Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	2nd June 2023	**Level(s)**	Foundation, Core and Specialty
Type of visit	Triggered (Virtual)	**Hospital**	Dumfries and Galloway Royal Infirmary
Specialty(s)	General Surgery	**Board**	NHS Dumfries and Galloway

Visit panel	
Dr Fiona Drimmie	Visit Chair – Associate Postgraduate Dean (Quality)
Dr Anna Dover	Foundation Programme Director
Dr Pragnesh Bhatt	Training Programme Director
Dr Sarah Milliken	Trainee Associate
Ms Sarah Chiodetto	Lay Representative
Mrs Jennifer Duncan	Quality Improvement Manager
In attendance	
Mrs Gaynor Macfarlane	Quality Improvement Administrator

Specialty Group Information	
Specialty Group	Foundation
Lead Dean/Director	Professor Clare McKenzie
Quality Lead(s)	Dr Fiona Drimmie & Dr Marie Mathers
Quality Improvement Manager(s)	Mrs Jennifer Duncan
Unit/Site Information	
Trainers in attendance	2
Trainees in attendance	12 (F1 - 4. F1 acute receiving – 5. CT – 0. ST - 3.)

Feedback session: Managers in attendance	Chief Executive	1	DME	1	ADME	0	Medical Director	1	Other	6
Date report approved by Lead Visitor	Dr Fiona Drimmie Professor Clare McKenzie									

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 review and triangulation of available data, including the NES Scottish Trainee Survey, a virtual Deanery visit is being arranged to General Surgery at Dumfries & Galloway Royal Infirmary. This visit was requested by the Foundation Quality Review Panel held in October 2022 around the following concerns:

<u>NTS Data (2022)</u>
F1 Surgery – Quadruple Red Flag – Clinical Supervision. Red Flags – Clinical Supervision Out of Hours, Educational Supervision, Feedback, Rota Design.
Core – All grey.
ST – Red Flags – Teamwork, Workload. Pink Flags – Clinical Supervision, Clinical Supervision Out of Hours, Regional Teaching, Rota Design.

<u>STS Data (2022)</u>
Foundation – Green Flags – Induction, Teaching.
Core Surgical Training – All yellow.
Core, General Surgery – All yellow.
ST – All white.

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 and pre-visit questionnaire. It was also agreed to add an additional trainee session to interview F1 trainees in acute receiving providing cover in general surgery.

Departmental Presentation:

The visit commenced with a presentation led by Dr Peter Armstrong, Director of Medical Education (DME). The presentation provided a useful overview of the structure of the hospital and staffing within the department. It focused on areas highlighted within the previous visit report and data from the 2022 National Training Survey (NTS) and Scottish Trainee Survey (STS). It provided insight into new and ongoing challenges faced by the hospital and department and detailed the areas they are working hard to improve.

2.1 Induction (R1.13):

Trainers: Trainers reported that they have a very successful shadowing and induction programme in the hospital which equips trainees well for starting in the department and ensures they have relevant IT access and are familiar with systems.

F1 Trainees: Trainees reported receiving a one-hour lecture from a surgeon however received no formal induction to the wards. They do not believe induction equipped them to work in the department. They commented that the team structure and how cover is provided when the on-call ST trainee or consultant is on leave was not made clear to them. Changes in the rota are also rarely communicated which contributes to F1 trainees being unaware of who to escalate problems to. In the event where they do get a contact for escalation often the consultant or ST trainees are in theatre and not available. They commented that ST trainees and consultants have unrealistic expectations of F1s and lack understanding of the F1 job. They are not aware of a departmental handbook.

F1 acute receiving: Trainees reported receiving an induction with all departments at the start of the post. It covered what was expected of them on shift and within the different areas they would be covering. No catch-up induction was provided for those that missed it or were absent at the first induction. Most trainees advised that they had already completed a post in surgery and therefore knew their way around.

ST Trainees: Trainees reported receiving both hospital and departmental induction which were of good quality and equipped them to work in the department. They commented that catch up induction

was made available to a trainee with a delayed start. They also recognised that improvements could be made to the F1 induction.

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

Trainers: Trainers were unsure as to how many regional teaching sessions F1 trainees have attended. They commented on F1s having a busy schedule and that should they be unable to attend a session that teaching is recorded and can be viewed later. There should be no issues in CT or ST trainees attending regional teaching and noted that non-attendance is due to on-call. They advised of a planning meeting that takes place every Friday to review rotas to ensure adequate cover is in place across the department, this also includes teaching sessions. They commented that feedback on departmental teaching is collected by the person delivering the teaching to allow them to adjust for future sessions if they wish.

F1 Trainees: Trainees reported receiving one-hour per week of hospital wide regional teaching and can attend around 80% of sessions depending on shift. They advised that there is no formal departmental teaching programme for F1 trainees.

ST Trainees: Trainees advised that there is no formal departmental teaching programme however they are provided with a lot of informal training opportunities which they value. They described attending a colorectal meeting on a Friday, multidisciplinary meetings and had attend x-ray meetings however these have now stopped. They confirmed being able to attend a reasonable number of regional teaching sessions and commented that on-call can prevent them attending teaching.

2.3 Study Leave (R3.12)

Trainers: Trainers reported no difficulties in supporting study leave at any training level.

F1 Trainees: Trainees reported being actively discouraged from requesting study leave and are advised to wait until F2.

ST Trainees: Trainees gave a mixed response regarding access to study leave. The described requests not being considered when the rotas are written, of having to arrange their own swaps and reported that staff grades will not cover on-call shifts of shifts on a Friday.

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

Trainers: Trainers reported having adequate time in job plans for supervisory roles and on receiving excellent support from the DME and the medical education team. Good online resources are available for the foundation training programme. They noted that placement supervision group (PSG) feedback and summary narratives have taken time to get used to. They stated that clinical and educational supervisory roles are considered at annual appraisals. They commented that all trainers have had experience of trainees with issues at F1 and ST trainee level and receive a good level of support from the DME.

F1 Trainees: Trainees reported having allocated educational supervisors who they have meet once since commencing in post. They will have a further meeting nearer the end of the post.

ST Trainees: Trainees reported having good access to supervisors who they see every day. Most have no concerns in arranging formal meetings or achieving sign off for the most. One trainee commented on having to get in touch with the training programme director (TPD) regarding cover for their supervisor who has had to take some time off. Trainees commented on fantastic opportunities in the hospital regarding numbers and volume of training opportunities available to them.

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 reported that trainees are informed at induction who to contact for support during the day and out of hours (OOH). There is a fixed escalation pathway where trainees should contact the ST trainee or consultant. They stated that F1s have no concerns in calling consultants directly with consultants happy to provide support. They are not aware of any instances where trainees may have felt they have had to cope with problems out with their level of competence. They stated that F1s will see acutely unwell patients and carry out initial assessments while waiting on the ST trainee or consultant to attend to initiate treatment. They believe this is part of training and support is always readily available to trainees. The department also have 2 advanced nurse practitioners, enhanced

recovery nurses and the critical care team also provide great support and are happy to assist. They advised that F1 trainees are not asked to seek consent this is a task undertaken by an experienced ST trainee or consultant.

F1 Trainees: Trainees stated that they are aware of who to contact for support during the day and OOH however they may not be contactable or available. Should support be unavailable they are aware they should contact the on-call registrar however are unsure who to contact after that. They reported often working beyond their level of competence. They provided an example of being on nights with a patient who had a medical condition escalated to the ST trainee who was not worried and informed them they should not be concerned. Later another ST trainee came to the ward and took over the patient who unfortunately died. This trainee just happened to walk by the ward however had the F1 trainee did not have this support, they would have escalated to the critical care team even though they have been advised that they should not make direct contact with this team as it is expected that a more senior team member will do so after they have reviewed the patient. They advised that accessibility to seniors is variable. They commented that if a patient presents with a medical problem, they can call the second on-call for medicine who is very helpful. They have also had to contact a medical consultant to deal with a surgical problem on a night shift. In this case the medical consultant escalated to critical care as F1 trainees are no allowed to do so as it is out of their remit.

F1 acute receiving: Trainees advised being aware of who to contact for supervision during the day and OOH. They reported coping with problems out with their level of competence due to being unable to access senior support. Often the surgical on-call and consultant on-call are in theatre. They described struggling for long periods until someone more senior arrives to assist. They can contact the medical registrar for assistance however there is a degree of reluctance from them to get involved if the surgical registrar has not reviewed the patient. They commented that seniors are approachable and accessible most of the time and acknowledge if they were not in theatre, they would be easier to contact for support.

ST Trainees: Trainees reported knowing who to contact for supervision both during the day and OOH with all consultants being accessible and approachable. They confirmed that they do not have to deal with problems that are beyond their level of competence.

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

Trainers: Trainers reported they are familiar with the curricula for F1 and ST trainees. They spend a lot of time in the relevant portfolios with trainees and know what is expected of them as educational and clinical supervisors. They advised that F1 trainees do not attend clinics but are encouraged to attend theatre sessions and can be called upon at weekends to support ST trainees in theatre. For those trainees who wish to there are opportunities available to them. Trainers stated that trainees may find it slightly more difficult to achieve learning outcomes in vascular surgery and urology due to regionalisation of common procedures now undertaken in Lanarkshire.

F1 Trainees: Trainees stated there are competencies they will have difficulties achieving when in post. There are very little teaching opportunities, and although the recognise it is not part of their curriculum, they have had no theatre experience. The expectation is that F1 trainees manage the wards and discharges which takes priority over learning. This post is perceived to be service provision. Should they attend any teaching opportunities there is no backfill to complete tasks and therefore trainees must stay late to do so. They believe 85% of their time is spent carrying out duties that are of little or no benefit to their education, training, or personal development. Most days are task heavy with little time with patients. They commented on having a huge amount of responsibility placed on them with being the only person on the wards and can be unsure if they are doing the right things or a good job as there is no senior around to provide feedback.

F1 acute receiving: Trainees reported that they feel forced to develop their skills and competencies in managing the acutely unwell patient due to being provided with no feedback on day-to-day decisions or management plans. They perceive most of their time to be spent providing service provision. They described admitting and clerking patients OOH taking medical history and carrying out reconciliation of drugs on HEPMA which they believe could have and probably should be carried out by a registrar. They also commented that the emergency medicine department have no access to HEPMA.

ST Trainees: Trainees reported no concerns in achieving all learning outcomes required for the post. They confirmed being scheduled for 1-2 theatre sessions, clinics, and endoscopy sessions per week if not on-call. They also confirmed that the post allows them to develop skills and competence in managing the acutely unwell patient. They commented on a 30:70% split of tasks that may be

deemed as non-educational and training time. They also commented on getting time to develop teaching skills with the chief resident providing teaching to juniors every 2-3 weeks. They provide juniors with informal teaching opportunities within ward rounds and commented on 3 junior doctors forum meetings as having taken place to date. Trainees were also asked if they had access to and use HEPMA. They stated that although they do have access their usage is minimal as they rarely prescribe. One trainee commented that they occasionally review medication with an F1 trainee and that some consultants occasionally review HEPMA within ward rounds.

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

Trainers: Trainers reported no concerns in any training grade achieving assessment requirements whilst in post.

F1 Trainees: Trainees stated it is extremely difficult to complete workplace-based assessments as they are rarely observed on a day-to-day basis. They find direct observation of procedural skills (DoPs) and Mini-CeXs the most difficult to obtain. The panel specifically asked if trainees had achieved enough for post sign off. They commented on obtaining some workplace-based assessments but not as many as they would have liked and will use assessments from previous posts for end of year sign off. Most assessments obtained in post have been completed by ST trainees.

F1 acute receiving: Trainees stated that they work alone OOHs and therefore are less likely to complete any workplace-based assessments at this time. They advised that there are no opportunities for them to attend theatre due to workload.

ST Trainees: Trainees reported no issues in obtaining workplace-based assessments in post. They commented on contributing to the assessments for F1 trainees. They also commented that F1 trainees have never approached them during a ward round for an assessment however this may be because they do not realise, they can do so. They often ask F1 trainees how they are getting on and if they need anything signed off.

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

Trainers/F1/ST trainees: Not asked.

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

Trainers: Trainers stated that trainees are very well supported and constantly encouraged to take part in quality improvement projects. ST trainees involve F1 trainees when undertaking a project and F1s are involved with audits and presenting findings at meetings.

F1 Trainees: Trainees reported that there are opportunities to take part in quality improvement projects and trainers encourage them to do so however there is little time in the working day to support this.

ST Trainees: Trainees reported good opportunities for involvement in quality improvement projects.

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: Trainers recognise that feedback is an area they can improve upon. Feedback is not always given immediately due to time constraints but is provided later. They find it easier giving feedback to CT and ST trainees as they spend more time together. Feedback tends to be verbal however on occasion is written. They consider OOH to be a better time to provide F1 trainees with feedback on everyday decisions and management plans. They commented that it is expected that F1 trainees should be able to provide primary and provisional diagnosis and updates for all patients without having to refer to case notes.

F1 Trainees: Trainees reported receiving no formal constructive or meaningful feedback on clinical decisions during the day or OOH. They commented that there is a greater responsibility OOH as one rota shift covers the work 5 F1 trainees would do during the day. Weekends are covered by one F1 trainee looking after the same number of patients. Patients will be reviewed by an ST trainee at some point on shift however they rarely receive on the job feedback. They noted mistakes are easily made when so busy. There is no regular senior review of HEPMA prescribing for surgical patients this is

generally undertaken by F1 trainees. They value the support from pharmacists and the microbiology team who are approachable and helpful.

F1 acute receiving: Trainees stated that they work alone the majority of the time therefore there is no one to provide any feedback.

ST Trainees: Trainees reported receiving constant on the job feedback which is constructive and meaningful feedback.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: Trainers stated trainees can provide feedback regarding their training at mid and end of placement meetings. Trainers have good relationships with trainees and encourage trainees to bring any problems to them. There is also a junior doctors forum they can raise concerns through, to date there has been no feedback from the group directed at surgery.

F1/ F1 acute receiving Trainees: Trainees reported attending a local trainee forum a few days prior to the visit taking place where they could raise concerns relating to the quality of training received. They are unaware of these meetings taking at any other time in post.

ST Trainees: Trainees reported providing informal feedback at Friday meetings and within junior doctor forum meetings.

2.12 Culture & undermining (R3.3)

Trainers: Trainers stated that they are making a conscious effort to improve team culture and try to involve F1 trainees in everything that goes on in the department. They are encouraged to present patients and provide consultants with updates however time constraints during the week can make this difficult. Often consultants only have a short time to review several patients before having to be in theatre. They find that over a weekend there is a more of a team-based structure which allows them to spend more time with trainees and allows them to go for coffee together. Trainers recalled a complaint of bullying received from F1 trainees regarding an ST trainee which was escalated to the TPD, and support put in place.

F1 Trainees: Trainees stated that they have little concerns with individuals in the senior team however noted the team structure does not work. They are aware of colleagues earlier in the training year raising concerns relating to support from the senior team which were escalated to the management team and foundation programme director (FPD). They are not aware that anything further was done following the report to the FPD. They felt their concerns are not listened to, not taken seriously, and are disregarded. They commented that they have witnessed and experienced behaviours of bullying and undermining and described being shouted at and told off in handover which leaves trainees feeling low. They do not feel well supported when presenting management plans to seniors. There is also an expectation that they should have in depth knowledge of all patients and management plans which they feel is unrealistic given the number of patients they are responsible for. They perceive these behaviours to be part of the culture in the department and a hospital wide problem. They described feeling frightened to raise any concerns for fear of repercussions. There is also varying acceptance as to how other team members treat F1 trainees and that although all staff are aware these behaviours are inappropriate no one present has ever challenged these behaviours.

F1 acute receiving: Trainees stated that seniors are supportive. They advised that OOH the acute receiving F1 trainees will also provide cover in admission and the night advanced nurse practitioner (ANP) will also provide cover on the ward. They described an OOH shift where there was no ANP cover resulting in the F1 trainee having to provide cover for both roles which was unsafe. They believe this was a management decision and was later escalated to consultant level by the F1 trainee however was taken no further. They reported witnessing and being subject to behaviours of bullying and undermining from ANPs at evening handover. Often the ANPs will off load their jobs from handover to the night F1 trainee. These issues have also been raised with no outcome.

ST Trainees: Trainees reported no concerns regarding bullying and undermining behaviours and commented on very supportive environment.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Trainers stated that there are ample opportunities available to trainees if they wish to take advantage of these. Rotas do not include clinic or theatre time for F1 trainees they must rearrange workload to be able to attend these sessions. Trainers reported no gaps in the current rotas, and should a gap be present it may be covered by a locum or often trainees help to cover gaps. They acknowledge pressures in the rota and that trainees may feel overworked however believe the only way to resolve this is by being allocated more trainees by the deanery.

F1 Trainees: Trainees reported no gaps in the F1 rota however there can be unexpected absences OOH which are generally managed and covered by another F1 trainee as the rota co-ordinator does not work OOH. They reported spending no time in clinics or theatres and in having no personal development time. They believe there are aspects of the rota that compromise their wellbeing. They commented on being the first point of contact and only person overnight with responsibility for patients in critical care. Duties can range from things such as fluid management however as these are very sick patient's problems can be complex and often, they feel out of their depth and must call the surgical registrar as they do not feel safe looking after these patients. Trainees stated there is no continuity in their ward placements and that they are frequently changing wards with the longest time spent on one ward being a few weeks however generally they tend to work different wards during the week to those at the weekend. They described a typical day as attending ward rounds and completing discharges. They also described attending an unproductive huddle with the consultant on-call for weekend changeover. At this huddle they run through patients who have come in overnight, the previous days patients including management plans and surgical patients' acute management ongoing. After the huddle they attend a ward round to see the surgical patients however it is not always possible to review them all. Ward rounds are fast paced, and difficulties were noted in keeping up with the recording of outcomes in notes. The timing of ward rounds varies from half an hour to an hour and a half. There is also a pressure to complete outstanding ward jobs and discharges instead of attending a ward round. There is no afternoon catch up.

F1 acute receiving: Trainees reported no gaps in the rota. They stated that the rota is tight and if one person was to go off it would become very challenging and often the F1 trainee on shift would be expected to cover 2 roles. The rota co-ordinator works from home during the day and therefore WhatsApp is used OOH to inform the team of any absence. They believe there are aspects of the rota that compromise their wellbeing. They commented on an intense rota with 3-week blocks of days and night, nights to days and long days. The medical rota is less intense than the other 2 areas covered.

ST Trainees: Trainees reported no gaps in the ST rota. They confirmed having time in the rota for clinics, theatre, and endoscopy. They believe that allocation of trainees to trainers could be done better and are concerned that staff grades in non-training post are given priority over those in training posts. This was raised with consultants and dismissed.

2.14 Handover (R1.14)

Trainers: Trainers reported handovers as taking place each morning with new admissions discussed and CT trainees responsible for updating the sheet with everything relating to patients. Handover takes place in a dedicated room with computer access to allow x-rays and scans to be viewed. Often F1 trainees are asked for their opinion which can put them on the spot however promotes learning and is in a supportive manner.

F1 Trainees: Trainees reported multiple handovers as taking place. They described a hospital wide handover as taking place at 9pm with the surgical F1 trainee in attendance. There are F1 peer handovers with no senior presence and ANP to F1 handovers. They are aware of the 8am morning meeting however as the F1 doesn't start until 9am they cannot attend. The consider morning handover to be adequate however evening handover has no other input from surgery other than from the F1 trainee. They find handovers to be intimidating, humiliating and dread attending due to management plans being picked apart, being shouted at and there being a general feeling of inconvenience at handing over incomplete jobs to the night team. They do not believe handover provides any learning. They stated this is a issue at the hospital wide night handover with inappropriate behaviours from ANPs and medical consultants.

F1 acute receiving: Trainees stated that ANPs cover surgical wards overnight who then provide handover to F1 trainees. The ANP shift pattern is 8am-8pm and 8pm-8am often handover takes place at 6am with ANPs then finishing shift shortly afterward leaving the night F1 trainee providing medical cover and back of house cover. They do not consider handover to be a learning opportunity.

ST Trainees: Trainees reported issues with handover in the last 4 months with work ongoing to resolve these. They confirmed surgical handovers as taking place every day however due to the surgical F1 trainee not starting on shift until 9am they are unable to attend the 8am consultant lead handover. They commented that ANPs should leave at 8am however often provide F1 trainees with a written handover between 6am-7.30am then leave the F1 trainee to cover an additional 6 medical wards for an extended period. F1 trainees work 9am-9pm with all other members of the team working 8am-8pm this is historical and to ensure cover is provided in critical care and medicine however ST trainees believe there should be sufficient medical cover in the hospital from 8am-9am and therefore no reason F1 trainees cannot be changed to 8am-8pm. Issues with ANPs have been raised and will be escalated. They consider morning handover to be a good learning opportunity.

2.15 Educational Resources (R1.19)

Trainers/F1/ST trainees: Not asked.

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 stated that the hospital are very good at supporting trainees in difficulty. The DME is first class, empathetic and very supportive. Occupational health can be contacted, and reasonable adjustments can also be considered depending on the trainee's individual needs.

F1 Trainees: Trainees advised that if they were struggling with their health, they would seek support from the education team and commented on excellent support provided by Anne-marie Coxon, Education Centre Manager. They stated that they would not be comfortable raising any health-related issues directly with anyone from the department.

ST Trainees: Trainees advised that support would be available to them should they be struggling with their health or any aspects of the job. They are also confident that the department support requests for reasonable adjustments to training based on individual need. One trainee commented on being well supported after an accident returning to amended duties.

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 stated that there is a committee that oversees the management of training however they are unsure as to how trainees are involved in this. They commented on the weekly Friday meeting to which trainees are encouraged to attend and can raise any concerns relating to training.

F1/ST Trainees: Not asked.

2.18 Raising concerns (R1.1, 2.7)

Trainers: Trainers commented that trainees are encouraged to use the datix system to raise concerns relating to patient safety. Often trainees will approach trainers or the ward sister to raise any concerns as they feel comfortable to do so.

F1 Trainees: Trainees stated that they can raise concerns regarding patient safety with senior nurses, senior staff, management, or their educational supervisor. However, they are concerned about consequences if they raise concerns which cause added stress to them. Trainees provided a few examples one of which were an ANP manager advised a trainee that concerns raised were inappropriate. This experience left the trainee feeling humiliated, belittled, let down and doubting their ability to raise concerns in the future. The trainee did discuss the incident with their supervisor.

F1 acute receiving: Trainees stated they were unsure as to how effectively patient safety concerns would be addressed. They are aware of the datix reporting system.

ST Trainees: Trainees advised that should they have any concerns regarding patient safety they would be taken seriously and acted upon.

2.19 Patient safety (R1.2)

Trainers: Trainers reported that they have no concerns regarding the quality or safety of surgical patients who are boarded on other wards. Consultants are diligent in seeing these patients on a daily basis. They commented that medical boarders within surgery do not receive as much senior input and recognise pressures on critical care beds with patients often requiring a little extra time before discharge. They described handover as the routine system for monitoring boarders. There are also ward rounds and midday huddles with nursing staff, occupational therapy and junior doctors in attendance where the ward board is reviewed, and issues highlighted. They believe there is a comprehensive system in place to manage boarders.

F1 Trainees: Trainees advised of concerns with the system for boarding patients in the hospital. They commented that patients do not receive regular review from the parent team. Managers make decisions relating to boarders which are not based on clinical circumstances and are without discussions with the parent team.

F1 acute receiving: Trainees reported that there are currently 2 trainee ANPs on the OOH rota who are unable to prescribe which means they continue to require foundation doctor support which adds to their workload overnight.

ST Trainees: Trainees reported they would have no concerns if a friend or relative were to be admitted to the department and have no concerns relating to systems for the boarding of surgical patients within the hospital.

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

Trainers: Trainers reported that the datix system is used to report adverse incidents. There are issues in the system, rarely is there any feedback or outcomes circulated and often cases disappear. Should the datix relate to a serious matter then feedback is provided. They advised that is something was to go wrong with a patients care there is no blame associated and trainees are provided with relevant support.

F1 Trainees: Trainees stated that if they are asked for feedback on errors, they are happy to discuss. They commented on regularly apologising to patients due to the time it has taken for them to be seen. Often, they receive valid concerns from patients and families and do not always receive senior support when dealing with these. They also commented that drug errors aren't reviewed on ward rounds, there are no electronic records these are written and there are no standardised checklist for ward rounds.

F1 acute receiving: Trainees reported that feedback from adverse incidents can be very much dependant on whether a supervisor tells you about the feedback. They commented that they are invited to attend morbidity and mortality meetings (M&M). They again commented that it can be consultant dependant on whether they will speak to a patient, or a member of their family should something go wrong with their care or whether this will be left to the F1 trainee. They described a situation where a patient hadn't had a drug stopped and therefore couldn't have their scheduled surgery this was left to the trainee to inform the patient. They have also been in situations where they have had to say to a consultant that they are not comfortable in communicating some information with patients.

ST Trainees: Trainees reported that should they be involved in an adverse incident that consultants are very supportive and approachable and would have no concerns in receiving feedback. They advised of attending monthly M&M meetings where serious incidents are discussed. They have had no issues in communicating when something has gone wrong with a patients care as consultants are very supportive.

2.21 Other

Overall Satisfaction Scores:

F1 – average 4/10
F1 acute receiving – average 0/10
ST – average 8.5/10

3. Summary

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

The panel commended the engagement of the DME team and department in supporting the visit and their proactive approach to making change. The panel noted a good training environment for CT and ST trainees however concerns were apparent at F1 level. The key areas for improvement noted at the visit relate to integration of F1 trainees into the wider team, departmental teaching, study leave, adequate experience, assessments, feedback, culture and undermining, rota/workload, adverse incidents. The next steps will be to conduct a SMART Objectives meeting and Action Plan Review meeting.

Serious Concerns - Patient Safety:

- Ensuring that night acute F1 is not the immediate responder for clinically deteriorating surgical patients in critical care.
  *Discussed with DME immediately after visit.

Positive aspects of the visit:

- Excellent engagement from site and department pre visit with an informative presentation delivered on the day.
- Trainers reported having time within job plans for supervisory roles and being well supported in these.
- High praise of DME and Medial Education Team regarding support and proactive approach to making change was noted in all sessions.
- Trainees reported good induction to the hospital.
- F1s reported no barriers to attending regional teaching.
- All training grades confirmed having an allocated educational supervisor with initial meetings completed.

- CT and ST trainees commented a lot of learning opportunities to support the completion of workplace-based assessments.
- CT and ST timetables are mapped to training requirements for theatre and clinic time.
- Trainers reported being provided with updates on the changes to the Foundation and Surgical curricula.
- Opportunities for involvement in quality engagement projects for all training grades.
- Positive benefits of Friday planning meeting for CT and ST trainees.
- Consistent flow of constructive, meaningful feedback provided to CT and ST trainees.
- Approachable seniors.
- Trainees commented on the positive role of the chief resident and the recent start-up of Junior Doctor Forum meetings.
- Morning handover was reported as having provided good learning opportunities for CT and ST trainees.
- Positive benefits to the department in the expansion of ANP roles.
- F1s noted good support from the Microbiology and Pharmacy teams.

Less positive aspects of the visit:

- Difficulties recognised in integrating F1s into the wider team with the challenges of ward based F1s and CT/ST and consultant in team-based structures.
- F1s reported difficulties in escalation when seniors are not available or contactable.
- F1s noted no departmental teaching programme.
- F1s are discouraged from requesting study leave to undertake taster sessions in their 3rd block.
- F1s reported no formal learning opportunities other than delivering day to day care and also no scope to attend theatre or clinic sessions.
- F1s reported difficulties in completing workplace-based assessments due to mainly being based on the ward with little access to senior staff.
- No formal mechanisms for F1s to receive feedback on their day-to-day decision making.
- F1s reported concerns regarding bullying and undermining behaviours within the hospital handover setting which are not challenged by other senior members (not surgery specific). They also described negative interactions with ANPs and the ANP manager.

- F1s have an intense rota and regularly work beyond rostered hours.
- Trainees raised concerns regarding F1s providing long periods of cross cover for medical wards with no formal agreement due to early handover from ANPs to F1s which can take place between 6am-7.30am.
- Difficulties were noted with HEPMA which is not regularly reviewed by CT/ST. F1s feel exposed regarding decisions for drugs and noted instances where things have gone wrong.
- The system for feeding back through datix/educational supervisors is not working with no action noted. There was a general feeling of issues being raised that are not listened to and go unresolved.
- Concerns were raised with F1s being the first point of contact over night for critical care and potentially managing complex cases beyond their level of competence.

4. Areas of Good Practice

Ref	Item	Action
n/a	n/a	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	Item	Action
5.1	All	Difficulties recognised in integrating F1s into the wider team with the challenges of ward based F1s and CT/ST and consultant in team-based structures.
5.2	2.3	F1s discouraged from requesting study leave to undertake taster sessions in post.
5.3	2.12, 2.14	Difficulties noted with HEPMA which is not regularly reviewed by CT/ST. F1s feel exposed regarding decisions for drugs and noted instances where things have gone wrong.

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	A regular protected programme of formal departmental teaching should be introduced appropriate to the curriculum requirements for F1 trainees.	March 2024	F1
6.2	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	March 2024	F1
6.3	Feedback to F1 trainees on their management of acute cases and day to day decision making must be provided to inform their learning and training (aiming for this in at least 40% of opportunities).	March 2024	F1
6.4	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.	March 2024	ALL
6.5	Rotas need to be developed to ensure trainees are not working beyond their rostered hours and are not providing cover to excessive numbers of patients	March 2024	F1
6.6	Ensure trainees engage in use of the Datix system and highlight the importance of utilising this reporting mechanism. Provide feedback on Datix cases logged and ensure trainees are aware of this feedback to ensure the system is seen as responsive and a learning opportunity.	March 2024	ALL
6.7	Doctors in training must not be expected to work beyond their competence. In particular F1 trainees being the first point of contact overnight for critical care.	March 2024	F1