Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	9 October 2019	**Level(s)**	Undergraduate, FY, CMT, IMT and ST
Type of visit	Revisit	**Hospital**	Aberdeen Royal Infirmary
Specialty(s)	Cardiology	**Board**	NHS Grampian

Visit panel	
Dr Stephen Glen	Visit Chair – Associate Postgraduate Dean for Quality
Dr Reem Al-Soufi	Associate Postgraduate Dean for Quality
Dr Jennifer Hanslip	Training Programme Director (Foundation)
Dr Christine Kay	Undergraduate Representative
Mr Albert Donald	Lay Representative
Heather Stronach	Quality Improvement Manager

In attendance	
Ms Claire Rolfe	Quality Improvement Administrator

Specialty Group Information	
Specialty Group	Medicine
Lead Dean/Director	Professor Alastair McLellan
Quality Lead(s)	Dr Reem Al-Soufi Dr Stephen Glen Dr Alan McKenzie
Quality Improvement Manager(s)	Heather Stronach and Alex McCulloch

Unit/Site Information		
Non-medical staff in attendance	6 non-medical staff	
Medical students in attendance	7	
Trainers in attendance	8 trainers	
Trainees in attendance	3FY, 3 Core trainees, 3 ST	

Feedback session: Managers in attendance	Chief Executive		DME	x	ADME		Medical Director		Other	x

Date report approved by Lead Visitor	14/11/2019

1. Principal issues arising from pre-visit review:

The last visit to cardiology at Aberdeen Royal Infirmary took place on 9 November 2018. At that time 15 requirements, that is aspects where General Medical Council's (GMC's) standards were not being met, were identified as needing to be addressed. These were:

1. There must be robust arrangements in place to ensure the tracking of all boarded patients and to support regular review by a consultant.
2. Those responsible for educational governance must investigate the allegations of undermining behaviours, and if upheld, put in place an appropriate action plan to address these concerns.
3. The site must foster a culture of learning that includes doctors in training both in reporting critical incidents using channels such as the Datix reporting system but also in the consequent learning that comes from an effective system.
4. All references to Senior House Officer (SHO) and 'SHO Rotas' must cease. The 'Say No to SHO programme' must be adopted, with all staff involved.
5. Staffing levels and their support in wards must be reviewed to ensure that workload is appropriate and does not prevent access to learning opportunities including outpatient clinics.
6. Solutions must be found to address non-compliant trainee rota which may have non-intended consequences such as patient and trainee safety risks.
7. There must be further support for regular consultant ward rounds which review trainee decisions and care plans and offer constructive feedback and teaching.
8. All trainees must have timely access to IT passwords and system training through their induction programme.
9. Departmental induction must be provided which ensures trainees are aware of all of their roles and responsibilities and feel able to provide safe patient care.
10. A process must be put in place to ensure that any trainee who misses their induction session is identified and provided with an induction.
11. There must be access to study leave for all eligible trainees and this must not be dependent on trainees arranging their own service cover.
12. Department must develop and sustain a local teaching programme mapped to curriculum requirements of the ST3+ trainees including a system for protecting time for attendance.

13. There must be a process that ensures trainees understand, and are able to articulate, arrangements regarding educational governance at both site and board level.
14. A trainee forum should be established and supported so trainees can safely raise concerns and provide feedback.
15. The allocation of specialty trainees to training opportunities must be equitable and reflect the training requirements of the individual trainees.

The panel met with trainers and non-medical staff as well as the following groups: Year 4 and 5 medical students (including a Physician Associate), foundation trainees (FY), core and internal medicine trainees and specialty training registrars (STs) in cardiology.

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.

2.1 Induction (R1.13):

Trainers: Trainers said that all trainees receive a NHS Grampian site induction and FY1s complete a further shadowing period of 4 days. Trainers said that previously when trainees had missed their hospital induction a catch-up induction was not routinely given, but this year they could confirm that all trainees had received hospital induction. Induction materials are also available on the intranet, but trainers suggested induction might be improved by emailing the materials to trainees in advance of them starting at NHS Grampian so that trainees are prepared from day 1 of work, rather than having to wait on access to IT systems.

Trainers said that department induction is delivered by either the Training Programme Director (TPD), Dr Duncan Hogg or Dr Awsan Noman.

Undergraduate ("students"): Year 5 students confirmed receiving an induction to the cardiology department by the Physician Associate (PA). Students considered that this was appropriate as the PA had worked in the ward longer than the FY1. Students said it was nice to see where everything was and they were shown what they needed in terms of practical things. An informal friendly induction with their supervisor also took place on the ward. Year 4 students confirmed being shown round and having a mini induction which they found helpful.

FY and Core: This cohort of trainees confirmed all receiving site induction and no specific areas for improvement were identified.

Two trainees did not receive a department induction and no catch-up induction was offered. For those who received departmental induction they said the standard was good overall. It was noted by this cohort of trainees that the written induction materials for the cardiology department require updating because some of the information is out of date and it was noted that there are references to 'SHO' in these materials. Trainees felt that more information could be provided about the specific roles and responsibilities of each training grade, for example, what the day to day tasks are on the cardiology ward for someone who has recently stepped up as an FY2.

ST: ST trainees confirmed receiving both site induction and department induction. Trainees said it would be helpful to have a rough guide or checklist on practical aspects, such as how to get access to the Picture Archiving and Communication System (PACS) and Dictaphone access.

Trainees agreed with trainers that it would be beneficial to receive the materials by email, rather than wait until they have intranet access.

Nursing and Non-Medical staff: Nursing and non-medical staff said that trainees seemed to settle into cardiology more quickly this year than previous years.

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

Trainers: Trainers said weekly unit teaching takes place on a Wednesdays at 12 noon. It is usually 1-hour long and is organised by the registrar alongside a consultant. Trainees are all encouraged to attend this teaching. Non-medical staff avoid bleeping trainees to try and make this session bleep free.

There are protected Thursday FY1 teachings coordinated by NHS Education for Scotland (NES).

There is a structured programme of local teaching for ST trainees. All STs are expected to attend except for those on call. This teaching takes place monthly and is mapped to the curriculum. The TPD works alongside the coordinating registrar to ensure this teaching is mapped to curriculum.

There are further national training days organised through the Scottish Cardiac Society.

There are also Friday morning multidisciplinary (MDT) meetings with cardiothoracic surgical colleagues which take place in the medical lecture theatre from 08:30-09:30am.

Trainers are considering revamping Wednesday teaching so that junior teaching is followed directly by registrar teaching with registrars presenting Morbidity and Mortality (M&M) clinical cases at these meetings.

Undergraduate ("students"): Year 4 students advised that cardiology comprised a 1-week attachment within a 5-week block and that tutorials occurred. They advised that the quality of teaching was very good. Year 5 students were attached to cardiology as part of an 8-week medicine block which included a student assistantship. All students could attend the Wednesday lunchtime department teaching.

Medical students can also access clinics, echocardiography teaching sessions and can attend the cardiac catheterisation laboratory. The amount of tutorial-based teaching they get per week can vary between 1 and 2 hours. Medical students were happy with the content of teaching.

FY and Core: This cohort of trainees confirmed Wednesday departmental teaching, FY1 Deanery and CMT/IMT specific teaching. There were no barriers to attending teaching. Trainees felt the content is relevant but considered that some of the cardiology department sessions could be more interactive.

ST: ST trainees also confirmed the Wednesday department teaching and monthly registrar teaching mapped to the curriculum. ST trainees said that where there are known curriculum gaps, speakers are actively sought to present on these topics. Trainees are able to attend around 70-80% of teaching sessions. There are plans to introduce a journal club.

Nursing and Non-Medical staff: Nursing and non-medical staff are supportive of trainees attending teaching. The PA appointment has helped to allow trainees to attend teaching. All ward staff are aware of the departmental Wednesday teaching programme and trainees can leave their phones with advanced nurse practitioners.

2.3 Study Leave (R3.12)

Trainees reported no problems accessing study leave.

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

Trainers: All trainers have appropriate time in their job plans (1 hour per trainee per week included in a 2 'supporting professional activity' (SPA) in the job plans). All are appraised for this role. Educational and clinical supervision is provided by the same consultant for junior doctors, whereas registrars are appointed an educational supervisor for 1 year and a clinical supervisor for 6 months. Trainers advised that supervisors are usually allocated to trainees according to their training year. Senior STs (ST6 and ST7) are usually allocated an educational supervisor that matches their specialist interest.

Trainers were able to provide concrete examples of where the need for additional support was identified for some trainees. This was felt to be managed well.

Undergraduate ("students"): Year 5 medical students confirmed having an educational supervisor who they see frequently on the ward. Their educational supervisor met with them during their first week and agreed to meet with them at the end of their attachment.

Year 4 medical students do not require a departmental educational supervisor during their attachment.

Trainees: All grades of trainees confirmed having educational supervision and had met with their educational supervisor to agree training objectives for the year. There were no concerns raised about educational supervision and STs commented they see their consultants frequently.

Nursing and Non-Medical staff: Nursing and non-medical staff felt that since the last Deanery visit trainees are now better supported. They said that the department has changed the receiving structure on the ward, and this is felt to be far more robust. They said that consultants are much more visible, and this is working well for trainees.

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

Trainers: Trainers said two consultants are responsible for organising the timetable for 4th year medical students to ensure they can take part in the variety of activity that takes place in cardiology. Trainers use the decision aid for postgraduate trainees to ensure they are obtaining the necessary experience required for their curricula.

The Coronary Care Unit (CCU) team is usually the consultant, the registrar, and an FY2 or IMT/CMT trainee. FY1s are encouraged to attend ward rounds in the CCU during their first 2-4 weeks on CCU. Otherwise it is the responsibility of the Foundation educational supervisor to ensure that FY trainees are aware of and can access their training needs.

Trainers said that the introduction of IMT has prompted changes in the middle grade rota so that this cohort of trainee are now rostered clinic days. (IMT requires a minimum of 20 outpatient clinics each year and a total of 80 over 3 years. Year 2 IMT trainees are advised to attend a minimum of 40 clinics). There are no rostered clinics for FYs.

The echocardiography lists are split equitably between ST3s and ST4s. Trainees who are interested in cardiac intervention or electrophysiology are identified and given this experience. The TPD assigns STs to clinics and regular cardiac fixed catheterisation laboratory sessions.

Trainers consider that ST trainees now have a better balance between training and service provision than in previous years. The experience for IMT/CMT trainees is also perceived to have improved, but clinic experience is still a sticking point. Ward 109 (an acute cardiology ward) may be perceived to be more service provision but three PAs have been introduced (and yet another PA approved), and plans are underway for a further 2 advanced nurse practitioners to provide additional support to Ward 109.

Undergraduate ("students"): Year 4 students said that their learning outcomes are known to them and they all considered that their experience will allow them to achieve their learning outcomes.

Year 5 students said their learning was more self-directed and they appreciate revisiting skills they had picked up in their 4th year and having continuity with patients.

FY and Core: FY2 and core trainees said that clinics with Dr Andrew Hannah and Dr Adelle Dawson in particular were a good learning experience with time taken to provide education and clinical feedback. Trainees said that in terms of accessing clinics the department is trying but there is still an ongoing struggle around accessing clinics. The introduction of IMT has prompted changes in the rota and trainees are aware of this.

Trainees said that formal feedback and learning on the wards feels scant.

This group of trainees consider that 50% of their time is educational and 50% is carrying out tasks that is of little benefit to their training.

ST: ST trainees were all happy with their training experience and felt the balance between training and service provision was appropriate.

Nursing and Non-Medical staff: Nursing and non-medical staff said that they think the balance has improved since the last visit because the PA is able to help with ward-based tasks.

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

Trainers: Trainers are aware of the assessments that trainees need to complete. They are familiar with their relevant curriculum. Trainers said that trainees can achieve their portfolio assessments (the only perceived issue is trainees submitting these just 1 week before their deadline).

There has been no formal benchmarking of assessments between trainers. Trainers discuss their trainees in general and have a good feel about how they are progressing. Informally there are times when there are two consultants in the room and a trainee is performing a procedure – trainees said they could use this as an opportunity to benchmark their assessments.

Undergraduate ("students"): Students said they can complete their Team Assessment of Behaviour (TABS) and clinical procedure assessments without difficulty. The mini clinical evaluation exercise requires sign off by someone above core level and they thought it would be helpful if formal opportunities could be created for this (rather than them having to seek out consultants).

FY and Core: This group of trainees said they can achieve their assessments.

ST:ST trainees all confirmed being able to achieve their assessments. Assessments are perceived to be fair and consistent across the board.

Nursing and Non-Medical staff: Nursing and non-medical staff confirm contributing to the assessment of trainees.

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

Trainers and trainees confirmed and described multi-professional learning opportunities such as working alongside PAs, cardiac physiologists in echocardiography and the catheterisation laboratory, and radiologists. ST trainees described this as a big strength in this hospital compared to others.

Nursing and Non-Medical staff: Nursing and non-medical staff were of the same view. They also mentioned M&M meetings and confirmed FY1 and FY2 attendance at M&Ms.

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

All trainees were aware of quality improvement opportunities and there were no concerns raised in this regard.

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

Trainers: All staff, including nursing staff, get to know who trainees are through induction. The nursing staff work alongside the junior doctors in the ward. They get to know them well and because the department is small everyone knows who is who.

Trainers said that trainees know who to contact for advice during the day and out of hours. This information is provided at induction. Trainers said that in the CCU trainees definitely know who to contact. Since the last Deanery visit supervision on the wards has also improved because now there is a ‘registrar of the week’ model available for junior trainees to contact for support. This means that

on the wards junior doctors can contact either the ward registrar or the on-call consultant (whose name is provided on the board). There is a separate induction for the Hospital@Night team and how to escalate concerns out of hours.

Trainers are not aware of any instances where trainees have reported feeling that they have had to cope with problems beyond their competence. Last year last minute changes to the ward left FY1 trainees feeling concerned about there not being a FY2 or CMT to support them, but ward cover feels much better now with the 'registrar of the week' model and the support of the PA.

Undergraduate ("students"): Year 4 students said they attach themselves to an FY1 or FY2. These trainees are quite happy to supervise them taking a patient history, for example.

Year 5s said there was always an FY1 about who they can seek help from. They get both front and back door work and they reported that the PA role provides invaluable support. Junior trainees were described as being very approachable and will go through procedures with medical students so that they know what they are doing, but there was a reluctance to ask more senior staff.

FY and Core: This group of trainees confirmed that induction advises who to contact both during the day and out of hours. Out of hours supervision was felt to be working well. However, during the day trainees report that there is confusion and a perceived conflict about who to escalate queries to. The default position is to call the registrar on call for the ward (who can be difficult to get hold of), and when they do, they are told to phone either the consultant or their registrar directly responsible for the patient and their ongoing management because the registrar on-call does not want to interfere with someone else's patient.

Some consultants were reported as being much more collegiate than others and trainees describe being unable to discuss patients with some individuals. This is described in more detail out with this report in direct communication with the Director of Medical Education.

ST: ST trainees had no concerns about clinical supervision.

Nursing and Non-Medical staff: Nursing and non-medical staff said that they can distinguish between the different grades of doctors in training. Wearing coloured lanyards was explored to make

this readily identifiable, but this was deemed too much of an infection risk. Instead, they have decided to signpost this information on the board in the ward. Nursing and non-medical staff said that there is always someone trainees can contact.

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: Trainers said they offer frequent informal face to face feedback. There is also a daily post take ward round that includes FY and CMT/IMT trainees where trainees are provided with feedback. STs are also provided with feedback when they present cases for M&M meetings.

Undergraduate ("students"): Students confirmed they complete an end of year block assessment. Year 5 students confirm receiving informal feedback.

FY and Core: This group of trainees perceived that feedback was provided mostly in their out of hours work.

ST: ST trainees said they receive feedback from consultants both in an out of hours and that feedback is constructive.

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

Trainers: Trainers said that feedback from trainees takes place as part of educational supervisor meetings. Trainers described a trainee forum where ST trainees meet with Dr Hogg. This formal process is expected to take part as part of the revamped Wednesdays. Trainers also said there was a Junior Doctors' Forum for non-ST trainees.

Undergraduate ("students"): Medical students complete the Student Course Evaluation Form (SCEF) which also asks for feedback on the facilities available to students. Medical students are asked at end of block assessment if there is anything that can be improved.

FY and Core: This group of trainees were not aware of any trainee forums.

ST: ST trainees confirmed regular meetings with Dr Hogg.

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

Trainers: Trainers said that workload and rotas have improved for trainees. Historically the rota was tight but the increased support from PAs and advanced nurse practitioners is making a difference to doctors in training.

Trainers said they have no control over junior rota as this is managed centrally.

FY and Core: This group of trainees did not raise any specific issues within the cardiology department. Trainees confirmed that the FY and CMT rota is centrally managed across the hospital.

ST: ST trainees said that they are now well-staffed with 7 registrars this year (as opposed to 6 last year). They said as a group they manage themselves and cover each other's rota gaps. They have a WhatsApp group for this. Overall, they feel that their rota is well designed observing that they are rostered into the catheterisation laboratory and at clinics. They are on call 1 in 7 weekends. STs reported no issues and felt that the rota was working well.

Nursing and Non-Medical staff: Nursing and non-medical staff acknowledged that there were gaps in the rota last year. The additional funding for non-medical staff has improved this. The rota has been monitored but needed to be repeated because the results were skewed unintentionally because the results of the Clinical Development Fellow were included. The repeat monitoring exercise was intended to be repeated, but trainees failed to submit their monitoring results.

The visit panel also heard of a concrete example where there was a last-minute gap in the rota. A solution was found which showed an appreciation of the rest period required for trainees.

2.13. Handover (R1.14)

Trainers: Trainers said there is a formal handover to the hospital@night team at 9pm and one again in morning at 9am. Every patient is discussed. Handover is used as a learning opportunity.

FY and Core: This group of trainees said there is a morning huddle on the wards which is attended by nursing and non-medical staff and FY / CT / IMT trainees. The huddle is still to become an

established routine for all medical staff. They confirmed that the FY1 goes to cardiology ward for the 9pm handover in order to handover any problems from the ward. CCU handover takes place in CCU.

ST: STs said that there are morning huddles that junior doctors attend but not registrars. Registrar handover takes place at 5:30pm each day to highlight any unwell patients to the next registrar. This handover is not a learning opportunity but a practical thing that needs to be done to keep patients safe. There is no consultant involvement.

Nursing and Non-Medical staff: Nursing and non-medical staff said that a night doctor will come and handover to day staff. On the wards at 9am there is a morning huddle that includes nursing staff, PAs and some of the medical team. They described the huddles as an essential action that is not yet functioning as intended due to the variable uptake of staff. FY1s/Core/IMT have been proactive about attending but the cardiology registrars were noted to be 'less engaged' in huddles and the perception is that registrars do not see this as part of their role to be there.

2.14. Educational Resources (R1.19)

Undergraduate ("students"): Medical students said that the IT facilities and educational resources at the Aberdeen Royal Infirmary are excellent. 5th year medical students confirmed having access to the systems they require to assist their learning, including Trakcare. For accessing PACS they must complete an extra module which they felt would have been handier to get all at once.

Trainees: Trainees had no concerns about educational resources.

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

Both students and trainees perceived the cardiology department would be supportive of reasonable adjustment requests. Nursing and non-medical staff said they would speak to a trainee's supervisor if they had any concerns about the performance of a trainee.

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

Undergraduate ("students"): Medical students confirmed that they were asked to feedback on the block through the Student Course Evaluation Forms and were aware of how the Medical School then fed back to students on any changes made in response to concerns from previous cohorts, for example, they were aware of the 'You said, we did' posters.

Trainees: Only one trainee was aware of the Director of Medical Education role and was able to name Dr Kim Milne.

2.17 Raising concerns (R1.1, 2.7)

Undergraduate ("students"): Medical students said they would approach someone more senior if they had any concerns about a patient. While no concerns had been raised, students felt they would be supported. Medical students also said they could go to Morag Simpson (the Year 4 and 5 MBChB secretary) who would then signpost them as what to do. They also mentioned Ashley Meldrum (ward coordinator) who they described as being very proactive and helpful.

Trainers: Trainers said that all staff are aware of how to raise concerns and are comfortable doing so. This is part of educational supervision. Trainees are told they are welcome to raise any concerns with their educational supervisor at any time in order to discuss concerns confidentially. Senior nursing staff are also available and are happy to discuss concerns with trainees if they do not wish to approach their educational supervisor as a first point of contact.

Trainees: Trainees said they would be comfortable raising concerns. Who they would raise concerns to depends on whether the incident occurs during the day or out of hours.

Nursing and Non-Medical staff: Nursing and non-medical staff would raise any concerns they have about trainees with their educational supervisor.

2.18 Patient safety (R1.2)

Trainers: Trainers said that the cardiology department is a very safe environment for patients. With the changes to staffing on the ward (that is, the 'registrar of the week' model) and increased staffing on the ward with the PA appointment, it feels safer.

Trainers stated that all trainees know that consultants are approachable and that they have their bleep/phone numbers. Trainees are not asked to do any tasks that are outside their capabilities. If a junior doctor is worried about doing a cardioversion, they will be supervised by the registrar.

The issue of boarded patients was problematic last year. Since the last Deanery visit, the department has escalated their preferred limit to the number of patients they can board out, with a preferred cap of 6 patients. So far, they have only exceeded this number only on two occasions.

Undergraduate ("students"): Medical students had no concerns about patient safety in the cardiology department.

FY and Core: This group of trainees expressed concern about the communication of decision making and escalation decisions including around end of life care.

Some trainees in this cohort were not aware of a boarding system in place.

Nurses and non-medical staff: Nurses and non-medical staff said that the cardiology department is a safe environment. They said that Datix submissions are reviewed regularly and these are not out with the norm.

Nurses and non-medical staff confirmed that there is now a patient flow manager and boarding occurs less frequently than last year. A cap of 6 boarded patients has been instituted since the last Deanery visit and this has only been exceeded twice which demonstrates that the situation since the last Deanery visit has greatly improved.

2.19 Adverse incidents (R1.3)

Trainers: Trainers said that they discuss adverse incidents at M&M meetings. A selection of cases are discussed and this is a good learning opportunity which encourages good decision making.

Undergraduate ("students"): Medical students were aware of Datix.[1] If there were any incidents medical students felt confident they would receive feedback from their supervisor.

Trainees: All trainees were aware of Datix and would feel comfortable approaching a senior colleague as well. Trainees were all aware that Datix submissions are used as a formal learning opportunity. They said that usually a registrar is assigned to present cases at M&M meetings.

Nursing and Non-Medical staff: Nursing and non-medical staff said there is a good divisional governance structure and there is a structured and robust approach to learning. Learning has also been informed by Ombudsman reports.

2.20 Duty of candour (R1.4)

All trainers and trainees were aware of the duty of candour.

2.21 Culture & undermining (R3.3)

Trainers: Trainers said that there is a team-based approach in the cardiology unit with a registrar assigned to a consultant. There are channels in place to report bullying and discrimination behaviours and trainees are advised to contact consultants if there are any issues with respect to undermining or bullying behaviours. This topic is covered at induction.

Undergraduate ("students"): 4th year medical students said they have a better rapport with junior doctors because they work alongside them and have learned a lot from them. 5th year students have enjoyed getting to know all individual team members and said that they find all colleagues approachable. Students have not experienced any bullying or undermining behaviours. If they did,

[1] Medical students are not expected to have involvement in the Datix system.

they said they would speak to the junior doctors first as consultants are less involved with medical students.

Trainees:
FY, IMT and Core trainees described that the majority of consultant staff were approachable and supportive. Specific undermining concerns were described and will be relayed to the Director of Medical Education out with this report.

Nurses and Non-Medical staff: Nurses and non-medical staff said they feel that the cardiology team is much more collegiate now than at the time of the last Deanery visit. They said learning from incidents has made a marked improvement to the environment making it feel much more supportive and educational. They said that in their view trainees feel much more comfortable raising issues. Nursing and non-medical staff were not aware of any current issues with undermining or bullying behaviours.

2.22 Other

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

- **FY/CMT:** Average = 5.3 out of 10
- **ST3+:** Average = 7.5 out of 10.

3. Summary

Is a revisit required?	Yes	No	Highly Likely	Highly unlikely

The visit panel noted the ongoing commitment of site leads, clinical and non-clinical managers, and consultant trainers in improving the educational environment. Many of the requirements from the 2018 visit have been addressed and progress against previous requirements is recorded as per the table below:

Ref	Issue	Progress noted at 2019 visit
1	There must be robust arrangements in place to ensure the tracking of all boarded patients and to support regular review by a consultant.	**Addressed**
2	Those responsible for educational governance must investigate the allegations of undermining behaviours, and if upheld, put in place an appropriate action plan to address these concerns.	**Some progress but new allegations during this visit**
3	The site must foster a culture of learning that includes doctors in training both in reporting critical incidents using channels such as the Datix reporting system but also in the consequent learning that comes from an effective system.	**Addressed**
4	All references to 'SHOs' and 'SHO Rotas' must cease. The 'Say No to SHO' programme must be adopted, with all staff involved.	**Significant progress (some out of date induction materials still reference 'SHO')**
5	Staffing levels and their support in wards must be reviewed to ensure that workload is appropriate and does not prevent access to learning opportunities including outpatient clinics.	**Addressed**
6	Solutions must be found to address non-compliant trainee rota which may have non-intended consequences such as patient and trainee safety risks.	**Addressed**
7	There must be further support for regular consultant ward rounds which review trainee decisions and care plans and offer constructive feedback and teaching.	**Some progress**
8	All trainees must have timely access to IT passwords and system training through their induction programme.	**Addressed**
9	Departmental induction must be provided which ensures trainees are aware of all of their roles and	**No progress**

	responsibilities and feel able to provide safe patient care.	
10	A process must be put in place to ensure that any trainee who misses their induction session is identified and provided with an induction.	**Some progress (this presently works for site induction but not department induction)**
11	There must be access to study leave for all eligible trainees and this must not be dependent on trainees arranging their own service cover.	**Addressed**
12	Department must develop and sustain a local teaching programme mapped to curriculum requirements of the ST3+ trainees including a system for protecting time for attendance.	**Addressed**
13	There must be a process that ensures trainees understand, and are able to articulate, arrangements regarding educational governance at both site and board level.	**No progress**
14	A trainee forum should be established and supported so trainees can safely raise concerns and provide feedback.	**Significant progress**
15	The allocation of specialty trainees to training opportunities must be equitable and reflect the training requirements of the individual trainees	**Addressed**

The training environment has significantly improved since the last Deanery visit and the 2019 revisit was largely positive. A summary of the 2019 visit is as follows:

Aspects that are working well:

- There is a clear knowledge of the differentiation between the different levels of training amongst staff. No-one used the term ‘SHO’ at this visit.
- The positive engagement from the consultant group who have moved to having an increased presence on the wards is to be commended. The ‘consultant of week’ model appears to be

effective, with ward staff describing seeing consultants much more. The appointment of PAs on the wards also helps support ward trainees.

- The experience of undergraduates is universally positive. Year 5 students report being able to get a lot of practical training.
- There are fewer rota gaps and junior trainees appear much more satisfied with the rota. We also heard of a concrete example where there was a last-minute gap and an appreciation of the rest period required was taken into account, which is positive.
- The boarding cap appears to be effective.
- PA and advanced nurse practitioner roles are having a good impact on trainee doctors, for example holding pagers/phones so that doctors can attend teaching bleep free.
- The 'registrar of the week' model is working well and registrars enjoy being attached to a consultant.
- M&M meetings are happening more regularly and there is good engagement from trainees at these meetings meaning that learning from incidents is encouraged.
- Trainees were all positive about Wednesday teaching and confirmed that this is now mapped to curriculum.
- Trainees comment on good support and education provided by cardiac physiologists in echocardiography and electrophysiology.
- There are no barriers to study leave.

Aspects that are working less well:

- Persistent undermining behaviours (2 consultants were named specifically, one of whom was named in the previous visit).
- Handover is not used as a learning opportunity and there is variable engagement from registrars in the ward huddles.
- 2 trainees did not receive a catch-up induction.
- The departmental induction requires updating for FY / CMT / IMT trainees to highlight roles and responsibilities. There are references to 'SHO' in these materials and trainees report that some information is out of date. Trainees said it would be helping to have a rough guide on practical aspects, such as how to get PACs access, dictaphone access etc. Trainees agreed with trainers that it would be beneficial to receive the materials by email, rather than wait until they have intranet access.

4. Areas of Good Practice

Ref	Item	Action
4.1	None noted	None required

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	None noted	N/A

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	Those responsible for educational governance must investigate the allegations of undermining behaviours, and if upheld, put in place an appropriate action plan to address these concerns.	**Immediately**	FY, CMT/IMT
6.2	There must be a clear escalation policy which is understood and followed by all involved.	**9 July 2020**	FY, CMT/IMT
6.3	Handovers must include senior input to ensure patient safety and learning opportunities.	**9 July 2020**	All cohorts
6.4	Update induction materials to remove reference to 'SHO'	**9 July 2020**	All cohorts
Note that the work to address the requirements listed under section 3 from the 2018 visit must continue to ensure these are resolved, and that resolution is sustainable. These have been added here:			

6.5	Departmental induction must be provided which ensures trainees are aware of all of their roles and responsibilities and feel able to provide safe patient care. All trainees must receive department induction.	**9 July 2020**	All cohorts
6.6	There must be a process that ensures trainees understand, and are able to articulate, arrangements regarding Educational Governance at both site and board level.	**9 July 2020**	All cohorts