Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	9th November 2023	**Level(s)**	Foundation, Core, Specialty
Type of visit	Revisit	**Hospital**	Inverclyde Royal Hospital & Royal Alexandra Hospital
Specialty(s)	Trauma & Orthopaedics	**Board**	NHS Greater Glasgow & Clyde

Visit Panel	
Dr Fiona Drimmie	Visit Chair – Associate Postgraduate Dean (Quality)
Dr Myles Connor	Training Programme Director
Dr Robert Laing	Foundation Programme Director
Dr Joshua Newmark	Trainee Associate
Mr Bill Rogerson	Lay Representative
Mrs Jennifer Duncan	Quality Improvement Manager
In Attendance	
Mrs Gaynor Macfarlane	Quality Improvement Manager

Specialty Group Information	
Specialty Group	Foundation
Lead Dean/Director	Professor Alan Denison
Quality Lead(s)	Dr Fiona Drimmie & Dr Marie Mathers
Quality Improvement Manager(s)	Mrs Jennifer Duncan
Unit/Site Information	
Trainers in attendance	12
Trainees in attendance	10 (5-F1, 2-F2, 3-ST)

Feedback session: Managers in attendance	Chief Executive	0	DME	1	ADME	1	Medical Director	1	Other	20

Date report approved by Lead Visitor	27/12/2023 Dr Fiona Drimmie 09/01/2024 Professor Alan Denison

1. Principal issues arising from pre-visit review:

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

Following a Deanery revisit in March 2022 and subsequent SMART Objectives meeting and Action Plan Review meetings a number of concerns remain regarding Foundation training in Trauma and Orthopaedics at Inverclyde Royal Hospital and Royal Alexandra Hospital.

IRH, NTS Data (2023) - Combines General Surgery and T&O.
F1 Surgery – Pink Flag – Educational Supervision, Overall Satisfaction. Red Flags – Adequate Experience, Clinical Supervision Out of Hours, Rota Design, Teamwork.

IRH, STS Data (2023) – F1 only.
T&O – Foundation – All White Flags.
T&O – Foundation – Grey Flag – Discrimination.

RAH, NTS Data (2023) - Combines General Surgery and T&O.
F2 Surgery – Bottom 2% - Significantly low scores.
F1 Surgery – All White Flags.

F2 Surgery – Green Flag – Facilities.
F2 Surgery – Pink Flag – Educational Governance. Red Flags - Clinical Supervision, Clinical Supervision Out of Hours, Educational Supervision, Feedback, Handover, Overall Satisfaction, Reporting Systems.

RAH, STS Data (2023) – Combines F1 and F2.
T&O – Foundation – Pink Flags – Educational Environment, Equality and Inclusivity. Red Flags – Clinical Supervision, Handover.

The last revisit to Trauma and Orthopaedics at Inverclyde Royal Infirmary and Royal Alexandra Hospital was conducted on the 1st March 2022 where the following requirements were set:

- The unit handbook must be kept up to date to reflect changes to departmental processes.
- Trainees must receive adequate induction to all sites they cover out-of-hours to allow them to begin out-of-hours working safely and confidently.
- Initial meetings and development of learning agreements must occur within a month of starting in post.
- There must be active planning of attendance of doctors in training at teaching events to ensure that workload does not prevent attendance. This includes bleep-free teaching attendance. Trainees should not be expected to complete this teaching in their own time.
- The learning environment for Foundation trainees must be supportive and inclusive.
- There must be senior support, including from consultants/recognised trainers to enable doctors in training to complete sufficient WPBAs/SLEs to satisfy the needs of their curriculum.
- There must be regular Consultant ward rounds which review trainee decisions and care plans and offer constructive feedback & teaching.
- Foundation trainees must not be expected to work beyond their competence by delivering sensitive and complex information to patients and their families unsupported.
- All staff must behave with respect towards each other and conduct themselves in a manner befitting Good Medical Practice guidelines. Specific example of undermining behaviour noted during the visit will be shared out with this report.
- Handovers involving Foundation trainees must include senior input to ensure patient safety and learning opportunities.
- Handover processes must be improved to ensure there is a safe, secure and robust handover of patient care with adequate documentation of patient issues, senior leadership and involvement of all trainee groups who would be managing each case during the day and out of hours.
- Measures must be implemented to address the patient safety concerns associated with ad-hoc ward rounds and the clinical governance issues raised by inadequate record keeping.
- A process must be put in place to ensure that any trainee who misses their induction session is identified and provided with an induction.

At the pre-visit teleconference the visit panel agreed that the focus of the visit should be around the areas highlighted in the survey data, the previous visits requirements and pre-visit questionnaire.

Department Presentation:

The visit commenced with Ms Zoe Higgs, Ms Alison Winter and Ms Rosaline McKenna delivering an informative presentation to the panel. This provided detailed information on induction, handover, clinical supervision, patient safety and escalation, workload, educational environment and teaching and team culture and wellbeing. Which included new developments and challenges.

2.1 Induction (R1.13):

Trainers: Trainers reported that trainees receive a wide-ranging induction to both sites. A significant amount of work has been put into developing and improving induction since the last visit. They recognise the difficulties in providing vast amounts of information to trainees in a short space of time however elements of induction are now reinforced throughout the teaching programme and within the handbook. Information from induction is also available in different formats so trainees can access at any time. The handbook has been updated and there are plans to conduct an audit of induction to ensure the processes are taking place as planned.

Foundation Trainees: F1 and F2 trainees reported receiving induction to the department and both sites. They believe it equipped them to work in the department however noted difficulties in being provided with an overwhelming amount of information from various sources. F1 trainees in their first post can shadow in the department the week prior to commencing in post however it was noted that this did not include out of hours (OOH). Those F1 trainees who studied in Glasgow also undertake a preparation for practice block which involves 5 weeks of shadowing. F1 trainees would have found it useful to have had an induction to Medicine OOH in Royal Alexandra Hospital as they felt unprepared for this and were unsure where to go. F2 trainees would have appreciated details relating to when and where handovers take place over the day.

ST Trainees: Trainees reported receiving both site and departmental inductions which they consider equipped them well to work in the department.

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

Trainers: Trainers reported that core teaching for Foundation trainees is protected and bleep free. Sessions are within the rota, so ward staff are aware, and clinical fellows (CFs) help support attendance. Training days for ST trainees are also detailed within the rota with suitable cover provided. Trainees also attend departmental teaching which is mapped back to the curriculum and trainees have been asked to highlight areas they would like included in sessions. Departmental teaching is not always recorded however feedback on topics and opportunities to obtain case-based discussions (CBDs) has been positive.

Foundation Trainees: F1 and F2 trainees described attending one hour of departmental teaching which is of good quality and relevant to their level of training. They commented that no cover is provided for teaching sessions and that they may be called back to the ward if required. They raised no concerns in attending core teaching sessions as cover is easier to provide for these sessions.

ST Trainees: Trainees reported regularly attending weekly metal work meetings, monthly journal clubs, monthly morbidity and mortality meetings (M&M) and audit presentation sessions. Theatre time can prevent attendance at teaching however this is only occasionally and when the educational value of being in theatre is greater. They also confirm being able to attend regional teaching which is requested via study leave.

2.3 Study Leave (R3.12)

Trainers: Trainers reported no concerns in supporting study leave and have received no feedback from trainees raising any issues.

F2 Trainees: Trainees reported having requests for taster weeks and mandatory ALS courses declined by the rota co-ordinator.

ST Trainees: Trainees reported no difficulties in accessing study leave.

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

Trainers: Trainers reported that all educational and clinical supervisors are given adequate time within job plans and generally feel very well supported by the Department of Medical Education. Several have attended the NHS Education for Scotland's Recognition of Training course. Should the department be allocated a trainee requiring additional support information would be provided via the training programme director (TPD) and trainee portfolio. They liaise with previous supervisors to ensure previous support is carried forward.

Foundation Trainees: Trainees confirmed having designated educational supervisors, who they have meet once so far in post. They found organising initial educational supervisor meetings straightforward. F2 trainees have also been offered the opportunity of assessments from educational supervisors.

ST Trainees: Trainees confirmed having designated educational supervisors, who they have meet regularly.

2.5 Clinical supervision (day to day) (R1.7, 1.8, 1.9, 1.10, 1.11, 1.12, 2.14, 4.1, 4.6)

Trainers: Trainers described clear and robust escalation policies with initial support provided by the parent team then the on-call team with lists of all teams noted in the handbook. They recognise there may not always be someone present on the ward however seniors are easily contactable. Communications tend to be via the switchboard, pagers, or mobiles. They reported that there have been instances where trainees have felt they have had to cope with problems out with their level of competence and felt encouraged that trainees were comfortable in raising these issues with seniors to allow quick resolution. They are confident that there are always open lines of communication to allow any issues to be addressed promptly.

Foundation Trainees: Trainees confirmed being aware of who to contact for clinical supervision during the day and out of hours. Escalation policies are clear with good support from the onsite medical registrar. They commented on occasionally feeling that they are expected to work beyond their level of competence. This is mainly due to working alone on the wards with very little senior contact. On occasion they may know little about a patient and the appropriate escalation and relevant contact for that patient. F1 trainees commented on feeling exposed for a short period of time each morning due to being alone on the ward when the trauma meeting is taking place. F1 trainees are the

only training grade not in attendance at the trauma meeting which they consider would be of great benefit to them. They find consultants friendly, approachable and are comfortable in asking questions related to orthopaedics.

ST Trainees: Trainees confirmed being aware of who to contact for clinical supervision during the day and out of hours. They do not feel they have had to work beyond their level of competence and find senior colleagues accessible and approachable.

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

Trainers: Trainers reported keeping up to date with changes to the different curricula. Guidance and requirements are regularly circulated. They have also recently received a presentation on improving surgical training in Foundation from Dr Caroline Whitton, Associate Postgraduate Dean Foundation West of Scotland. They commented on an orthopaedic clinical skills checklist being available for all grades of trainee based on their level of training which has been well received. Trainees in IRH regularly attend clinic and theatre afternoons and are encouraged to use opportunities at departmental teaching to obtain CBDs. Trainees are actively encouraged to seek out opportunities and ask seniors for assessments. They recognise this can be difficult for F1 trainees who may require some guidance and signposting. They acknowledge difficulties with trainees in RAH in getting CBDs due to short ward rounds. They find ST trainees very proactive is seeking assessment opportunities. Trainers are not aware of any curriculum competencies that trainees will have difficulties obtaining. Foundation trainees believe that they lack orthopaedic competence and experience and have provided feedback on this. They do however understand that this is not part of the foundation curriculum. Should an ST trainee be short in operative numbers then adjustments will be made within the rota to accommodate this.

Foundation Trainees: Trainees reported having no difficulties in achieving learning outcomes when in post. F2 trainees can attend clinics in IRH if workload permits. F1 trainees described limited opportunity to develop their skills in acute management as they do not have a more senior colleague alongside them at all times for learning. F2 trainees commented that they can develop skills in managing the acutely unwell patient, they commented that medical review of patients can on occasion take a significant amount of time. They consider placements to be long enough to get to know the team and build relationships.

ST Trainees: Trainees reported ample opportunities to achieve learning outcomes and have no concerns in accessing theatre and clinic time. They work within a team-based structure working directly with their consultant. They believe the post allows them to develop their skills in managing the acutely unwell patients as they take referrals from Emergency Medicine.

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

Trainers: Trainers reported sufficient opportunities to allow trainees to meet assessment requirements. They actively encourage trainees to take advantage of all opportunities and are happy to provide support.

Foundation Trainees: Trainers reported sufficient opportunities to allow them to meet assessment requirements. They highlight Mini-Cex as being slightly more difficult to obtain due to there not always being time for people to observe a procedure. They find presenting at weekly teaching an excellent opportunity to obtain CBDs. F2 trainees also find TAU a useful place to obtain assessments.

ST Trainees: Trainees reported no difficulties in obtaining workplace-based assessments in post.

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

Trainers/Foundation Trainees/ST Trainees: Not asked, no concerns raised in pre-visit questionnaire.

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

Trainers: Trainers reported providing trainees with opportunities to be involved in audit and quality improvement project. They provide supervision and the opportunities for trainees to present locally and externally.

Foundation Trainees: Trainees reported being encouraged to take part in quality improvement projects with good consultant support. F2 trainees commented on being able to present at monthly M&M meetings where feedback is provided.

ST Trainees: Trainees reported having adequate opportunities to take part in audits and quality improvement projects. They have offered juniors opportunities to be involved in audits however have not had many take up the offer.

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: Trainers reported that trainees are provided with regular on the job feedback in areas such as the trauma meetings, handover, and within the department multidisciplinary team meetings (MDTs). They provided an example of encouraging trainees to participate in the teaching of medical students where they receive direct feedback on their teaching.

Foundation Trainees: Trainees stated that they rarely receive feedback on their clinical decisions. They commented that wards are busy and that there is little oversight into what they do on a day-to-day basis as they rarely interact with registrars or consultants. F2 trainees commented that feedback is more often received from the medical or ortho-geriatric teams rather than the orthopaedic team. When wards are busy Foundation trainees conduct daily reviews and F1 trainees discuss cases with F2 trainees who will provide feedback. There were some positive interactions noted with the weekend on-call consultant as they tend to work more closely with them at weekends.

ST Trainees: Trainees reported receiving regular feedback in clinics and the morning trauma meetings which they consider to be constructive and meaningful.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: Trainers reported that trainees can provide feedback on their training via the chief resident and foundation trainee representative who attend regular consultant meetings to discuss any issues raised. There are departmental feedback forums with representation from trainees, senior clinicians, and management. Also, they offer trainees the opportunity to be part of the peer mentoring programme.

Foundation Trainees: When prompted F1 trainees commented on being aware of a meeting taking place to which an F2 trainee will take forward any concerns raised by Foundation trainees. F2

trainees noted attending a monthly consultant meeting where they raise concerns provided by peers for discussion, feedback is not always provided.

ST Trainees: Trainees reported good access to trainee reps who attend various meetings taking forward any concerns from the trainee body.

2.12 Culture & undermining (R3.3)

Trainers: Trainers stated that they are a supportive group of consultants. They aim to keep culture and undermining a topic of discussion and encourage trainees to come forward to allow any issues to be taken forward quickly. They have worked hard to make improvements on the previous visit report regarding team culture and wellbeing and are not aware of any recent issues. Trainers have undertaken Civility Saves Lives sessions and plan to attend Active Bystander training when available. They have introduced team activities such as weekly bake off, name the bone, pink Wednesdays, and provide all new staff with a welcome pack all of which are very well received.

Foundation Trainees: Trainees reported on approachable consultants however couldn't comment on senior trainees as they rarely work together. They would feel comfortable in raising any concerns relating to bullying or undermining with a member of the consultant team. They are also aware of the datix system for reporting adverse incidents however have not yet used the system.

ST Trainees: Trainees reported no concerns regarding bullying and undermining. They are comfortable in raising any concerns with consultants or supervisors.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Trainers reported that the rota in IRH details clinic and theatre sessions. There are regular check-ins with trainees to ensure they are taking up opportunities which are supported by the checklist. They are considering introducing collapsible rotas however recognise difficulties in managing sick leave and maintaining a minimum threshold. They believe that workload at RAH may be affecting trainee wellbeing due to it being a very busy unit. A mapping exercise is underway to help understand workload and identify areas where support is required.

Foundation Trainees: Trainees reported being aware of a gap in the rota at the start of the post caused by a long-term CF leaving. They question whether minimum staffing numbers are being met and believe the mix of training grades on the rota at the same time is not always right. F1 trainees, F2 trainees and CFs work on the same rota which comes with the assumption that the different grades are working at an equivalent level. They also commented on difficulties in differentiating between training grades, no coloured lanyards are used instead the different level are identified by a small line on a name badge. F1 trainees stated they should escalate up to F2 and CF first however there are uncertainties when escalating to the CFs due to their varying experience. Some are new to the ward and require time to adjust and develop however are placed fully on the rota even if they are functioning at a lower level. F2 trainees commented on a high on-call burden due to cross cover of the IRH site. F2 trainees recognise the pressures F1 trainees are under in post and have raised concerns with staffing levels which have been dismissed as minimum staffing levels are being met. They commented on swapping wards after 2 months which they find beneficial. They consider junior staffing on the rota to compromise their wellbeing. F2 trainees noted no structure to ward rounds.

ST Trainees: Trainees confirmed 2 gaps in the rota both of which are covered. They believe the rota supports attendance at clinic and theatre sessions. They are happy to contact the rota co-ordinator if they have any concerns and do not believe the rota compromises trainee wellbeing. They commented that having the rota issued earlier would be of great benefit to them, they are aware of on-call and nights well in advance however have no details of what site they will be working in or what clinics or theatres they will be attending until a few days before. This issue has been raised by the trainee rep with a request made to have the rota issued 2 weeks in advance.

2.14 Handover (R1.14)

Trainers: Trainers commented on the introduction of TRAKCARE for documentation and to log tasks. IRH are also using live patient lists which are available via Microsoft Teams. There is a morning middle grade led handover which uses a checklist to guide the handover. In RAH there is consultant led morning handover within the trauma meeting, an evening handover at 5pm and weekly metal meeting all of which provide good educational opportunities. Foundation trainees at RAH have also developed a peer handover which takes place at 4pm. Feedback on improvements to handover have been received via the ward MDT which has shown an improvement in patient flow and

communications on the ward. The recognise that ward MDTs are time consuming and engagement in the processes is key.

Foundation Trainees: F1 trainees reported no agreed structure to how patient information is handed over in the department. They commented that at the start of shift, they spend a period going round nursing staff and asking about patients as they do not attend the morning trauma meeting therefore are not given the list of new admissions or the patient rundown the F2 trainees receive. They are not aware of an electronic handover system or of a 4pm handover meeting to which F1 trainees can attend. They are aware that an F2 handover from the wards to the trauma assessment unit in the Emergency Medicine department as taking place. They also commented on a good and supportive group of F2 trainees and would find it useful to be passed information from the F2 trainee covering the trauma and assessment unit (TAU) and a nursing handover. F2 trainees noted handover as taking place at 8am trauma meeting and an 8.30pm to the H@N team, with TRAKCARE used at weekends to handover tasks to F1 trainees. IRH handover in the morning which is attended by ST trainee, F2 trainee, F1 trainee and advanced nurse practitioner (ANP) along with daily MDTs.

ST Trainees: Trainees commented that handover is structured and takes place at the same time each day covering new admissions and patient run through. They believe the morning trauma meeting provides good opportunities for learning. IRH handover takes place in the morning with seniors available to be contacted until 4pm.

2.15 Educational Resources (R1.19)

Trainers/Foundation Trainees/ST Trainees: Not asked, no concerns raised in pre-visit questionnaire.

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

Trainers: Trainers reported several avenues to support trainees who may require additional support. They foster an open-door policy for trainees to raise concerns at any time. They offer pastoral support on a Tuesday afternoon which is discussed within induction. There are lead nurses and the clinical service manager who have also offered to provide pastoral support. Trainers and trainees can also

seek support via the Trainee Development and Wellbeing Service, through the Medical Education team and Postgraduate team including Foundation Programme Directors (FPDs) and APGDs.

Foundation Trainees: Trainees reported that support would be provided by consultants, or the junior doctor lead should they be struggling with any aspect of their training or health. They would feel comfortable in taking any issues to Miss McKenna and Miss Higgs.

ST Trainees: Trainees believe adequate support would be provided should they be struggling with any aspect of the job or their health. They are aware of reasonable adjustments to training being made such as less than full time training.

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

Trainers/ Foundation Trainees/ST Trainees: Not asked.

2.18 Raising concerns (R1.1, 2.7)

Trainers: Trainers described the use of the datix system for trainees to raise concerns relating to patient safety which is highlighted at induction. Feedback forms were also used to gain trainee feedback on boarders at IRH with results discussed and taken forward.

Foundation Trainees: Trainees reported that they would raise any concerns relating to patient safety with the relevant consultant and are aware of the datix system for reporting adverse incidents.

ST Trainees: Trainees stated that they would raise any patient safety concerns with the on-call consultant and escalate from there. They are aware of the datix system for the reporting of adverse incidents.

2.19 Patient safety (R1.2)

Trainers: Trainers described a daily e-mail to the relevant consultant on any patient issues that are boarding to ensure all are up to date on where patients are and what support is required.

Foundation Trainees: Trainees stated that in general they would not be comfortable if a friend or family member was to be admitted to the ward. This is due to the structure of the department and the variable staffing levels and number of junior doctors on the ward. F2 trainees reported creating a handover system for ward 21 where they use a whiteboard to ensure all tasks are completed. They noted challenges with things being missed due to seniority of staffing levels and inexperienced CFs. F1 trainees believe that F2 trainees step up to the challenges of the role and provide excellent support. They consider the wards to be safe when fully staffed with F2 trainees. They also noted safety concerns due to the combinations of training grades placed on the rota at the same time which can see an F1 trainee escalating to a CF who is not yet working at that level and often require the support, guidance, and assistance of the F1 trainees on the ward. F2 trainees also noted pressures to provide support for CFs who are inexperienced, not communicating well, and not passing over tasks that are beyond their level of competence. F2 trainees recognise that raising concerns about a medical (non-orthopaedic) issue with the STs is often unhelpful, as the STs tend to direct them to the medical registrar. They were unable to comment on systems used to track medical boarders as this task is undertaken by the trauma liaison team.

ST Trainees: Trainees stated they would be comfortable if a friend of family member were admitted to the ward. They raised concerns regarding transfer time of patients between sites which can be lengthy and required for seriously ill patients. They commented on the trauma liaison team who track boarders.

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

Trainers: Trainers reported the use of the datix system for reporting adverse incidents which are discussed at monthly M&M meetings where cases are presented, and learning provided. Trainers stated that should something go wrong with a patient's care; a trainee would not be expected to deal with this alone; a consultant would take the lead. They advised duty of candour is part of the ST curriculum however they would not be expected to undertake this without appropriate supervision.

Foundation Trainees: Trainees commented on being aware of the datix system for reporting adverse incidents however have no experience of using the system. They believe appropriate levels of support would be provided by seniors. F1 trainees stated that they would not be expected to communicate something that may had gone wrong with a patients care as this is a role more likely to

be undertaken by an F2 trainee. They noted feeling very protected by F2 colleagues. F2 trainees believe that consultants will only tend to deliver bad news if it is related to a surgical problem and therefore, they can feel unsupported when having to communicate something that has gone wrong with a patient.

ST Trainees: Trainees commented on being aware of the datix system for reporting adverse incidents and regular M&M meetings being held.

2.21 Other

Overall Satisfaction Scores:

F1 – /10.

F2 – /10.

ST – /10.

3. Summary

Is a revisit required?	**Yes**	**No**	**Dependent on outcome of action plan review**

The panel commended the engagement of the site and medical education team in supporting the visit and note the considerable efforts being made by trainers to improve training across the sites. The panel noted serious concerns relating to workload and patient safety. Other areas for improvement noted at the visit relate to induction, support, workload, clinical/educational supervision, handover, and feedback. An action plan review meeting will be arranged 6 months post visit where the department will be given the opportunity to show progress against the requirements listed below.

Serious concerns:

- Foundation trainees expressed feeling exposed daily to patient safety issues, with a specific example provided to the department after the visit.

Positive aspects of the visit:

- Excellent engagement from the Medical Education team and site management teams in supporting the visit.
- Recognition of the work and engagement of the Trainers who are working extremely hard to make sustainable improvements across the sites and are committed to providing a good training environment.
- Trainers commented on a good level of support available from the Medical Education Team and Trainee Development and Wellbeing Service.
- Foundation trainees commended the support provided by Miss McKenna and Miss Higgs.
- Trainees described supportive relationships with nursing teams on the wards.
- F1 trainees commended the support received from F2 trainees.
- ST trainees feel well supported and report high levels of overall satisfaction within the post.
- The development of a 'collapsible rota' described in the presentation session is considered a good concept.
- Good induction programme which is well received.
- Good department teaching programme, which is relevant, well attended, and landing well with all trainees.
- Mandatory teaching is built into rotas with few barriers to attendance.
- All trainees highlighted good opportunities for involvement in quality improvement projects.
- All trainees commented on an approachable and accessible consultant team.
- Foundation trainees reported that the MDT meeting on the wards with nursing staff is very supportive and helpful.
- All trainees commented on robust and clear escalation policies.
- Foundation trainees commented on receiving good feedback within Ortho-geriatrics ward rounds where they find in depth patient reviews are useful and are provided with good support from the team when requesting the review of a patient.
- Foundation trainees commented on positive support from Medicine when they are required to escalate a patient through pathways.
- The clinical skills checklist is an excellent initiative and is extremely helpful in ensuring trainees obtain required WPBAs while in post.
- ST trainees have a good approach to utilising elective and clinical opportunities over the 3 sites.

- ST trainees value the flexible approach offered by trainers where the more senior trainee gets opportunity to work more independently with greater responsibilities.
- ST trainees commended the organisation for the management processes within the service, specifically that provided by the trauma liaison service.
- All trainees confirmed having designated educational supervisors who they meet regularly.
- The FY doctors are not always met with sympathetic and approachable feedback from Orthopaedics when they request support. It was recognised that within the escalation policies when they ask for support from the medical team care that they receive the support without resistance. They reported that on occasions they will ask for an Orthopaedic person to come and be with them to assist with escalation of a patient and that the answer from registrars is firmly 'no', call the medical registrar.
- Clinical fellows appear to be in a development phase and unable to offer support at this time, but it is hoped they will be able to do so as they come more familiar with the working environment.

Requirements from previous visit (Trauma & Orthopaedics, Inverclyde Royal Infirmary and Royal Alexandra Hospital 1st March 2022).

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

Ref	Issue	Trainee cohorts in scope	Progress
6.1	The unit handbook must be kept up to date to reflect changes to departmental processes.	All	Addressed
6.2	Trainees must receive adequate induction to all sites they cover out-of-hours to allow them to begin out-of-hours working safely and confidently.	Foundation	Partially
6.3	Initial meetings and development of learning agreements must occur within a month of starting in post.	All	Addressed
6.4	There must be active planning of attendance of doctors in training at teaching events to ensure that workload does not prevent attendance. This includes bleep-free teaching	Foundation	Addressed

	attendance. Trainees should not be expected to complete this teaching in their own time.		
6.5	The learning environment for Foundation trainees must be supportive and inclusive.	Foundation	Partially
6.6	There must be senior support, including from consultants/recognised trainers to enable doctors in training to complete sufficient WPBAs/SLEs to satisfy the needs of their curriculum	Foundation	Partially
6.7	There must be regular Consultant ward rounds which review trainee decisions and care plans and offer constructive feedback & teaching.	Foundation	Partially
6.8	Foundation trainees must not be expected to work beyond their competence by delivering sensitive and complex information to patients and their families unsupported.	Foundation	Partially
6.9	All staff must behave with respect towards each other and conduct themselves in a manner befitting Good Medical Practice guidelines. Specific example of undermining behaviour noted during the visit will be shared out with this report.	Foundation	Addressed
6.10	Handovers involving Foundation trainees must include senior input to ensure patient safety and learning opportunities.	Foundation	Partially
6.11	Handover processes must be improved to ensure there is a safe, secure and robust handover of patient care with adequate documentation of patient issues, senior leadership and involvement of all trainee groups who would be managing each case during the day and out of hours.	Foundation	Partially
6.12	Measures must be implemented to address the patient safety concerns associated with ad-hoc ward rounds and the clinical governance issues raised by inadequate record keeping.	Foundation	Addressed

6.13	Ref: Page 20, Item 7.7 Carried forward – T&O RAH 21/01/2020 All handovers within Trauma & Orthopaedics must be more structured and more robust with written or electronic documentation.	All	Partially
6.14	Ref: Page 20, Item 7.8 Carried forward – T&O RAH 21/01/2020 The morning and/or evening handover must be scheduled within the rostered hours of work of the trainees.	All	Addressed
6.15	Ref: Page 22, Item 7.13 Carried forward – T&O RAH 21/01/2020 A process must be put in place to ensure that any trainee who misses their induction session is identified and provided with an induction.	All	Addressed
6.16	Ref: Page 22, Item 7.7 Carried forward – T&O IRH 28/01/2020 All handovers within Trauma & Orthopaedics must be more structured and more robust with written or electronic documentation.	All	Partially

4. Areas of Good Practice

Ref	Item	Action
4.1	Good department teaching programme, which is relevant, well attended, and landing well with all trainees	
4.2	The clinical skills checklist is an excellent initiative and is extremely helpful in ensuring trainees obtain required WPBAs while in post	

5. Areas for Improvement

Areas for Improvement are not explicitly linked to GMC standards but are shared to encourage ongoing improvement and excellence within the training environment. The Deanery do not require any further information in regard to these items.

Ref	Item	Action
5.1	F1 trainees commented on feeling exposed on the wards between 8.30am and 9am when the trauma meeting is taking place. The plan to include F1 trainees in the morning trauma meeting from December will address this concern.	
5.2	F1 & F2 doctors are providing support to newly appointed clinical fellows and taking on additional duties as the fellows are within a development phase. Future processes for Clinical fellows should aim to mitigate this problem by considering when OOH working is appropriate to commence	
	Those providing immediate clinical supervision must be supportive of trainees who seek their help and must never leave trainees dealing with issues beyond their competence or 'comfort zone'.	
5.3	The FY doctors are not always met with sympathetic and approachable feedback from Orthopaedics when they request support. It was recognised that within the escalation policies when they ask for support from the medical team care that they receive the support without resistance. They reported that on occasions they will ask for an Orthopaedic person to come and be with them to assist with escalation of a patient and that the	

	answer from registrars is firmly ‘no’, call the medical registrar.	
	Clinical fellows appear to be in a development phase and unable to offer support at this time.	

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	Trainees must receive adequate induction to all sites/departments they cover including roles and responsibilities. RAH processes should include the cover for medicine OOH.		Foundation
6.2	The grade of a trainee must be easily evident to those that they come in contact with.		ALL
6.3	Handover processes must be improved to ensure there is a safe, secure and robust handover of patient care with adequate documentation of patient issues, senior leadership and involvement of all trainee groups who would be managing each case during the day and out of hours.		Foundation
6.4	A process for providing feedback to Foundation doctors in training on their input to the management of acute cases must be established and feedback provided from incidents recorded on the Datix system. This should also support provision of WPBAs.		Foundation
6.5	Foundation trainees must not be expected to work beyond their competence by delivering sensitive and complex information to patients and their families unsupported.		Foundation