Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	18th May 2021	**Level(s)**	Foundation, CT, Specialty
Type of visit	Revisit	**Hospital**	Royal Infirmary Edinburgh
Specialty(s)	Trauma and Orthopaedics	**Board**	NHS Lothian

Visit panel	
Dr Geraldine Brennan	Visit Chair – Associate Postgraduate Dean (Quality)
Mr Evan Crane	Training Programme Director
Dr Lisa Black	Foundation Programme Director
Dr Sarah Bowers	Foundation Programme Director
Ms Vicky Hayter	Quality Improvement Manager
Mrs Elaine Mowat Mrs Nasreen Anderson	Lay Representative Shadowing Lay Representative
In attendance	
Mrs Gaynor Macfarlane	Quality Improvement Administrator

Specialty Group Information	
Specialty Group	Foundation
Lead Dean/Director	Professor Clare McKenzie
Quality Lead(s)	Dr Geraldine Brennan & Dr Marie Mathers
Quality Improvement Manager(s)	Mrs Jennifer Duncan
Unit/Site Information	
Trainers in attendance	8
Trainees in attendance	F1 – 4, F2 – 5, CT/ST - 10

Feedback session: Managers in attendance	Chief Executive	0	DME	0	ADME	2	Medical Director	0	Other	19

Date report approved by Lead Visitor	14th June 2021 Dr Geraldine Brennan

1. Principal issues arising from pre-visit review:

Following a Deanery visit in November 2018 a number of concerns were raised regarding Foundation training in the Trauma and Orthopaedics Department at the Royal Infirmary of Edinburgh. The department was revisited in November 2019 and a number of improvements had been made. Whilst the visit team were impressed with the improvements, they were unable to validate the sustainability of these changes due to poor attendance. It was therefore agreed that a further revisit should be conducted. This decision was upheld by the Foundation Quality Review Panel in August 2020.

Below is data from the GMC National Training Survey 2019 (NTS) and the Scottish Training Survey 2020 (STS).

NTS Data 2019

Foundation NTS data combines both General Surgery and T&O.
F1 – Red Flags – Educational supervision, Reporting systems.
F2 – Red Flags – Educational supervision, Induction.

Core – Aggregated Green Flags – Clinical Supervision Out of Hours and Educational Governance
Pink Flags – Educational Supervision and Supportive Environment

ST – Green Flags – Handover, Reporting Systems.

STS Data

Foundation - White Flags – Clinical Supervision, Educational Environment, Induction, Teaching, Team Culture, Workload.
Foundation - Pink Flags – Handover.

Core Surgical Training – White Flags – Clinical Supervision, Educational Environment, Handover, Induction, Team Culture and Workload
Aggregated Core Surgical Training - Lime Flag – Teaching
Aggregated Core Surgical Training – Green Flag – Educational Environment
ST – Lime Flag – Teaching.
ST – White Flags - Clinical Supervision, Educational Environment, Handover, Induction, Team Culture, Workload.

At the pre-visit teleconference the visit panel agreed that the focus of the visit should be around the areas highlighted in the previous visit report recommendations.

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.

Department Presentation:

The visit commenced with Mr Tim White, Consultant Orthopaedic Surgeon delivering an informative presentation to the panel which provided an update regarding the progress against the previous visit requirements and the current structure and working arrangements within the unit.

2.1 Induction (R1.13):

Trainers: Trainers reported a robust induction day with all services being represented. Trainees meet with nurses and consultants who discuss the ward structure and what is expected of them. Trainees are sent a comprehensive induction booklet around 6 weeks before starting in post. If a trainee cannot attend induction this would be done a couple of days later.

Foundation Trainees: Trainees confirmed they received both hospital and department induction. They confirmed it was comprehensive and covered all roles and responsibilities with clear guidance on escalation. Trainees suggested an improvement would be to provide information around their role in covering cardiac admissions in future as this is not currently part of induction.

Core/Specialty Trainees: Trainees confirmed they received both hospital and departmental induction which was very useful and covered day to day aspects of the job.

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

Trainers: Trainers reported bleep free teaching for all grades of trainees. Regional teaching is timetabled for higher trainees and they are not expected to be at work during this time. The ANPs or ST doctor take the bleep for the foundation trainees. Trainers request feedback regarding topics trainees would like covered for teaching and one out of four sessions is provided by a member of the orthogeriatric service

Foundation Trainees: Foundation Year 2s are encouraged to hand over bleeps to very supportive advanced nurse practitioners (ANPs) and have no issues attending teaching unless they are on a zero day. Departmental teaching is organised by the junior orthopaedic ST and trainees are allocated a slot to present a case during sessions. Foundation Year 1s reported it can be difficult to attend

teaching depending on which ward they are on, especially if there are wards jobs to be completed and no orthopaedic geriatric service (OGS) as this means they need to stay beyond the working day.

Core/Specialty Trainees: Trainees reported no issues attending teaching which is bleep free. Priority is given to those closest to exams and there is limited tailored teaching for ST1 and ST2s.

2.3 Study Leave (R3.12)

Not asked.

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

Trainers: Trainees are allocated to consultants six weeks prior to induction. Trainers have one hour per week or one session per month within their job plans for their educational role. Foundation trainees are allocated to a “buddy” from the ST group, who is matched according to the consultant supervisor.

Foundation Trainees: The majority of trainees had not met with their educational supervisor and agreed a learning plan at the time of visiting and only three out of nine trainees confirmed that they had done so.

Core/Specialty Trainees: All trainees have met with their educational supervisor and agreed a learning plan.

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 advised that it is made clear on the ward and at induction who to contact for support during the day and out of hours. Trainers are not aware of trainees working beyond their competence as the unit has a “multi-layered escalation structure” and there is always someone available to offer advice and support.

Foundation Trainees: Foundation year 1s reported a very clear escalation process out of hours but it is not always clear who to contact during the day for advice. Patients are looked after by a team and foundation year 1s were often uncertain whether the named higher trainee to contact was on shift or not. They also reported feeling out of their depth on ward 209, working in relative isolation from the remainder of the team and at times beyond their competence. Due to Covid arrangements foundation year 1s are often the only doctor on that ward. Foundation year 1s reported a high turnover on ward 220 and although there is a "ward registrar" nominated, there is no elective team, therefore it is not always clear who to contact if that trainee is not contactable. The foundation trainees reported that this trainee provides a variable level of support which can be person dependent.

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Core/Specialty Trainees: All trainees reported a good level of supervision from accessible approachable consultants. All trainees know who their supervising consultant is in theatre, but there was a report of specialty trainees running clinics, both on and off site, without a supervising consultant.

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

Trainers: Trainers advised they have an excellent in-depth understanding of the curriculum for specialty trainees but are not as well versed with the foundation curriculum. Specialty trainees are timetabled to attend clinics and theatre. Foundation year 2 trainees are also timetabled to attend these with their supervisor and allocated buddy. There is a specialty trainee allocated to provide ward input on a weekly basis which has led to a better interaction with foundation trainees. There are two phlebotomists, however no cover is available for their absence when they are on leave. Discharge letters must be completed by a doctor therefore the foundation trainees complete these.

Foundation Trainees: Foundation Year 1s reported 99% of their time is spent in service provision with no time scheduled for clinics or theatre. Ward 209 tasks consist of mainly completing discharge letters and prescribing, with responsibility for daily reviews after a brief ward round at the start of the day. Multiple consultants may attend simultaneously so the trainee cannot always be present for all of them. Foundation year 2s have four educational days and are encouraged to attend clinics and theatre. Trainees reported supportive and helpful advanced nurse practitioners (ANPs) who were

prescribers. They advised that their allocated buddies are very approachable and helpful in signing off supervised learning events (SLEs) and undertaking teaching on orthopaedic related topics.

Core/Specialty Trainees: Trainees reported that there are particular competencies which are difficult to achieve due to regional differences, but these can be completed in a simulator setting

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

Trainers: Not asked.

Foundation Trainees: Foundation year 1s reported struggling to achieve sign off for Mini-CEXs and case-based discussions (CBDs). None of the trainees interviewed have had any SLEs signed off by an orthopaedic consultant as they reported having minimal contact with them and therefore little opportunity to do so.

Core/Specialty Trainees: Trainees advised that work placed based assessments are completed by a mixture of specialty trainees and consultants, mainly consultants for ST6+ and are completed following a ward round or during clinics and theatre.

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

Not asked.

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

Not asked.

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: Trainers advised informal feedback is given to trainees during ward rounds and formal feedback at mid and end of term meetings. Trainees can receive a dual stream of feedback if they are on a ward with the orthopaedic geriatric service.

Foundation Trainees: Trainees advised that they do not receive feedback unless they are in a ward which has OGS cover as senior orthopaedic colleagues are not aware of the decisions, they have made day to day. Trainees reported an increased workload when there is no OGS cover available on the ward.

Core/Specialty Trainees: Trainees advised they receive feedback during the trauma meetings and regularly throughout the day and out of hours in theatre. Consultants discuss the case, give a plan and make it a learning opportunity. Trainees are regularly asked if there is any particular training they would like to undertake.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: Trainers have recently made provision for improved feedback and now hold meetings with trainees every two weeks to discuss any concerns. These meetings are chaired by a specialty trainee and have a manager and consultant who also attend.

Foundation Trainees: Not asked.

Core/Specialty Trainees: Trainees reported there is a trainee forum which meets four times a year with junior and senior representation. They can also feedback at the end of a block or during their appraisals with consultants.

2.12 Culture & undermining (R3.3)

Trainers: Trainers create a team culture by making trainees feel part of the team. This includes having educational days allotted to them when they turn up to clinics and theatre. Trainers offer support to trainees and offer options to talk to different members of staff should they have any concerns. If there have been tensions in the past these have been dealt with and resolved and trainers are happy there is no bullying or undermining occurring. The hospital works well to resolve any issues with other departments and has developed rules of engagement which has improved the boarding situation considerably. TRAK notes have a clear pathway with a named specialty trainee and consultant for each boarded patient which has helped relationships with other teams.

Foundation Trainees: Trainees have not witnessed or experienced any bullying or undermining behaviour.

Core/Specialty Trainees: The majority of trainees advised they have not experienced or witnessed any bullying or undermining behaviour and commented that consultants were accessible and supportive. However, there was a report of alleged undermining received from a trainee following the visit, the detail of which has been discussed with the Associate Medical Director and Associate Director of Medical Education.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Trainers advised that the rota design accommodates learning opportunities to match the trainee's curriculum requirements. Foundations trainees have educational days and attend theatre and clinics. Specialty trainees have monthly educational days. Rota gaps are managed by employing locums or nurse practitioners, however trainers reported that they would prefer to have more foundation year one trainees. Trainers are not aware of any issues compromising a trainee's wellbeing.

Foundation Trainees: Two junior STs ensure adequate rota cover and are extremely helpful with accommodating swaps and leave requests to ensure that shifts and leave are fairly distributed. These trainees are approachable and act as a point of contact for the FY1 and FY2 reps who meet them during the post to highlight any immediate issues that may arise. One trainee reported that this robust support system had not been experienced in any of their previous foundation placements.

Core/Specialty Trainees: Trainees advised there had been rota gaps on a number of occasions, but locum cover had been very good and there was enough scope within the rota day to day to ensure that the ward was covered.

2.14 Handover (R1.14)

Trainers: Trainers advised that handover is working well and provides a safe continuity of care for new admissions and those in downstream wards. Foundation trainees, the ward specialty doctor and ANPs attend handover, which has educational input.

Foundation Trainees: Trainees advised there is a reasonable structure for their handover which happens between junior staff and ANPs but has no senior input on a consistent basis. Handover is not used as a learning experience. When trainees switch wards, there is no handover of patients and they reported that they spend a lot of time catching up on reading previous patient notes.

Core/Specialty Trainees: Trainees reported that foundation trainees have a robust handover that involves specialty trainees at 8am and 8pm. There is no specific middle grade trainee nominated to supervise the foundation handover, except on a Friday when that is done by the specialty trainee who is working at the weekend. Handover can be used as a learning opportunity.

2.15 Educational Resources (R1.19)

Foundation Trainees: Not asked.

Core/Specialty Trainees: Trainees advised they have access to a registrar room which is a valuable resource for private study. There is an orthopaedic library which is well resourced and rooms for teaching which can be booked via the university. Computers on the wards are slow.

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

Not asked.

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: Trainers advised there is a specialty training committee with trainee representation which trainers feed into every three months.

Trainees: Not asked.

2.18 Raising concerns (R1.1, 2.7)

Not asked.

2.19 Patient safety (R1.2)

Trainers: Trainers advised that there are systems in place to report and discuss any patient safety concerns. Any safety issues arising are discussed at the trauma Morbidity & Morality (M&M) meeting or at a departmental M&M meeting which happens every two to three months. Trainers reported that the care of boarders is not as streamlined as had the patients been on a parent ward and so their preference is to avoid boarding where possible. A consultant is allocated to each patient at the start of their admission who remains responsible for their care throughout. The patient is seen each day and the department ensures that the patient list is kept up to date. Consultant and ST contact details are recorded on TRAK and in the patient notes

Foundation Trainees: Trainees advised they would feel uneasy if a friend or relative was admitted to ward 209. Foundation year 1s are responsible for daily review of patients on ward 209 and they would feel happier if there was a middle grade trainee who also reviewed patients. Trainees advised if this was their first foundation placement, they would find this more difficult than in post 3 as there is no consultant assigned to the ward, but only to individual patients who are reviewed after their operation. Trainees described a deteriorating patient in ward 209 who required input from the critical care team. Once the patient was stabilised, they remained under the care of the foundation doctor which the trainees felt very uneasy about. Trainees reported that the patient mix within ward 209 was similar to wards 108 and 109, but the major difference is that the other wards have OGS input to provide support for some patients. Medical boarders are sometimes assigned to the ward and trainees reported no issues with escalating to medical teams during the day, but this can be more difficult to do out of hours as it falls to the medical megistrar on call who is very busy.

Core/Specialty Trainees: Trainees advised that the overall quality of orthopaedic care in the department is excellent. Optimal care is different depending on which ward a patient is on and trainees believe that wards are safer, and patients are seen more frequently when based on a ward with an OGS. If trainees had any concerns with patient safety, they would escalate these and believe they would be taken seriously and acted upon.

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

Trainers: Trainers advised there is a dual system to discuss adverse incidents. There is a regular orthopaedic M&M meeting and an M&M structed review meeting for all serious medical events for everyone to attend which is recorded through the TRAK system. Datix is used for individual cases. There is also a weekly arthroplasty meeting.

Foundation Trainees: Not asked.

Core/Specialty Trainees: Trainees advised if there is an adverse incident it would be discussed at either the daily trauma meeting or the monthly or quarterly M&M fostering educational learning throughout the department.

2.21 Other

Overall satisfaction score:
Foundation Year 1: (only 2 scores) *2/10, 4/10*
Foundation Year 2: (only 2 scores) *6/10, 10/10*
CT/ST Trainees average score: (8 scores) *7.6/10*

3. Summary

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

The visit panel were extremely grateful for the level of attendance at the visit across all levels of staffing and for the work put into progressing previous visit report requirements. There are still some significant areas of concern in relation to undermining and foundation training and the visit panel look to seek improvements in the next few months with a follow up action plan review meeting at the start of the next training year and a revisit within a year. If significant improvements have not been made at that stage, it may be necessary to recommend enhanced monitoring.

Positive aspects of the visit:

- The visit team recognise the efforts to improve the training environment since the last visit.
- Very good engagement with visit across all levels of staffing.
- Excellent training environment for the majority of higher trainees.
- Very good local induction and a pro-active approach to sending a comprehensive handbook which prepares doctors well for working in the T&O department.
- Excellent buddy system between STs and foundation trainees which is well received.
- Supportive oversight of foundation rota by junior STs
- Supportive and helpful ANPs.
- Support for maintaining rotas with introduction of locums, pending more definitive solutions
- Excellent support received from the Orthogeriatric service (OGS) where available.
- FY2 trainees report significant improvements in their ability to attend protected teaching and have timetabling for educational experience in clinic or theatre.
- Protected teaching for ST/CT which targets trainees approaching fellowship exams
- Clear guidance is available to support the care of boarded patients in hours.
- Clear escalation guidance out of hours

Less positive aspects of the visit:

- Foundation trainees reported lone working on ward 209 leaving them feeling isolated and vulnerable when a patient becomes unwell.
- F1 trainees reported working beyond their competence.
- F1 trainees reported a comprehensive escalation structure overnight however during the day they report difficulty in knowing whether the contact for this support is available or not.
- Concerns with regards to non-educational tasks undertaken by F1s, trainees reported 99% of their time is used for service provision.
- Only 3 of 9 foundation trainees at the time of the visit had met with their educational supervisor and agreed a learning plan for this post.
- F1 trainees struggle to attend teaching if only 2 trainees are on the ward, due to workload issues.
- Foundation trainees report that few if any of their workplace-based assessments are signed off by a Consultant.

- Trainees reported an increased workload when based on a ward with no OGS input available.
- Lack of induction for foundation trainees to their role in covering cardiac admissions.
- Handover is rarely a learning experience for foundation trainees as more senior input to this is not consistently available.
- Limited tailored teaching available for ST1& ST2s.
- A report of undermining behaviour was received from a trainee following the visit feedback meeting.
- Following the feedback meeting, a trainee reported that STs in the unit frequently ran clinics in the absence of a supervising consultant.
- Ward 209 was highlighted as a particular area of concern by all trainee groups due to lone foundation working, lack of senior support with no OGS.

Requirements from previous visit (25/11/2019)

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

Ref	Issue	Progress noted – September 2020	Progress – May 2021
1	Barriers preventing F2 trainees attending their dedicated teaching days must be addressed.	Teaching days are currently in rota. Locum cover will be arranged for trainees who would have had ward duties to ensure they are able to attend.	Partially addressed – still issues with zero days
2	Handover processes must be improved to ensure there is a safe, 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.	The elective (non-trauma) handover will be formally passed onto the ward ST doctor and the elective FY in the morning from the ANP. Update 09/2020 elective orthopaedics was stopped during the first wave of the pandemic. This work is ongoing.	Some progress has been made however Foundation handover lacks senior leadership on a consistent basis
3	The Board must make sure there are enough staff members who are suitably qualified to manage the additional workload associated with the selection, assessment and management of boarders within Orthopaedics. This refers to complex letters and referrals for boarded patients within Orthopaedics being performed by FY1s.	RIE boarding policy provides direction on supervision of FYs when managing boarders. This policy was introduced about 4 years ago and is discussed on an annual basis ahead of the winter period. It was again circulated ahead of the winter season. Increased funding has been sought and provided for	Clear guidance is now available to support the care of boarded patients in hours. Work should continue to seek a robust solution for out of hours cover.

		additional medical cover for boarders. There are major efforts at Board level to reduce/control the number of boarders and improve flow through the hospital. This is dependent on the HSCPs being able to provide effective care in the community. NHSL is working closely with all HSCPs to increase capacity outside the RIE. Update 09/2020 Boarding policy has been recirculated ahead of winter. Due to the events of the last 6 months there has not been a time when the wards have had significant numbers of boarders (some T&O wards were repurposed during the pandemic and FYs supported the change in service)	

4. Areas of Good Practice

Ref	Item	Action
4.1	Excellent buddy system between STs and Foundation trainees which is well received.	n/a
4.2	Very good local induction and comprehensive handbook preparing doctors well for working in the T&O department.	n/a

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	Action
5.1	A more tailored teaching programme for ST1s and ST2
5.2	Work placed Based Assessments to be signed off by Consultants in a timely manner

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	Allegations of undermining behaviour must be investigated, and if upheld, an appropriate action plan must be instigated to address them	Immediate	All training grades
6.2	Medical staffing must be reviewed to ensure this is appropriate to safely manage the workload and avoid lone working of junior trainees	Immediate	All training grades
6.3	All trainees working within clinics must be supervised by a Consultant.	Immediate	All training grades

6.4	Tasks that do not support educational and professional development and that compromise access to formal learning opportunities for Foundation doctors should be reduced.	February 2022	Foundation
6.5	Doctors in training must not be expected to work beyond their competence.	February 2022	Foundation
6.6	Barriers preventing Foundation trainees attending their dedicated teaching days must be addressed.	February 2022	Foundation
6.7	Educational supervisors must understand curriculum and portfolio requirements for the Foundation trainee years 1 and 2 groups.	February 2022	Foundation
6.8	Educational Supervision structures must be formalised, and regular meetings held with trainees. An initial meeting must be held within 4 weeks of commencing in post.	February 2022	Foundation
6.9	Trainers must ensure the availability of Specialty Trainees and Consultants to support Foundation trainees and provide a clearly documented escalation policy.	February 2022	Foundation
6.10	A process for providing feedback to doctors must be established. This should also support the trainees in achieving WPBAs to demonstrate progression in training	February 2022	Foundation
6.11	Handovers involving Foundation trainees must include consistent senior input to ensure patient safety and learning opportunities.	February 2022	Foundation
6.12	An induction or induction manual/guide must be provided to trainees who cover Cardiac Admissions	February 2022	Foundation

Action undertaken by NHS Lothian to address requirements can be found by logging in to NHS Lothian's Medical Education Directorate website. See "Action Plan" - located at the bottom of the webpage.