They could not grant study leave for GIM regional teaching days to all trainees all at the same time because a minimum of trainees are needed to help staff the hospital. Trainers said that trainees can catch up with any GIM teaching sessions they miss online via the College website. Study leave had always been granted for higher trainees.

Trainees: All cohorts of trainee confirmed they were able to access study leave most of the time. One FY trainee could not get study leave for the taster week because they were working on the on-call rota. GPST trainees had only been in post since February and had not yet

submitted any requests. ST trainees said access to study leave was 'fine', but noted that it can be more difficult for smaller specialties to support it.

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

Trainers: Trainers said that educational and clinical supervisors are allocated trainees in accordance with their job plans. When induction materials are emailed out to trainees, trainees are also advised who their supervisors are.

At the last Deanery visit the view was raised that trainers do not have enough time allocated in their job plans for training. This continues to be an ongoing discussion. Trainers informed there is a current exercise underway to map the gap. All departments have been asked to carry out this task as part of job planning this year. Trainers felt that the '9:1 contracts' that new consultants are being recruited to allowed even less time for supervision. Trainers also felt there was a disparity across the specialty groups.

All educational and clinical supervisors are trained and appraised for their roles. Trainers feel there is a robust system for passing on known concerns about trainees.

Trainees: All trainees had been allocated educational supervisors and had met with them. GPSTs' educational supervisors are trainers in their general practice setting.

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

Trainers: Trainers said that consultants arrive at 8am on the acute receiving unit and formal handover starts at 9am. This means that between 8am and 9am is a good opportunity for trainees on the night shift to talk to consultants about patients they have seen overnight and allows trainees to complete case-based discussion (CBDs) assessments, or the acute care assessment tool (ACAT). Trainers have worked hard to ensure that the learning culture is embedded at this time. They also said that the 9am handover is an educational opportunity. Cardiology, infectious diseases and respiratory medicine were specialties observed to have scheduled clinics into their rotas. Some clinics (infectious diseases and rheumatology clinics) are offsite at Gartnavel General Hospital.

Cardiology described having consultant presence on the floor all day Monday – Friday. After every ward round there is a sit down with trainees as an opportunity to discuss cases. These can sometime be multidisciplinary, for example, the heart failure clinical team has a multidisciplinary team meeting.

Infectious diseases was noted to have a Friday morning ‘sit down’ ward round with trainees and this universally gets good feedback from trainees: that is additional to the regular consultant ward round. There is also an xray meeting where in- and out- patients are discussed. There is hospital-wide teaching provided by infectious diseases on antibiotic prescribing/managing infection, which is felt to be educationally beneficial. There is a further 4pm ward round led by the registrar where they talk about cases they have been phoned about during the day, some of which form the basis for CBDs on e-portfolio. All infectious diseases clinics are offsite and middle grade doctors must attend those clinics.

In respiratory medicine trainees have good access to clinics (it is rostered in their timetables). Respiratory trainees generally achieve ten clinics within 4 months, under consultant supervision, and the department receives good feedback for this. Trainees are supernumerary at respiratory medicine clinics and can easily achieve supervised learning event assessments from their time at clinic.

Endocrinology and diabetes mellitus have a diabetes/vascular multidisciplinary at 8:30am on Wednesdays. As trainees do not start work until 9am this meeting is poorly attended by trainees.

Gastroenterology clinics are also offsite and it is acknowledged that it is difficult for trainees to access these clinics. Commitment to the night rota also affects trainees’ attendance at clinics. Trainers advised that for gastroenterology trainees are allocated two scope lists per week. In ST3, trainers ensure that the first 6 months of training focuses on upper GI including access to endoscopy clinics.

Efforts have been made to reduce the time trainees spent in the acute medical receiving unit during the week to allow trainees more time on the wards in their specialties and to increase

the number of 'uninterrupted weeks.' Trainers said that the burden of non-medical tasks increases at the weekends as there are fewer clinical support staff on shift to undertake them. It was also noted that there was a reduction in acute internal medicine (AIM) trainees, unfortunately this has led to registrars within other medicine specialties to have an increased commitment to the IAU, which in turn impacts on the number of clinics trainees are able to attend. Dr Ritchie is continuing to work on the rotas to try and maximise clinic experience for trainees.

FY1 Trainees: FY1s feel there are ample opportunities to carry out procedures. All FY1s were confident they are going to achieve their curricular procedural requirements. FY1 trainees said they do not get the opportunity to attend clinics as they are ward based, but this is not mandatory for their curriculum.

FY1 trainees enjoy night shifts as they can carry out the first review of patients under supervision. During the day, they report that 50-80% of their time is spent doing tasks of non-educational benefit. Trainees thought it would be helpful if some of the nurses on the ward were trained to insert Venflons.

Trainees said access to support from phlebotomists and ECG technicians can be difficult. They report that phlebotomists are instructed not to take samples from patients who are barrier-nursed. Phlebotomy was noted to be only available until 2pm on a Saturday and that thereafter all blood samples revert to the FYs.

FY2: FY2s said they get to see lots of patient presentations and are exposed to a good case mix. FY2s said they are primarily ward-based and described the time they spend carrying out tasks of little educational benefit as 'better than in FY1.' Some FY2s had managed to access a few specialty clinics, but none had been to any GIM clinics. FY2s described improved continuity of their attachments to base wards – with the majority of each 4 month post being on the same ward, apart from 6 weeks' undertaking OOH duties or medical receiving.

CMT and GPST: In general this training environment meets their learning needs with good exposure to a broad range of medicine. Feedback (see page 15) opportunities on overnight duties in the stack have improved with the introduction of the 08:30 stack handover.

Interactions with consultant supervisors are improving and cardiology and respiratory were noted to be doing well in regard to supporting learning opportunities.

Cardiology and respiratory have built clinic opportunities into the rota although service needs can still be a barrier. Difficulties regarding getting to gastroenterology clinics was raised through the Junior Doctor Forum and progress has been made enabling one trainee per week to sit in on gastroenterology clinics. CMT have been involved in designing rotas to incorporate clinic attendance.

When middle grade doctors were asked whether they feel they spend more time on service-based tasks, trainees responded that it 'depends on where you work'.

Trainees said that they generally enjoyed their experience of covering the main building or 'the stack' at nights although cover of 8th floor was reported to be particularly challenging (see section 3.18). There is one FY1 per floor in the stack, all covered by one CMT who is 'acting up'. FY1s escalate their concerns to the CMT, and they enjoy this 'step up' in training. CMTs confirmed that they also have the support on the on call registrar as an appropriate safety net.

CMTs reported that FY1s take a lot of bloods and often they too are asked to carry out non-educational tasks in addition to their CMT duties. This frequently occurs at weekends because of limited phlebotomy services that results in FY1s doing bloods etc until 4pm and CMT trainees feel this is taking a step backwards in their training.

ST: STs said they appreciate being able to see the wide range of clinical presentations at the Queen Elizabeth University Hospital that would only been seen infrequently in a district general hospital setting. STs said there are lots of acute medicine opportunities, but this is at the expense of general internal medicine. It feels like a very pressured environment.

Access to clinics was limited for some – because of staffing (this was noted for infectious diseases and diabetes/endocrinology), and because clinics were off site (rheumatology).

ST trainees said that AIM trainees spend almost all their time doing the unselected take within the IAU. This was felt to be a service provision job with little time to do anything else. The rota is also set up so that AIM trainees spend most of their OOH work doing unselected take in the

IAU as well. Concern was expressed for AIM trainees that they might not get enough exposure to critical care or general internal medicine to meet their curriculum requirements. The numbers of AIM trainees in Queen Elizabeth University Hospital was noted to be two in comparison with the previous year when there were four. The arrest page is also their responsibility 3 days a week so even if the unit is not busy they are limited in what they can do with any spare time. STs said it is a good working environment with excellent consultant support, just that there is not enough exposure to other areas of medicine.

When asked how much time is spent developing as a doctor versus how much time they spend carrying out activities of little or no educational benefit, STs said that previously the balance was acceptable but now that they are short staffed their training feels compromised. Trainees reported not being able to get to clinics because there are not enough trainees to cover the service and the ST needs to be present to manage diabetes inpatient referrals. STs also said that the middle tier rota feels stretched, so that they sometime backfill for them by conducting ward rounds.

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

Trainers: Trainers did not report any curriculum competences that were more difficult to get than others, but said trainees often required signposting to get them.

FY: FY trainees reported no difficulties completing assessments and they felt their assessments were consistent and fair.

CMT: CMT trainees also reported no difficulties completing assessments. One CMT thought this was better at the Queen Elizabeth University Hospital than at other hospitals. One trainee volunteered that they have not achieved any ACAT assessments yet but felt that these would be achieved when they were rostered to work on the night acute receiving shift. The Pods provided good opportunities for ACATs. Trainees said that they do get feedback on overnight stack cover activities at the 8:30am stack handover during the week Monday – Friday.

GPST: GPST trainees had only been in post in 4 weeks and said it was a bit too early for them to comment on assessment.

STs: STs said that some workplace-based assessments were more difficult to complete. They said that consultant supervision and support is excellent but that ACAT and Mini CEXs can be difficult to get as they require direct observation (as opposed to CBD which can easily be discussed afterwards), especially in the IAU which is where they tend to be based during receiving shifts.

Nursing and Non-Medical Staff: Nursing and non-medical staff contribute to trainee's assessments by providing feedback to them for their workplace-based assessments.

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

Trainees: STs said multidisciplinary team meetings (MDTs) differed from specialty to specialty and most of the learning was gained by working together on the wards. Endocrinology and diabetes was noted to have daily MDT meetings.

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

Trainees: No issues were reported by trainees regarding accessing opportunities for quality improvement activity or audit.

3.9. 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 advised that they have restructured how the receiving unit works so that over the winter period a consultant is available until 10pm, whereas usually there is 8 am – 8pm consultant presence. When trainers were asked how trainees know who to contact for advice or support during the day and OOH, trainers advised that this is covered at departmental induction. They also said that each week all trainees receive a weekly rota including a list of phone numbers to call for support. The challenge previously was that when managing patients within the IAU, there were so many specialists that trainees sometimes did not know who to call. Trainees were reassured that if they try to contact someone and it was not the right person that was OK and they would be advised who the correct person was. More recently, trainers have developed a 'contingency consultant role' for the IAU and this has

addressed the ambiguity about who to call for support in the areas that do not fall within the clearly defined specialty areas.

FY1 Trainees: FY1 trainees said that they always know who to contact for support during the day and OOH. Trainees highlighted that on some wards they had to cover ward rounds alone (examples given were infectious diseases, diabetes and cardiology). They said their senior colleagues were approachable and supportive and if they were unsure, they could run things past seniors. They have never felt forced to work without appropriate supervision.

FY1s felt that there is lack of support OOH. At night, there is one 'ward response doctor' who is a middle grade doctor responsible for providing support to all four medical floors. While trainees appreciate the safety blanket provided through this support, the middle grade doctor can be difficult to call and is often too busy themselves to be able to provide immediate support. As a result, FY1s report being in situations where they feel out of their depth, and for some period of time. They feel like they are left to deal with things that would need a senior review. They recognise that this provides potentially useful learning opportunities.

FY2 Trainees: FY2s feel they received access to appropriate supervision in the out-of-hours period but less so in some of the wards during the day. They said they there is frequently only one middle grade and one FY1 doctor on the ward to look after thirty patients; this means unfamiliarity with patients and lack of time to carry out less urgent tasks or referrals which leads to patients waiting longer periods of time in hospital. They consider that there is a suboptimal ratio of staff to patients. Whilst there is a named on-call consultant for the ward, it is not always possible to contact them as this relies on adequate mobile phone signal and them being available from other clinical commitments.

They noted that within endocrinology and diabetes it can be difficult to get senior support as the registrars were regularly away at clinics in other hospitals. Clinical supervision in infectious diseases was commended. Despite the difficulties in some wards obtaining senior support, trainees did find their senior colleagues to be approachable and did not feel they worked beyond their competence.

CMT: Trainees confirmed they had access to clinical supervision both during the day and the out-of-hours period. Trainees were confident they were not expected to work beyond their

competence and felt their senior colleagues were approachable when asked for support. CMTs' involvement in high dependency unit (HDU) shifts was reported to be an issue. It was reported that this is agreement that medical HDU should be led by Intensivists, but current manpower does not achieve this consistently. In the absence of consultant presence/supervision of this role is reported to be 'very poor'. There is a safety net of access to 2nd on anaesthetic registrar for support, but nevertheless this role leaves trainees feeling exposed.

GPST: Did not report any problems with clinical supervision.

ST: At the previous Deanery visit, trainees reported that they were sometimes unsure who to contact for clinical supervision OOH. Now trainees said they know who to contact and the implementation of the 'contingency consultant role' has helped with this significantly. They said that if there is a specialty specific problem there is always someone you can phone.

STs said it is clear who the consultants for the IAU and the pods are, but it was less clear who covers boarders in the medical and surgical wards, patients in the medical HDU, boarders in the surgical HDU, and patients who are based at Gartnavel General Hospital.

ST trainees did not feel they had ever had to cope with problems out with the experience or competence.

It was noted by the visiting panel that trainees frequently used the term SHO. When asked to explain where this usage comes from, trainees said that the rotas and whiteboards refer to them as SHO.

Nursing and Non-Medical Staff: Nursing staff were comfortable that trainees knew who to contact for support amongst their senior colleagues.

Non-medical staff can find it difficult to identify trainees are when they are working in the medical receiving unit as this is not their primary base; however they are happy to ask. Non-medical staff were aware of coloured badges that identify the different grades of trainees. They said it can be difficult to know who to contact for support, and described an instance where they had to support a foundation year trainee having to undertake a difficult conversation with a

family. At times, nurses have had to escalate matters when they have considered it is best to do so.

3.10. Feedback to trainees (R1.15, 3.13)

Trainers: Trainers said that trainees get lots of informal feedback. They described a monthly Junior Doctors' Forum with a Chief Resident who sets the agenda for meeting. Trainers also described feedback as taking place daily via morning huddles and the safety debrief, both of which are daily mechanisms.

Trainees: All junior trainees felt feedback 'on the job' was limited and particularly infrequent during the day. Trainees generally have to ask for feedback. Junior trainees described the continued practice of parallel ward rounds, but said there is time at the end of parallel ward rounds to discuss new/complex/unwell patients with a senior to raise issues to and seek advice if need be. The senior management team advised that parallel ward rounds are actively discouraged but acknowledge that sometimes these occur and have asked that consultants are able to give advice to doctors in training following their ward rounds (when these are conducted separately).

Feedback in relation to the acute medical receiving workload is provided well, in the setting of the 'pods', for those grades of trainees who work there. However, very little feedback is provided on higher trainees' input to the overnight acute medical management of patients in relation to the IAU; the higher trainees only work in the IAU setting.

While there is an aspiration that the HDU ought to be staffed by Intensivists, this is not feasible consistently, currently. Supervision and feedback to middle grade trainees are issues when there isn't an in-situ consultant Intensivist.

3.11. Feedback from trainees (R1.5, 2.3)

Trainers: Trainers highlighted informal routes as well as formal channels for feedback such as the Junior Doctor Forum that meets approximately monthly (this includes doctors in training, the Chief Resident, the Clinical Director, non-clinical managers and Dr Neil Ritchie and

consultants). There is a daily huddle that is a safety brief that presents opportunities to raise concerns. The 08:30am stack handover is another opportunity to share feedback on challenges and safety issues.

Trainees: Trainees said they could provide feedback to their educational supervisor and Training Programme Director. The majority of FY and GPST trainees were unaware of the Junior Doctors' Forum. However, CMTs were aware of and had engaged with the Chief Resident and the Junior Doctor Forum.

By contrast, ST trainees were aware of the Junior Doctors' Forum (and Chief Resident) as a place to provide feedback to their seniors about the quality of their training. They thought that it was a useful forum. They said that minutes from the Junior Doctors' Forum go out in a newsletter and consultants respond to any issues raised.

3.12. Workload/ Rota (1.7, 1.12, 2.19)

Trainees: Trainees noted that there were frequent rota gaps. Trainees said that if the rotas were fully staffed they may just work. Trainees felt exasperated that long term known rota gaps had not been filled. They were also concerned about late notice given of rota changes (an example was given of a trainee being emailed at 10:00am to do a night shift when the situation was known about since the previous week). Trainees said it was difficult to swap shifts without breaking European Working Time Regulations. There had recently been a lot of discussion over rota gaps and how best to fill them and they had asked a representative from the British Medical Association (BMA) to attend as a source of advice. Trainees confirmed that the rota is compliant with twenty-six doctors available. At present there are only twenty, so the board is in the process of recruiting four more to ensure compliance.

The following themes were raised about workload and rotas:

- Rota gaps impacting on workload - trainees report that the time available to complete all routine ward tasks and review unwell patients is constrained. When there is only one FY1, bloods can often need to be taken after 5pm. It can therefore be more than 24 hours before issues from blood results are picked up on. Also, the prescribing of intravenous fluids can be delayed.

- Weekend staffing levels on the wards were felt to be unsafe - the volume of routine tasks plus the number of acute issues with unwell patients was felt to be almost overwhelming at times. Particular mention was made of the 8th floor weekend cover where one FY1 and middle grade doctor cover three wards. It was felt to be 'slightly manageable' if the registrar can help. Trainees felt that the current staffing level does not provide any flexibility for peri-arrests or patients become acutely unwell.
- Phlebotomy access –the numbers of blood samples taken was restricted to phlebotomists and phlebotomists had been told by their manager not to take blood samples from patients undergoing barrier nursing.
- At weekends it was noted phlebotomy is only available on Saturday mornings. This impacts on Foundation doctors but has a knock on effect on the middle grades' time too.
- One trainee described conducting a ward round for twenty-eight patients.
- Responsibility for offsite inpatients can be stressful to manage, if the workload onsite is high. Trainees can be left feeling like they are not doing as good a job as they would like for some patient interactions due to time pressures.
- There have been staff shortages affecting the diabetes and endocrine team that have impacted on the team covering inpatient referrals. As a result, trainees are unable to attend clinics without the being interrupted and often referrals are made after 3pm which results in having to extend our working hours outwith the rostered working time.
- Volume and flow of the IAU (see pages 23 - 24 for further details).
- Nightshifts in the IAU were reported to be associated with a 'phenomenal workload' for the registrars. It was clear that the staffing for this workload was totally inadequate and the pressures experienced by the STs were extreme.

Nursing and Non-Medical Staff: Non-medical staff were also aware of the issues around gaps in the rotas. They said there have been 'lots of meetings' and were also aware of the BMA representative being present at these meetings to provide support. Non-medical staff said the fill rate for night shift is less than three percent. Non-medical staff are aware that this item has been raised to the chief resident at the junior doctors' forum and discussions to find solutions are ongoing.

3.13. Handover (R1.14)

Trainers: On the receiving unit handover to the wider team starts at 9am and includes a discussion of interesting cases to provide feedback and an additional opportunity for learning.

There is an 8:30am handover meeting in the stack wards. Trainers said these have been revamped so there are 4 FY1s and one middle grade trainee with a consultant. Handover consists of case-based discussions on things encountered on the night shift before the day shift starts, this helps CBDs to be achieved and also reduces the need to go into the wards to discuss patients individually.

Trainers felt there was robust and effective handover in place for most wards and it was difficult to see any gaps. The use of a crib sheet ensures formalised handover in the stacks. Track care is also being used and developed for weekend shifts, though this is still a work in progress.

Trainees: The greatest concern shared by trainees regarding handover was the absence of handover of patients from the emergency department about patients being admitted to Pods. There were examples of how the absence of handover regarding severity of unwellness and of risk of deterioration led to later-than-appropriate intervention and treatment. Junior trainees considered that the 5pm handover on the wards work well. Most trainees felt that the 9pm handover to the night team was also effective (although some views were expressed that it can be poorly done at times when multiple people are speaking at once, which can lead to confusion and incorrect information being handed over).

Trainees had different perceptions of the 08:30 morning handover in the stack. Some thought it worked well, other less so – but it was noted to be in its infancy. Concerns were shared that there was no one to handover to.

Nursing and Non-Medical Staff: Non-medical staff reported issues around trainee attendance at handover.

3.14. Educational Resources (R1.19)

Trainees: Trainees felt facilities were adequate to support their learning and noted the library and the teaching and learning centre to be very good. They said the resources at the Queen Elizabeth University Hospital was 'better than at most hospitals'.

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

Trainees: No issues were raised around support.

Nursing and Non-Medical Staff: Non-medical staff were confident that reasonable adjustments would be made if a trainee needed this.

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

Trainers: The visiting panel heard from the clinical director that there is a recently established educational governance group in place which brings together all training programme directors across the medical specialties, and the chief resident is also invited to take part who will raise any issues brought by trainees to this forum.

Trainees: As seen previously in this report most (although not all) junior doctors did not have a good awareness of how the quality of education and training is managed. STs trainees had a better awareness.

3.17 Raising concerns (R1.1, 2.7)

Trainees: Trainees said they could raise concerns with their educational or clinical supervisor. Of the few trainees who were aware of the Junior Doctors' Forum, they said they would also be happy to raise concerns via this forum. One trainee reported having raised a concern to a consultant and this was appropriately referred to the clinical director.

3.18 Patient safety (R1.2)

Trainers: Trainers raised concerns about patient safety within the IAU OOH. During the day the IAU is well supported by two consultants and it tends to receive good feedback. Due to the volume of work coming through the IAU, both consultants and nurses working there adapt their way of working. Consultants are responsible for having the oversight of patients and assess and triage them.

The IAU is 'over full' all day. The night team from 9pm often face a backlog of up to fifty patients, with twenty-eight cubicles in the unit and 10+ hour waits are not unusual. These hours are manned only doctors in training without consultant presence.

Overnight the IAU is 'overwhelming' with both the volume, management and flow of patients to other areas of the hospital being difficult. Often there are not enough beds within the IAU, within the receiving pods or within the wards to accommodate the number of patients coming through. Trainers report that further efforts are underway to ensure timely discharge from the stack to try to improve flow to accommodate more patients coming into the wards via the IAU. Unfortunately, during busy periods, there have often been occasions when patients have been accommodated in beds in the corridors of IAU at night. The challenges of flow and volume and delays in assessment and management of patients are issues known to the management team, to the Board and to Scottish Government.

Trainees:

IAU: Trainees also raised that IAU was a significant ongoing cause of concern for them. For the OOH 'registrar' overnight, the intensity of workload within the IAU is felt to be 'untenable'. The OOH registrar clerks all admissions; takes thrombolysis calls; takes inpatient referrals; takes GP advice calls; provides OOH stroke advice city wide; manages the acute referrals and organises and undertakes procedures (eg, bloods and electrocardiograms) for patients coming through the IAU; and also manages any medical emergencies that arise.

Trainees report sometimes having to start nightshift with twenty patients to see, another twenty expected, and those already in the department having waited over 6 hours. Trainees report that there are not enough beds and triage can involve seeing a patient in a chair to determine 'how

sick' they are before a bed can be found. Trainees said it is very difficult to triage patients as there were simply too many patients coming through and not enough staff to support the volume of tasks. Patients could wait 10+ hours for first medical assessment and for initiation of treatment.

At busy periods, for example, it was not uncommon to admit fifty patients overnight. During this time, occasional additional support was provided from the medicine for the elderly registrar/stroke registrar and middle graders covering surgery.

Other concerns (both during the day and at night) about the IAU were:

- Stroke ward (1c) is said to be a receiving area 24/7. GP admissions go directly to ward if there is a bed.
- Rarely patients have received medications (for example, antibiotics) whilst in the corridor, so managing patients who are not in a bed.
- The on-going priority is to transfer patients from accident and emergency within the 4 hours target to 'boarding' medical beds in surgical receiving when medical receiving pods are full. The responsibility then falls to the GP receiving unit team to review them who may already have ten to fifteen patients still to be seen. This leads to long delays in the first review of patients and the feeling that patient care/safety is compromised because of this wait.
- Despite an already heavy workload, the IAU registrar is also expected to provide advice and support for the middle grade doctors (who could all be FY2 level) who clerk in the emergency department admissions.

Trainees said that when there are bed pressures, bed managers also override consultants' decisions around not to board.

Overnight staffing on the wards: Trainees expressed the view that there is insufficient support on the wards overnight especially if there were several sick patients to be seen at once, giving rise to patient safety concerns. 8th floor at weekends presents an unmanageable workload for the FY1 and the middle grade doctor.

Medical HDU: Some trainees reported feeling out of their depth working in the medical HDU including OOH. Trainees reported their understanding that it had been agreed that there should

always be an Intensive Care Medicine consultant on for the HDU, but current staffing levels do not permit this. In the absence of such a consultant, trainees did not feel this was a good experience, and described it as 'intense' and felt 'out of their depth'. Having a second middle grade doctor to cover HDU would help alleviate their concerns in terms of both service and additional support. However, trainees said they get more educational benefit out of their experience in HDU when there is consultant support, otherwise the broad feeling is that it is 'unsupervised with no-one to learn from'. Clinical leads told the visiting panel that the board is looking at any residual winter funds to staff more intensivists in the HDU.

At the last visit concerns were raised about the care of medical boarders. Trainees were aware that there is now a 'boarders' team' in place and said that 'one of the best things at the Queen Elizabeth University Hospital is a clear escalation pathway'. This item had been previously been raised at the Junior Doctors' Forum, and the 'boarders' team' was introduced as a response to that.

Differentiation among different grades of medical staff: It was noted that efforts to eliminate reference to 'SHO' were underway. It was noted that coloured badges differentiate among different grades. However, in practice 'SHO' was still being used some of the time but that at other times 'middle grade doctor' was being used – a term that was noted to carry the same risk as 'SHO', because it covered a few grades of doctors on the rota and nurses and others were not always aware of the different grades of doctors and their capabilities when calling them.

Nursing and Non-Medical Staff: Non-medical staff raised similar concerns about the IAU.

3.19 Adverse incidents (R1.3)

Trainees: Trainees understood that the main formal process for raising concerns was through Datix. Of those who had submitted a Datix, some had received feedback and others had not. Trainees said they could also raise concerns with their educational or clinical supervisor. FY1 and FY2 trainees could not recall receiving training on the use of Datix and few of the FY trainees we spoke had received feedback on Datix submissions, FYs reported being

threatened occasionally with the use of Datix about them by nursing colleagues. They were not aware of any morbidity and mortality meetings taking place.

Nursing and Non-Medical Staff: Non-medical staff also spoke of the Datix system and said these are received and reviewed but that ‘they don’t get feedback.’

3.20 Duty of candour (R1.4)

Trainees feel they would be supported by their senior consultant colleagues if they were involved in an incident when something went wrong.

3.21 Culture & undermining (R3.3)

All staff must be encouraged to behave with respect toward each other and conduct themselves in a manner befitting Good Medical Practice guidelines. A specific allegation of undermining behaviour noted during the previous visit remains to be addressed.

4. Summary

4.1. The visit panel noted the ongoing commitment of site leads, clinical and non-clinical managers, and consultant trainers in improving the educational environment. Some of the initiatives developed, such as, the dedicated boarders team, ‘contingency consultant role’, ‘ward response doctor’ role, are to be commended.

4.2. Progress against previous requirements from 2018 visit:

Progress against previous requirements recorded as ‘addressed’, ‘significant’, ‘some progress’, ‘little or no progress’.

Ref	Issue	Progress noted at 2019 visit
7.1	The general lack of a culture supporting education and training in relation to most (but not all) units	Significant progress

	within 'medicine' must be addressed as a matter of urgency.	
7.2	Access to educational opportunities and training must be improved.	Significant progress
7.3	Levels of medical staffing at junior and middle-grade levels, plus appropriate levels of clinical support workers, must be provided at weekends.	Little or no progress
7.4	All cohorts of doctors in training, including Foundation, GPSTs and CMTs, must be assigned to the same base ward for several weeks and, ideally, for most of the duration of their post.	Significant progress
7.5	Consultant-led ward rounds must be vehicles for feedback to doctors in training on their input to the management of their patients and for learning. Consultants must conduct ward rounds with their trainees and not in parallel to them.	Some progress
7.6	FY1 trainees must not work beyond their competence. They must have oversight of their ward rounds and receive feedback on patient care plans.	Some progress
7.7	On the job feedback to trainees from consultants needs to be formalised and embedded on a daily basis.	Some progress
7.8	Core Medicine trainees must be enabled to achieve their curriculum competencies.	Significant progress
7.9	Access to clinic opportunities for doctors in training must be increased.	Significant progress
7.10	Opportunities for trainees to complete Workplace Based Assessments and have them signed off should be improved.	Significant progress

7.11	Escalation pathways when senior medical staff are offsite must be clarified to ensure that doctors in training can escalate concerns at all times.	Significant progress
7.12	The practice of boarding overnight from front door to ARU5 must be reviewed to ensure patient safety.	Some progress
7.13	Clarity should be provided to trainees around the consultant responsibility for HDU patients OOH & at weekends to allow escalation to the right seniors.	Uncertain
7.14	IAU: Measures must be implemented to address the patient safety concerns associated with the lengthy delays between arrival and definitive assessment of GP referrals.	Little or no progress
7.15	Work must be done to eradicate the use of 'SHO terminology' by trainees. Consideration should be given to implementing the "SaynotoSHO" campaign.	Some progress
7.16	The allegations of undermining of junior trainees must be investigated and if confirmed, must be addressed.	Little or no progress

4.3 Aspects that are working well:

- Engagement - we commend the engagement of site leads, clinical and non-clinical managers, and consultant trainers in improving the educational environment.
- Opportunities to learn – all trainees felt that they could progress and achieve their curricular requirements. Trainees describe a good case mix and volume of work.
- Approachable, accessible and supportive consultants.
- Escalation pathways – there is clarity around escalation pathways, and innovation with the introduction of the 'contingency consultant' role.
- Response to concerns – we noted responsiveness to concerns including to previous requirements but also those raised via other channels such as the Junior Doctor Forum – examples of resulting actions include: the 'ward response doctor' role, and rostering of

clinics (although not universal across all general internal medicine specialties). See comment on Datix in section 4.4 below.

- Pods function in way that delivers feedback to trainees (FY and CMT) on their management of acute medical cases within the receiving unit. Trainees recognise this as an opportunity to undertake ACAT assessments and this is proactively supported by consultants.
- The acute medical receiving opportunities for CMTs provide excellent feedback and learning opportunities.
- Dr Toolbox app.

4.4 Aspects that are working less well:

- Safety, volume and flow of the IAU, concerns recognised by NHS Greater Glasgow & Clyde.
- Lack of handover of patients from the emergency department to the pods – trainees provided concrete examples of unwell patients whose care was significantly delayed and was not felt to be appropriately managed as a consequence.
- Workload for medical staffing at weekends – in particular on the 8th floor.
- Variable provision of phlebotomy services.
- Rota gap management - particularly around known long-term gaps.
- Datix - lack of training and scarce feedback on Datix cases.
- HDU – inconsistent named consultant support.

4.5 Overall satisfaction

All groups of doctors were asked to rate their overall satisfaction' with their placement and the average scores are presented below:

FY1:	Range = 5 - 9, Average = 6.5 out of 10
FY2:	Range = 6 - 7, Average = 6.8 out of 10
GPST:	Range = 4 - 7, Average = 6.6 out of 10
CMT:	Range = 6 - 8, Average = 6.8 out of 10
ST3+:	Range = 4 – 7, Average = 5.5 out of 10.

4.6 Overall conclusion

The site remains on Enhanced Monitoring. Following discussion, the Deanery awaits clarification around the GMC's response to the ongoing safety issues in relation to the IAU.

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

5. Areas of Good Practice

Ref	Item	Action
5.1	Introduction of the 'contingency consultant' role.	None
5.2	Ward response doctor role	None
5.3	Dedicated boarders' team	None
5.4	Pods function in way that delivers feedback to trainees (FY + CMT) on their management of acute medical cases within the receiving unit. Trainees recognise this as an opportunity to undertake ACAT assessments and this is proactively supported by consultants.	None
5.5	Dr Toolbox app.	None

6. Areas for Improvement

Ref	Item	Action
None		

7. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
7.1	Measures must be implemented to address the ongoing patient safety concerns in relation to the IAU, described in this report (see also requirement 7.14 from 2018 visit).	Ongoing priority	FY, GPST, CMT, ST
7.2	A process must be put in place to ensure that any trainee who misses their hospital induction session is provided with an induction.	22 November 2019	FY, CMT
7.3	The burden of tasks for all cohorts of doctors in training that do not support educational or professional development and that compromise access to formal learning opportunities must be significantly reduced. The provision of phlebotomy must be improved.	22 November 2019	FY, CMT, ST
7.4	The scope of the ward cover and the associated workload overnight and at weekends must be reduced as currently they are not manageable, safely. This is generally an issue – but also 8 th Floor has particular issues in this regard.	22 November 2019	FY
7.5	The medical staffing of the IAU overnight must be sufficient to ensure these staff have a safe and manageable workload that enables them to provide quality care to their patients.	22 November 2019	ST
7.6	Alternatives to doctors in training must be explored and implemented to address the chronic gaps in the rota that are impacting on training.	22 November 2019	FY, GPST, CMT, ST
7.7	Consistent and appropriate clinical supervision of middle-grade doctors in training in HDU must be provided at all times.	22 November 2019	CMT

7.8	A process for providing feedback to doctors in training on their input to the management of acute cases must be established.	22 November 2019	ST
7.9	Handover of care of patients transferred from the ED to Pods must be introduced to support safe continuity of care and to ensure unwell patients are identified and prioritized.	22 November 2019	CMT, ST
7.10	Work must be undertaken to ensure that trainees are supported to attend clinics and other scheduled learning opportunities without compromise because of service needs.	22 November 2019	GPST, CMT, ST
7.11	Trainees must know how to engage in use of the Datix system and receive feedback on Datix cases.	22 November 2019	FY, CMT, ST
Note that the work to address requirements listed in section 4.2 from the 2018 visit must continue to ensure these are resolved, and that resolution is sustainable.			