Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	22 May 2018	**Level(s)**	FY, CMT, GPST, ST3+
Type of visit	Re-Visit	**Hospital**	Forth Valley Royal Hospital
Specialty(s)	General Internal Medicine	**Board**	NHS Forth Valley

Visit panel	
Professor Alastair McLellan	Visit Chair - Postgraduate Dean
Dr Reem Al-Soufi	Associate Postgraduate Dean – Quality
Dr Caroline Whitton	Foundation Representative
Dr Alison Garvie	GPST Representative
[Name Redacted]	Lay Representative
Heather Stronach	Quality Improvement Manager

In attendance	
Mr Alex McCulloch	Quality Improvement Manager (Shadowing)
Ms Patriche McGuire	Quality Improvement Administrator

Specialty Group Information	
Specialty Group	Medicine
Lead Dean/Director	Professor Alastair McLellan
Quality Lead(s)	Dr Reem Al-Soufi Dr Stephen Glen

	Dr Alan McKenzie	
Quality Improvement Manager(s)	Heather Stronach and Alex McCulloch	
Unit/Site Information		
Non-medical staff in attendance	4 non-medical staff	
Trainers in attendance	11 consultants	
Trainees in attendance	38 trainees	14 FY, 9 CMT, 6 GPST, 9ST
Feedback session: Managers in attendance	Director of Medical Education, Medical Director of NHS Forth Valley and Service Managers	

Date report approved by Lead Visitor	29th May 2018 

1. Principal issues arising from pre-visit review

Medicine at Forth Valley Royal Hospital (FVRH) was last visited by the deanery on 28 February 2017 to follow up on areas of improvement identified at the previous visit on 24 May 2016. (The May 2016 visit was part of the deanery's five year "scheduled" visiting programme, whereby all units delivering medical training are visited by a deanery panel).

In 2017, the visit panel identified the following requirements:

1) Working Hours/Workload
    - Rota/ timetabling management must be addressed to: eliminate frequent and short notice movement of trainees away from their base ward; give several weeks advance notice of rota shifts; and be designed to ensure equity of work demands within each cohort.
    - Each cohort of trainees must have regular opportunities to input to improving rota planning & management with appropriate senior support.
    - The rota coordinator must be accessible & communicate effectively with all those impacted by rota issues. There must also be appropriate and timely response to trainee's rota concerns.
2) Induction
    - Induction must be available to all trainees.
    - Induction must ensure trainees understand how to manage key cases and seek advice out of hours.
3) Adequate Experience
    - The volume of routine tasks undertaken by FY1, that support neither educational nor professional development, continues to be a barrier to accessing training and must be reduced.
    - Access to opportunities for FY2s, GPSTs, CMTs and ST3+ trainees to actively participate in an appropriate number of out-patient clinics continues to be an issue; these opportunities must be consistently provided within the different cohorts of trainees. For CMTs there is a mandatory curricular target number that must be facilitated. Active allocation of trainees to clinics should be developed.

4) Formal Teaching
    - There must be active planning of attendance of doctors in training at teaching (including bleep-free attendance) events to ensure that workload and rest days do not prevent attendance at local or regional teaching events.
5) Undermining
    - All staff must be encouraged to behave with respect toward each other and conduct themselves in a manner befitting Good Medical Practice guidelines, particularly in the Acute Assessment Unit and at morning handover.

The Director of Medical Education (DME) provided an action plan responding to the above requirements.

The 2018 visit panel will consider whether improvements have been made, and whether concerns remain about the training environment.

The below table indicates areas that may require improvement according to trainee responses from the most recent data sources:

- NTS = National Training Survey (2017)
- PVQ = Pre-Visit Questionnaire (2018)
- STS = Scottish Training Survey (2018)

Issue	**Foundation**	**Core**	**GPST**	**ST3+**
Adequate Experience	NTS	NTS, STS		NTS
Clinical Supervision +OOH	NTS	NTS	NTS, PVQ	
Feedback	PVQ	PVQ		
Handover	STS, PVQ	PVQ		
Induction	PVQ	NTS, PVQ	NTS	
Patient Safety	PVQ		PVQ	
Teaching (formal)	PVQ	STS, PVQ	NTS, PVQ	NTS
Workload/Working Hours	PVQ		PVQ	
Study Leave	PVQ	NTS		
Supportive	PVQ		PVQ	
Environment/Undermining	PVQ			
Learning from adverse incidents	PVQ			
Educational Governance	NTS		NTS	
Overall Satisfaction	PVQ	NTS	PVQ	

2. Introduction

FVRH has 25 wards, 16 operating theatres and 4000 rooms with 860 beds/day care spaces. The Hospital provides a wide range of inpatient, outpatient and day services including critical care (high dependency and intensive care services), cardiology, medical services, renal unit, oncology (cancer) unit, and an ambulatory care (endoscopy, day medicine services and day surgery) day unit. FVRH is supported by four community hospitals, in Stirling, Falkirk, Clackmannanshire and Bo'ness to provide an integrated network of care across Forth Valley.

This report is compiled with direct reference to the General Medical Council's (GMC's) Promoting Excellence - Standards for Medical Education and Training. Each section heading includes numeric reference to specific requirements listed within the standards.

3.1 Induction (R1.13)

Trainers

Trainers receive good feedback from trainees on induction. Copies of the slide content are accessible online afterwards. The induction handbooks for acute medicine and for geriatric medicine are available on the shared drive.

Trainees starting on nights receive a separate induction. Where possible, the rota is organised so that a trainee with previous experience at FVRH begins on night shift. Trainees who are unable to attend induction are offered a separate face-to-face induction session. FVRH offers trainees some aspects of induction (such as mandatory training on LearnPro) ahead of the commencement of training.

FY

All FYs received a site and department induction. They had access to good online training on the Picture Archiving and Communications System (the system used to access patient radiographs and CT Scans), 'Order Comms' & 'Sci Store'. Trainees appreciate the opportunity to refresh their clinical skills within the simulation centre during the first week of shadowing before going onto the wards.

During induction trainees were split into groups to introduce them to receiving, to medicine and to surgery. They suggested a potential improvement would be a session including all three elements to provide an overview of how the hospital works.

One trainee started on nights in receiving and had a tailored induction and felt well supported by colleagues.

CMT

All CMT trainees received both a site and departmental induction. Trainees said induction could be improved by:

- Clarity around what counts as clinic experience in the context of mandatory target numbers and, in particular, whether 'day medicine' can count towards clinic numbers (the CMTs reported differences in perception as to whether 'day medicine' can count or not, depending on whether they were East of Scotland or West of Scotland trainees).
- Improved information about roles and responsibilities within 'day medicine'.
- Improved information about handover (where it is and what you do).
- Better information about out of hours for the whole hospital (for example, how to escalate matters).

GPST

All GPs received both a site and department induction. LearnPro mandatory modules were completed ahead of the first day of work. GPST trainees were particularly impressed that the Medical Director was present at induction; they felt valued that he took time out of his day to attend and it 'was nice to put face to name'. One GPST who started on nights received a 'catch up induction' 1 month after starting in post. A trainee who had worked at FVRH previously as a foundation trainee was not permitted to attend the induction but reported that it would have been helpful to have done so to refresh awareness. GPST trainees had a departmental 'walk around' that was helpful.

ST

ST trainees also received both a site and department induction. The trainee who started on night shift received a one-to-one version of induction. There was a pre-employment meeting

where ID badges were distributed in advance of starting. IT systems were introduced on the first day of work and those trainees scheduled to be on call received a separate IT session before starting work to ensure they were set up on the system and ready to commence clinical duties. Some trainees only had access to computer systems training 2–3 weeks after having started work.

All trainees thought that department induction was satisfactory. The only suggestion for improvement was around roles and responsibilities regarding what falls under the category of 'medicine' as this can differ across Heath Boards.

Non-Medical Staff

Non-medical staff thought induction for trainees was thorough and included IT and prescribing systems on the first day. As a safety net, nurse practitioners are not permitted annual leave within the first 2 weeks of new trainees starting at FVRH.

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

Trainers

Trainers described a suite of teaching available at FVRH including:

Monday	Medicine Division 'Grand Round' meeting (all grades)
Alternate Tuesdays	Medicine teaching across the whole hospital (Mortality and Morbidity meetings, or Quality Improvement projects presented by trainees)
Wednesday	AM - Mandatory FY2 teaching (bleep free) PM – Teaching session for CMT and ST trainees Palliative Medicine teaching (weekly)
Thursday	Mandatory FY1 teaching (bleep free)
Friday	Ageing Health teaching

Trainers told that panel that:

- Foundation trainees attend the teaching programme available at FVRH listed above. Teaching is mapped to the foundation programme curriculum.
- GPST trainees attend regional teaching but must advise appropriate colleagues at least 6 weeks in advance by email (to ensure the base ward has appropriate cover).
- CMT trainees are expected to attend regional teaching delivered by video link (trainees on annual leave or on call are not expected to attend). Time for regional teaching is included in their rota. An email is sent reminding trainees of teaching sessions taking place. Unfortunately, there were problems with the video link at the start of the training, but these technical issues are now resolved.
- A variety of specialty-based teaching is also available.[1]
- All trainees have access to the simulation centre.
- Most consultants are Membership of the Royal College of Physicians (MRCP) Practical Assessment of Clinical Examination Skills (PACES) examiners and trainees can seek help preparing for the PACES examination, if desired.

FY

FY trainees described the weekly FY teachings tabled above and confirmed that attendance is bleep free. Trainees were interested in attending these sessions and said the quality of teaching is good, but the acute assessment unit (AAU) rota restricts their access to teaching. On average, trainees suggested they attend 1–2 hours per week of formal local teaching. Many FYs work within the AAU for 4 months and their access to teaching sessions is more limited (averaging 30mins per week).

CMT

CMTs said the quality of teaching is good. On average, they manage to attend just 1 hour of teaching per week due to the rota. CMTs could access their regional core medicine education programme (CoMEP) training by videoconference, with trainees reporting having been able to access 3, 5 or 7 of 9 sessions so far.

[1] This report focuses exclusively on general internal medicine.

GPST

GPSTs manage to attend just 0–15 minutes of teaching per week. Consistent with the other cohorts interviewed, GPST trainees described ward pressures and lack of staff/rota impeding their ability to attend teaching.

GPST trainees said they have no time to return to their usual GP practice. If they wish to do this, they need to do it in their own time.

GPST trainees suggested it would be helpful if regular (weekly) email communication is sent advising what teaching sessions are scheduled to take place each week.

ST

Trainees described the teaching sessions tabled above. They also told us about consultant led Monday morning grand ward rounds; however, average attendance is around 5 in 45 weeks because these are scheduled on Mondays and shift patterns affect a trainee's ability to attend Mondays. Trainees further described variable attendance at ST teaching on Wednesdays. On average, STs attend once every 2–3 weeks. Estimated actual attendance at formal educational meetings 30 mins–1 hour per week for this cohort.

Average attendance at regional teaching was 3–4 teaching sessions, about 50% of total available.

Non-Medical Staff

The advanced nurse practitioners (ANPs) hold the bleep for trainees. 'Backdoor' teaching is not as well protected as it relies on nurses informing other nurses that teaching is taking place (to prevent interruptions). There are no posters to show that teaching is taking place.

3.3 Study Leave (R3.12)

Trainers

There are no challenges in supporting study leave.

Trainees

Trainees across all cohorts were all granted the study leave they had requested.

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

Trainers

Trainers told us that the education lead with the postgraduate education manager allocate supervisors for all new trainees starting in post. If a consultant leaves, a new supervisor is allocated for the trainee. FVRH advises trainees who their supervisor is on day one of training.

If there are concerns about the performance of a trainee, the designated clinical supervisor will feed back to the educational supervisor who will formally share this with the trainee. An interim meeting is set and any discussion and targets are documented on eportfolio. If required, support can be requested from the Medical Educational Services at FVRH.

If existing concerns are known about a trainee who requires additional pastoral support, the educational supervisor of this trainee would not be assigned any other trainees to ensure that the additional support can be provided.

All supervisors have undergone the formal ‘Recognition of Trainers’ approval process and have time (0.25%) allocated in their job plans to provide supervision. Their educator role (and any requirements in this regard) is formally reviewed at appraisal.

FY

All FYs had met with their educational supervisor. They did not raise any concerns about supervision.

CMT

All CMT trainees had met with their educational supervisor (on average 4 or 5 times since starting post).

GPST

GPST trainees said they had met with their hospital based supervisor 1 or 2 times. One trainee's clinical supervisor is not based on the same ward as the trainee.

ST

ST trainees had all formally met with their educational supervisor (on average 4–5 times).

Non-Medical Staff

Non-medical staff volunteered that the AAU is well supported. There is a consultant and acute physician available 7 days a week from 8am to 8pm.

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

Trainers

All trainers understand their supervisory and curriculum requirements for general medicine. Trainees get a good breadth of acute medical experience. Trainees move from their base ward to another ward if there is need, but this has been substantially reduced since the last deanery visit. The rota team works together with trainees to avoid short term rota shifts; however, there has been many vacancies (some at short notice) in the last 6 months, and this has negatively impacted on training resulting in short notice rota changes and infrequent access to outpatient clinics for trainees.

For trainees in craft specialties with a set target number for procedures – these needs are highlighted early after starting and are factored into their training. An example of how the rota is tailored to support these needs is where there are ST5 trainees (or more senior) in craft specialties such as gastroenterology or respiratory – two such trainees will share a line on the general rota.

'Day medicine' is a known issue. It tends to be staffed with middle graders but is moving to become ANP-led. The services it provides include the DVT service, for the administration of biological therapies and endocrine investigations. A CMT will spend 3 brief blocks of 1 week duration per year here. There was reported to be immediate access to patient's own consultants when required.

FY

FYs considered working within medical receiving gave them good exposure and experience; they would have no problems achieving their curriculum outcomes.

Attending clinics was raised as an issue for FY2s - with trainees attending just one outpatient clinic within the last 4 months. FYs said writing discharge letters was an administrative burden in some wards and of no educational value, but that in other wards ANPs help with this task. There is also variable support from the wider health team within wards (for example, phlebotomy services were available at weekends for half of the medical wards, but not the other half where this became the responsibility of trainees).

CMT

Trainees described A12 as an exemplary ward in terms of providing an excellent training experience. In A12 trainees are expected to attend clinic. On most other wards attending clinic was challenging (on average, most CMT trainees had attended 7 clinics since August (excluding clinic experience whilst on A12) but numbers ranged from 6 or 7 to 24.

Trainees find it difficult to obtain experience in some practical procedures, for example, pleural aspiration and CV lines. The simulation centre has been used for a ('non-essential') knee aspiration scenario, but no other training has been offered using the simulation centre.

In the last 6 months trainees felt that the balance between time spent developing as a doctor and other activity of little or no educational benefit has shifted to the latter.

GPST

GPST trainees are based at FVRH for 6 months. GPST trainees describe limited, to no experience at all, in acute medical receiving. This makes it difficult to achieve specific assessments, such as mini-CEXs and CBDs. GPSTs felt that acute medical receiving is reserved for CMT trainees. If they require 'front door' experience, GPST must try and arrange this for themselves by swapping shifts. During night shifts GPST trainees cover the 'back of the hospital'. GPSTs have escalated the matter to the rota committee, but are unaware of any outcomes.

GPST trainees would like time scheduled in their rotas to attend clinics. (On average, GPST trainees had attended 0–1 clinics).

GPSTs described the weekend ward shifts as challenging, but felt that such shifts provided useful experience because they are required to make senior decisions.

ST

STs were all able to achieve the required competencies for general internal medicine. Trainees reported that rota gaps are impacting on attendance at clinics (less than 1 clinic per month). Trainees reported that 90% of their work was based on non-educational service-oriented tasks.

Non-Medical Staff

Non-medical staff described the FY induction and use of the simulator. Nurses contribute to the learning of doctors on an ad hoc basis via verbal feedback, and sign off certain procedures.

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

Trainers

Trainers understand what assessments are required for training. Trainees are encouraged to approach seniors directly to complete assessments. The acute care assessment tool (ACAT) is difficult to achieve by trainees, and consultants have developed a protocol to assist trainees to achieve ACATs called the 'ACAT cold debrief'. Some direct observation of procedures (DOPs) were also difficult to achieve: examples given were pleural procedures (increasingly carried out respiratory medicine), ultrasound (requires a level one trained sonographer to be present in addition to a clinical supervisor) and central venous lines. In the interim, the proposed solution is that trainees undertake such procedures using the clinical skills lab or with supervision from anaesthetic colleagues, until the implementation of the new internal medicine 1–3 curriculum.

FY

Trainees described that DOPs could be more difficult to obtain on the wards where no clinical procedures are undertaken and there is low turnover (in contrast to acute medical receiving where there are plenty of opportunities to have procedures observed). FY2s spend more time on the wards than in acute receiving, hence the difficulty.

CMT

Trainees said they would manage about 10 patients, on average, per night, and perhaps about 100 per block. They estimated receiving feedback on only 5% of these patients, and out of those that had managed to get feedback, it tended to be in the context of the novel 'ACAT cold debrief'. Some had received no feedback at all on the cases they had managed.

GPST

See 3.5.

ST

ST trainees mentioned the same issues as described previously in this section. They also estimated receiving feedback on only 5% of the patients they had managed through medical receiving.

Non-Medical Staff

Non-medical staff contribute to assessments primarily via the multisource feedback tool.

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

Trainers

Trainers told us that multidisciplinary team (MDT) meetings take place on almost a daily basis, and also described the 'morning huddle' as an example of multi-professional learning.

FY

FYs suggested the morning handover at A12 was an opportunity for multi-professional learning as there was pharmacy presence. Nurses attend teaching sessions within ageing health. There are no other joint teaching sessions involving the wider multi-professional team.

GPST

GPSTs did mention the weekly MDT meetings on the ward, but told us they are simply too busy to obtain any form of formal multi-professional learning experience. They referred to their learning as 'learning by osmosis.'

ST

STs only achieve the bare minimum of workplace based assessments required for their curriculum. Trainees described the new ACAT protocol of making note of a list of patients seen and emailing these to the consultant for discussion (there is no opportunity to see these patients at the same time as consultants due to the volume of work). Trainees felt that they received little (less than 5%) formal feedback on their acute medical cases (section 3.6).

Non-Medical Staff

Non-medical staff told us that all staff are invited to teaching sessions, however nurses primary stay on the wards to ensure there is an adequate provision of care for patients.

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

Trainers

Quality improvement (QI) projects are available to those who wish to pursue them.

FY

FYs stated that QI projects are available to those who wish to pursue them.

CMT

As above. Trainees felt that due to time constraints, any QI project needs to be completed within their own time, but there are opportunities to undertake QI.

GPST

GPSTs said that QI projects are encouraged at induction and it is recommended that this is a collaborative exercise between FYs and GPSTs. Any project is self-directed. GPST trainees felt that structured support for QI projects is not available due to workload pressures.

ST

QI projects are available to those who wish to pursue them.

Non-Medical Staff

Non-medical staff have access to the rotas and can find out what level of training a trainee is at using the rota (although not all nurses were aware of this). Non-medical staff said that within out of hours it is not always apparent what training grade each doctor is – once you find out, it is much easier. Non-medical staff are not aware of any instances where trainees have had to cope with problems out with their competence, and said that two ANPs are available every night to support trainees.

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

Handover utilises a white board which identifies the level of training for each doctor to ensure trainees are working within their competence and experience. The training grade of each doctor is also written in the rota underneath each trainee's name. It was observed that the term 'senior house officer' (SHO) is still in use.

Trainers said each ward has a consultant attached to it and a 'weekly ward planner' shows who to contact when trainees require senior input. The switch board also hold this information. Who to contact out of hours is covered during induction, but the default position is to contact the consultant of the week. Trainers are not aware of any instances where trainees have had to cope with problems beyond their competence. Guidance is available in the intranet about seeking consent for procedures in which doctors are only competent to do so.

FY

FYs stated they always know who to contact both during the day and out of hours. Senior colleagues are very approachable and trainees had never had to cope with problems beyond their competence.

CMT

CMT trainees had variable degrees of contact with their educational supervisor, as some educational supervisors are based on the same ward as the trainee, whereas others are not. If a trainee's educational supervisor is based on a separate ward, trainees were not aware of a separate clinical supervisor being assigned.

GPST

An issue was reported during annual leave of a locum consultant – when there had not been formal provision of explicit cover and responsibility for his/her patients – leaving care entirely in the hands of the GPST and the foundation trainee.

On the occasions GPSTs do get to do a receiving shift, there is no post-receiving feedback on their cases to inform their learning.

In downstream wards their experience of going on ward rounds with their consultant to get feedback on their contributions to the management of their patients varies – with four consultant rounds per week in the stroke unit, and similar good opportunities in ID, but this is not consistent in all ward areas.

ST

STs always have access to clinical supervision and have never felt that they have had to cope with problems beyond their competence or experience. Senior colleagues were reported to be very accessible and approachable when asked for support.

The opportunities to conduct ward rounds with consultants varied – depending on the ward and staffing levels – but were very limited (see section 3.10).

Non-Medical Staff

Non-medical staff are aware of the rota gaps but consider the rota is much improved this year. (They reported that last year some trainees had finished a series of night shifts and were rostered to work on Tuesday morning after having finished night shift on the previous Monday morning). Weekends are particularly busy during daytime hours but nurses felt trainees were working well together despite the heavy workload caused by rota gaps.

3.10 Feedback to trainees (R1.15, 3.13)

Trainers

Trainers said that feedback is provided to trainees about decisions they make and treatments they plan during the day and out of hours through huddles. There is also a daily consultant

available to contact. Trainers acknowledged that feedback was lacking for trainees working within medical receiving.

FY

FYs described their primary roles as clerking patients, creating management plans, and writing discharge letters. Trainees do not routinely have the opportunity to present patients they have clerked to as a means of seeking feedback. There is no active feedback provided by seniors. At AAU, a quarter of trainees had received some sort of feedback but only because they had asked. FYs described senior trainees as a good source of support for advice and feedback when handling a difficult case over the weekend.

CMT

CMT trainees also said that no active feedback is provided by seniors in relation to the acute patients they manage, but that it is available if requested. Feedback is not always available on ward rounds (CMT trainees described reviewing one half of patients while the consultant concurrently reviews the other half with a FY trainee in ward A12 – but there was an opportunity to briefly run through cases afterwards). In A31 the trainees tended to conduct their own rounds, but there are two consultants now and this has improved. Care of the elderly wards are an exception where ward rounds are always consultant-led.

GPST

GPST trainees described the same experience as CMTs. They were no formal opportunities for feedback and they were not going on ward rounds. A comment was made that ‘FYs will learn a lot from GPST mistakes.’

ST

STs described regularly being called back to wards to carry out activities usually undertaken by a junior doctor. The opportunities to conduct ward rounds with consultants varied depending on the ward and staffing levels. In general, there were few opportunities to do ward rounds with consultants with one reporting having managed this on one occasion over the 9 months of this training year so far. Wards A12 and B32 were described as having good opportunities to discuss patients’ management with the consultants.

Non-Medical Staff

Non-medical staff felt that handover is more structured than previous years, with a set room and use of whiteboard with relevant numbers given for pagers. They also described the process of the weekend updated electronically on the shared drive.

3.11 Feedback from trainees (R1.5, 2.3)

Trainers

There is a weekly rota meeting and trainees from each training cohort are encouraged to attend. A trainee forum has also been recently implemented at FVRH and this is in its infancy.

FY

Trainees described the trainee forum and told us that it was open to all trainees. Only 3 of the FYs who met with the panel had attended. They described that work commitments impeded their ability to attend the forum. Trainees who had attended said that they were unsure whether the forum was formally minuted but that people who attended had taken notes. They were not aware of any action plans or results/outcomes from previous meetings.

CMT

CMT trainees also described the junior doctor forum in addition to the chief resident role. Examples of items brought to the junior doctor forum was A31 and day medicine. A31 had improved, as a consequence.

GPST

GPSTs said there is a suggestion box on the ward. They also said they could give feedback to the chief resident or provide feedback by attending the junior doctor training forum. However, trainees felt they never had the time to attend the forum, and unfortunately the last meeting clashed with a teaching session. GPSTs have taken the initiative to set up informal meetings between themselves. To date, they had only managed to meet once.

ST

STs held the view that the junior doctor forum was not really for them.

3.12 Workload/ Rota (1.7, 1.12, 2.19)

Trainers

The panel noted feedback from trainees expressing dissatisfaction about pre-determined annual leave within the rota (trainees were asked to rank their top 3 holiday preferences and this was scheduled accordingly). From August, the rotas will change so that this is no longer applicable.

Rotas are available on the shared drive and a weekly email is sent to consultants and trainees. A WhatsApp group was established to allow trainees to swap shifts if desired but this is not available now because there is no access to Wi-Fi. E-rostering had previously been considered and dismissed but there are plans to reopen this discussion. There is a new rota manager and this appears to be working well.

It was noted that CMT2s who had passed PACES can act up on the senior rota.

FY

FYs said the shortages in staffing resulted in them frequently changing wards (although this did not happen if they were the only FY on the ward). One trainee described having worked in three different wards within 1 week. FYs felt that the effect of rota gaps could impact on patient safety, especially out of hours where there is only one FY and one CMT covering the ward. FYs suggested the rota could be improved by increasing middle grade staff. Trainees talked about the rota meeting but felt it was only there 'to plug in gaps,' rather than to propose alternative solutions to effect change. Consultant support at these meetings was not always available.

CMT

Trainees said that annual leave and on call times were fixed on the rotas. They felt that this should be changed. Trainees did not feel that staffing shortages impacted on patient safety but felt that it was having a negative impact on their training.

GPST

GPSTs said that the hospital has been short staffed and they were aware of commitments to improve the rota by specific individuals who they felt were very approachable and fair with the rotas. However, this task was perceived to be very burdensome for the trainee involved.

Short term notice of rota changes still occurs frequently and one trainee described being asked to swap shift while on annual leave (this was felt to be a problem as you should not be expected to respond to work emails whilst on annual leave).

Trainees further stated that every out of hours shift has been understaffed and so trainees must prioritise acutely unwell patients. They felt that the hospital environment provides very few learning opportunities compared to their practice, and morale amongst trainees is low.

ST

STs said their workload is heavy, that it can be very busy at 6pm, and nights can be chaotic. Some patients had to wait a long time before they were reviewed.

3.13 Handover (R1.14)

Trainers

The front door has 8am and 8pm consultant-led handovers. There is also a 4:30pm handover led by CMTs. There is a weekend handover on Fridays.

Ward rounds start at 9am and are consultant led. There is a document on the shared drive that trainees can use to input any concerns about patients they have seen over the weekend to be discussed at the Monday morning handover.

FY

FYs reported that handovers were effective in passing on information about sick patients.

CMT

CMT trainees felt that handover provided an opportunity to learn and was effective in ensuring safe patient care.

GPST

GPST felt that handover was good. Handover could be improved by making introductions mandatory as GPSTs sometime have difficulty knowing who is who (they also suggested that coloured badges could be helpful). They further offered that STs miss front door handover as they are on the back door (and GPST trainees consider that this should be the other way round).

ST

Front door and back door handover happen at the same time. The expectation is that the middle grades will inform the registrar of any need to know information arising from the acute receiving handover. STs felt that handover is not used as a learning opportunity.

3.14 Educational Resources (R1.19)

FY

FYs described the library and the library computers. Only five trainees had used the library resources as they were too busy on the wards to regularly access the library.

CMT

CMT consider that the library suite is good. CMTs suggested that rooms on the wards with dictaphones would be beneficial. The absence of Wi-fi was reported to be an issue.

GPST

GPST trainees do not use the hospital library. Some reported that the library has good resources for preparing for exams. GPSTs reported on the absence of Wi-Fi and phone reception.

ST

STs were happy with the educational facilities, although were also frustrated that there was no Wi-Fi access available at the hospital.

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

CMT, GPST, ST

CMTs described the postgraduate office as a useful point of contact. They felt there is good support from the educational supervisor, good support out of hours and that all consultants are approachable and friendly. This was also reflected by a less than full-time trainee.

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

Educational governance has been improved since the last deanery visit. As previously outlined in this report, trainee representatives from each cohort are now included in the rota team.

A short life working group (SLWG) has been set up to discuss educational matters and set targets to improve education and training at FVRH. This SLWG meets monthly and comprises the assistant postgraduate dean, DME, medical director, general manager, and trainers. A current example of a target achieved by the SLWG is funding approval for the appointment of locums and 11 Clinical Development Fellows to relieve the burden of tasks on trainees.

There is a QI Training Initiative in progress, but this is in its infancy.

FY

FYs are not aware how the quality of educational and training is managed at FVRH. If they had any concerns about their training, they would raise it with their educational supervisor.

CMT

Trainees described a disagreement between senior hospital management and trainees about the management of patients over the winter period. CMTs felt decisions were being made on their behalf without their input. This was raised with the chief resident and discussions are ongoing. Trainees have also raised the idea of having a mess area.

Trainees are aware of the new DME appointment and seem to have a good understanding of how educational governance works within the hospital. Trainees further mentioned the trainee

forum, noting lack of engagement from trainees in other specialties. They also felt it was unfortunate that the last meeting was scheduled at the same time as a teaching session.

GPST

GPSTs are not aware how the quality of educational and training is managed at FVRH.

ST

STs were not aware of the educational governance structure. Trainees were aware of the chief resident – a position that has been in place for only a couple of months. Current themes with the chief resident, in addition to a trainee mess area, are: driving trainee experiences in management, and a trainee celebration night. Trainees consider that the chief resident's role and educational governance activities could be better advertised. Their perception was that service-training leads were swift to act to respond to issues.

3.17 Raising concerns (R1.1, 2.7)

FY

FYs reported that if they had a concern about patient safety they would raise it via appropriate channels (with senior colleagues or nursing staff subject to the nature of the concern). If they had major concerns they would bring this to the attention of their educational supervisor.

CMT

CMT trainees would raise training concerns to their chief resident and patient concerns with the consultant or educational supervisor. Of those who had raised concerns, all had received appropriate feedback.

GPST

GPST trainees said they would speak to consultants.

ST

STs described the same processes at FY and CMT trainees.

Non-Medical Staff

Non-medical staff described raising concerns with the charge nurse or a consultant dependent on who they felt it was most appropriate to raise the concern to. They said that there is a safety huddle in AAU each week.

3.18 Patient safety (R1.2)

FY

FYs felt that boarded patients do not receive the same standard of care as those on their own ward. Some consultants routinely review their boarded patients whereas others do not and must be reminded by trainees – some patients had been known to go a week without seeing a consultant. FYs described boarded patients in wards 6 and 8 receiving suboptimal experiences. Patients can be boarded directly from acute receiving and some lack consultant review.

CMT

As above. Trainees felt there was no clear procedures about boarded patients and who is responsible for their care. Many described that the expectation is that boarded patients would be looked after by middle grade doctors, however there is no consistency on how boarded patients are managed. Inpatients can go for a week without consultant review.

GPST

As above.

ST

STs reflected their perception of an ‘exceptionally poor patient experience’ during the winter pressures of last winter (but it was acknowledged this was a NHS-wide issue). They noted issues relating to delays in the assessment of patients, discontinuity of care, movement of patients including boarding, and boarding from the front door. Ward A31 had been a particular concern but the issues have been addressed through the appointment of two new consultants.

3.19 Adverse incidents (R1.3)

Trainers

Trainees are encouraged to submit an IR1 form. Trainers advised that IR1 forms are formally discussed by hospital management. There are M and M meetings that trainees can attend.

FY

FYs were aware of the IR1 form for reporting adverse incidents, although trainees said there was no demonstration on how this is done or what the form looks like.

Five FYs had submitted an IR1. Most trainees only received an automated email stating that the incident was closed and they did not receive any feedback about the outcome of their IR1 submission as a learning opportunity. Only one trainee had received some other form of feedback about the incident they had raised.

CMT

CMT trainees also described the IR1 form. No one had received training but they advised that information is available on the intranet and completing the form is straightforward. Feedback was given to those who had raised an IR1.

GPST

GPST also mentioned the IR1 but stated that it ‘disappears into the ether.’ There had been no induction to IR1s and no training in its use. One of 3-4 who had submitted IR1s, one had received feedback relating to their submission.

ST

As above.

Non-Medical Staff

Non-medical staff were aware of the IR1 system.

3.20 Duty of candour (R1.4)

All cohorts of trainees and non-medical staff felt they would be supported if they were involved in an incident where something went wrong. This item was not discussed with trainers.

3.21 Culture & undermining (R3.3)

All cohorts of trainees felt that FVRH is a supportive work environment and all senior colleagues are very approachable and helpful. Some trainees mentioned an isolated incident but this had been addressed effectively. They reported they were able to raise concerns and felt supported.

Non-medical staff advised the panel of ‘cake Fridays’ to support a positive working environment.

4. Summary

The visit panel acknowledged that there were several initiatives underway to improve the training environment at FVRH. Action has been taken to address the requirements identified by the last visit panel: many of these are still in their infancy and for some the solutions are yet to be implemented. The feedback from trainees highlighted that their training has been impacted by workload/rota gaps, but they feel well supported by an approachable body of trainers. The persistence of significant concerns over a prolonged period prompted consideration as to whether there would be benefit in escalating to the GMC’s enhanced monitoring process, but it was the view of the panel that that would not be beneficial currently, given the commitment to improve, the investment in a significant cohort of Clinical Development Fellows (from August 2018) and the appointment of a new DME. A further visit will, however, be necessary to review the impact on the ongoing requirements.

All group of doctors were asked to rate their overall experience of their placement and the average scores are presented below:

Foundation: range 5-9, average 6.5 out of 10

Core: range 4-8, average 6 out of 10
GPST: range 4-5, average 5.8 out of 10
ST3+: range 2-9, average 5.5 out of 10.

Aspects that are working well:

- Keen and engaged group of consultants who were universally reported as being very supportive.
- Engagement of 2 x 'chief residents' to support improvements.
- Personal engagement of the medical director in the hospital induction programme for the doctors in training, reflecting value to the organisation of doctors in training.
- The 'junior doctors' forum' (JDF) and the engagement of the medical director. Attendance of trainees at the JDF is a potential weakness.
- Mandatory bleep-free FY1 & FY2 teaching.
- The ageing & health team's commitment to teaching / training, an example being the support of trainees' attendance at the Friday teaching session.
- Ward A12 was commended as an example of a training environment with strong commitment to teaching and training.
- Responsiveness to trainees' concerns resulting in a number of initiatives to address these.
- The commitment and investment of resources to support the appointment of a cohort of 11 Clinical Development Fellows (in post from August 2018).
- Provision of a good range of formal teaching meetings – although, in practice, access to these teaching sessions is challenging for all cohorts of trainees – see below).

Aspects that are working less well:

- Absence of timely feedback to all cohorts of doctors in training to inform their learning in relation to:
    a. The trainees' management of acutely unwell patients (whether the patients were seen by day or overnight), post-take, (estimates suggest that feedback is at best provided on less than 5% of the patients they assess and manage), and

b. Ward rounds not being conducted consistently with consultants in the medical wards, thus preventing feedback opportunities (FY2s-ST7s typically miss out on feedback and learning from consultants because of the current ward round arrangements).

- The training of GPSTs is particularly poor – because of the minimal exposure to acute medical receiving opportunities and the near absence of outpatient clinic opportunities.
- Discontinuity of base-ward attachments of trainees (likely to have been exacerbated by rota gaps).
- Rota design – and the lack of differentiation among FY2s, GPSTs, CMTs and ST3+ trainees in relation to ward commitments.
- Lack of outpatient clinic opportunities for FY2s, GPSTs (as referred to above), CMTs and ST3+ trainees. *Some CMTs seem to have accrued acceptable numbers but this seems to reflect the 'counting' of 'day medicine' sessions, around which there was reported to be inconsistency – clarity will be provided from the deanery on what should count*.
- Absence of Wi-Fi access.
- Burden of non-educational administrative tasks for FYs.
- Lack of attendance of trainees at the JDF.
- While the provision of good formal teaching opportunities is commendable – the ability of doctors in training to attend these is minimal - with estimated average weekly attendance at formal teaching ranging between 0– hr (max) per week.
- Use of SHO terminology, by the doctors in training, in particular.

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

5. Areas of Good Practice

Ref	**Item**	**Action**
5.1	ACAT cold debrief – as a partial solution to supporting the provision of ACATs.	
5.2	Engagement of the medical director in the induction programme for doctors in training,	

	reflecting the value placed by the organization on its trainees.	

6. Areas for Improvement

Ref	Item	Action
6.1	The junior doctor forum should be promoted and trainees should be supported to make this a more effective means of engagement between doctors in training and senior medical and education leads.	
6.2	Trainee input to support rota management by others (rota manager and consultant/s) should involve more than one trainee.	

7. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
7.1	Feedback to all levels of trainees on their management of acute medical receiving cases must be provided to inform their learning and training (aiming for this in at least 40% of the acute medical caseload).	6 months	FY, GPST, CMT, ST3+
7.2	Ward rounds in downstream wards must provide feedback to trainees on their management of medical inpatients.	6 months	FY, GPST, CMT, ST3+
7.3	The training opportunities provided to GPSTs must be tailored to their needs – and must provide significantly more opportunities to manage acute medical referrals and to manage patients in outpatient clinics, among other opportunities.	6 months	GPSTs

7.4	Doctors in training must have greater continuity of attachments to their base-wards to support continuity of patient care and of supervision.	6 months	FY, GPST, CMT
7.5	The rota must provide opportunities that reflect differences in seniority among trainees.	6 months	ST3+
7.6	Outpatient opportunities must be accessible to all trainee cohorts from FY2 and above, and must enable CMTs to meet the target numbers.	6 months	FY, GPST, CMT, ST3+
7.7	Wi-fi must be provided to support the learning needs of doctors in training.	6 months	FY, GPST, CMT, ST3+
7.8	The burden of non-educational administrative tasks performed by foundation trainees must be reduced.	6 months	FY
7.9	Doctors in training of all grades must be enabled to attend the (good) range of formal locally provided education meetings.	6 months	FY, GPST, CMT, ST3+
7.10	The efforts to eradicate use of ‘SHO terminology’ must include use among the doctors in training themselves.	6 months	FY, GPST, CMT, ST3+, all staff