Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	1st February 2023	**Level(s)**	Foundation, Core, Specialty
Type of visit	Triggered (virtual)	**Hospital**	University Hospital Ayr
Specialty(s)	General Surgery	**Board**	NHS Ayrshire & Arran

Visit panel	
Dr Fiona Drimmie	Visit Chair – Associate Postgraduate Dean
Dr Linzi Peacock	Training Programme Director
Dr Peter Armstrong	Foundation Programme Director
Dr Aaron Taylor	Trainee Associate
Mrs Jennifer Duncan	Quality Improvement Manager
Mr Bill Rogerson	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 Fiona Drimmie & Dr Marie Mathers
Quality Improvement Manager(s)	Mrs Jennifer Duncan
Unit/Site Information	
Trainers in attendance	4
Trainees in attendance	7 (F1 - 4, CT - 2, ST - 1)

Feedback session: Managers in attendance	Chief Executive	0	DME	1	ADME	0	Medical Director	1	Other	8

Date report approved by Lead Visitor	08/03/2023 Professor Clare McKenzie 07/03/2023 Dr Fiona Drimmie

1. Principal issues arising from pre-visit review:

Following review and triangulation of available data, including the NES Scottish Trainee Survey, a virtual Deanery visit was arranged to General Surgery at University Hospital Ayr. This visit was requested by the Foundation Quality Review Panel held in October 2022 around the following concerns:

NTS Triage List: Bottom 2% - Red flags and significantly low scores.
STS Triage List: Bottom 2% - Red flags, significantly low score and persistent low scores.

NTS Data (2022) – combines data for General Surgery and Trauma & Orthopaedics
F1 Surgery– Red Flags – Clinical Supervision, Clinical Supervision Out of Hours, Feedback, Induction, Overall Satisfaction, Reporting Systems, Supportive Environment. Pink Flags – Educational Governance, Educational Supervision.
F2 Surgery – All grey.
Core – All grey.
ST – All grey.

STS Data (2022) – General surgery
Foundation – Red Flags – Clinical Supervision, Handover, Team Culture.
Core Surgical Training – All grey.
Core, General Surgery – All yellow.
ST – All grey.

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.

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 a presentation delivered by Dr Hugh Neill, Director of Medical Education. The presentation provided a useful overview and focused on specific improvements and work that has taken place relating to the areas highlighted within recent survey data.

2.1 Induction (R1.13):

Trainers: Trainers reported that F1s attend hospital induction on the morning of the first day in post followed by departmental induction in the afternoon. Departmental induction was provided by core trainees (CT) advanced nurse practitioners (ANPs) and consultants and covered topics such as working on the wards, expectations, on-call, team structure and who to contact for support. Trainers explained that there are not enough F1s to allow them to work in a team-based structure and therefore they are ward-based working across the 3 general surgical wards, urology and receiving. They are responsible for history taking, GP referrals, bloods, and are the first to see patients. Trainers recognise this is a big responsibility however felt there are benefits as they are working doctors from the first day in post. Should a trainee miss induction a catch up is provided in the ward setting with a consultant, ANP, F1 and clinical fellow (CF).

F1 Trainees: Trainees reported receiving a useful hospital induction. They also received a half hour departmental chat however no specific departmental induction was provided. The chat gave a brief overview of what it could be like on the ward which was not considered to have prepared them for their role. Trainees would have found it more useful to be introduced to the team, who they will be working with directly, which CT and ST trainees work within each team, how the ward round works, what is expected of the F1 at ward rounds and more detailed information on the day-to-day job. There is no clear distinction between the patients belonging to different ward teams this can be very challenging for example if a general surgery patient is in urology, it is difficult to know who to reach out to for support or to seek clarification on any matters.

Core and ST Trainees: Trainees reported attending departmental induction, receiving a handbook, having attended a hospital induction and of having completed mandatory online modules. They felt that improvements could be made to prescribing and IT system sessions, the session provided on HEPMA was not adequate if you had not used the system previously. They would have also found it useful to be formally assigned to shadow the on-call person.

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

Trainers: Trainers reported that attempts are made to release F1s from the ward to attend teaching. ANPs help with bleeps and all except the F1 on receiving should be able to attend. They stated that weekly Friday teaching and monthly morbidity and mortality meetings (M&M) are compulsory for all trainees to attend. F1s and middle grades present cases for discussion at Friday teaching sessions. F1 attendance at M&M meetings is variable. Trainees are also encouraged to undertake taster weeks where cover is provided. The onus is on the CT and ST trainees to inform the department of their regional teaching session however there is plenty of support available in the department to allow attendance.

F1 Trainees: Trainees reported receiving 2-3 hours per week of teaching which consists of 1-hour regional teaching on a Wednesday and 1-2 hours departmental teaching from general surgery on a Friday with opportunities for F1s to present and undertake quality improvement projects. They consider this to be good quality. There can be challenges in attending Friday teaching as it takes place at 12.30pm and people are trying to finish jobs for the weekend. Trainees commented that they felt there was a disconnect between F1s and consultants and a lack of understanding of the F1 workload and how this can prevent attendance at teaching. Should trainees attend teaching tasks are left and build up as there is no one else to undertake these. Trainees confirmed regional teaching is protected, and they have no concerns attending unless there is an emergency.

Core and ST Trainees: Trainees reported attending 1-hour per week of locally delivered teaching. Case presentations are presented by F1s for discussion. They also commented on a teaching initiative that took place in December for senior grades, which was meant to take place on a Thursday but only 2 sessions have taken place to date. On-call and getting stuck in theatre can prevent attendance however they confirm being able to attend around 70% the teaching sessions as Friday's are generally quieter days with only one theatre list. They commented that teaching could be

improved as this can be F1 focused. They would welcome the Thursday sessions being reintroduced as these sessions were more relevant to their stage of training. No concerns were raised regarding attending regional teaching for ST trainees. Regional teaching for CT trainees has moved back to face-to-face with most session taking place in Edinburgh which can make attendance difficult more difficult as travel time means the full day away from work and avoiding on call around the teaching day.

2.3 Study Leave (R3.12)

Trainers: Not asked.

F1 Trainees: Not applicable.

Core and ST Trainees: Trainees reported no concerns in requesting or taking study leave.

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

Trainers: Trainers stated that they are allocated between 2 and 3 trainees. Core and ST supervisor allocation can be based on a trainee's special interest to allow them to work directly with the consultant for 6-12 months. They confirmed having time within their job plans for supervisory roles. They feel well supported in these roles, receive appropriate training and supervisory roles are considered during appraisal. They stated that should they be allocated a trainee with concerns that the supervisor/clinical director/training programme director (TPD) would discuss the issues and how best to address these in the department.

F1 Trainees: Trainees confirmed having a designated educational supervisor who they have met once since starting in post. They stated that mid and end point reviews would also be arranged in due course. They do not expect to have any other interaction with them out with these meetings.

Core and ST Trainees: Trainees confirmed having designated educational supervisors who they have met once formally however work in the same team so interact daily. One trainee was based in a different team to their supervisor and therefore they only met at review periods.

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 coloured name badges being used to differentiate between the training grades. They stated that contact sheets with names and numbers of those who should be contacted for support during the day and out of hours (OOH) are available. Each ward is also aware of the on-call team page holder and each team has at least 3 middle grades along with an ST and a consultant who are approachable and contactable. They recognise that trainees can at times feel like they are working beyond their level of competence however there are clear escalation processes and consultants are available via mobile phone. Trainers stated that they supervise trainees in the consent process and provided an example of an ST3 undertaking a laparoscopy. Firstly, the trainee would observe the consultant discussing the procedure with the patient, then observe the procedure and then they would be given the opportunity to undertake the procedure under supervision with feedback provided. The consent process is always conducted by a person who knows the procedure and any complications that may arise. F1s do not seek consent.

F1 Trainees: Trainees reported knowing who to contact for support during the day and OOH. They stated that CTs are very helpful, respond quickly and give good advice. However, there is no support available above middle grade level. Trainees described difficulties in contacting seniors and on the occasion when they have been able to contact a senior no help was provided. They felt that there are occasions where they are working beyond their level of competence particularly when dealing with palliative patients. They stated that some consultants are approachable when seeking support. There is an expectation from seniors that F1s should know all patients regardless of how long they have been on the ward. They commented that frequent short notice moves in ward base make this impossible and are causing instability. Trainees have no continuity, no consistency and do not feel part of the team.

Core and ST Trainees: Trainees reported knowing who to contact for support during the day and OOH. They confirmed the on-call consultant are approachable and easily accessible. They all agreed that they have not had to cope with problems out with their level of competence. CT trainees commented that consultants can be more accessible and approachable than ST trainees. They described an issue with some specialty doctors who are on the formal rota as on-call, however, would prefer not to be contacted and will seek out those also on shift to inform them that they have not to be disturbed. Trainees have raised this issue along with the CFs however it has been very difficult to deal with and since there have been a lot of back handed comments which is creating a poor team

culture. They stated that if they need support, they will call the on-call ST but must be firm in stating they need help.

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

Trainers: Trainers stated they are aware of changes to the foundation and surgical curricula and that guidance and training is available. The surgical portfolio documents requirements for each level of trainee. Core and ST trainees also inform supervisors of their individual requirements at the start of the post. They have a weekly rota system where specialty doctors are assigned to theatre and clinics sessions which can be tailored to areas of interest. F1s can attend theatre if they have an interest. They advised that opportunities to undertake laparotomies and appendicectomies can be fewer therefore when these cases present trainees are encouraged to get involved. Trainers commented that the balance of time spent developing as a doctor and undertaking other tasks that may be of lesser educational benefit has been highlighted in the past and to help improve this theatre and clinic sessions were incorporated into the rota. They consider the experience of the F1s to be good as they are treated like doctors, they are the first point of contact, they take the patients history and attend morning handover which provide excellent learning opportunities. F1s are also supported on the wards by ANPs to help lessen the amount of non-educational tasks on the wards.

F1 Trainees: Trainees stated that there are opportunities to achieve all learning outcomes in post. They commented that there is no formal time scheduled for F1s to attend theatre or clinic sessions however they are allocated 3 development days over the year which can be used to this. These days are very well received, and trainees appreciate the efforts made to reschedule should a day be cancelled. Suggestion was made that F1s should be offered a weekly slot in theatre which would be of particular benefit to those with an interest in surgery which has been raised recently with supervisors. All trainees agreed that the post allows development of skills in managing the acutely unwell patient. They reported spending 75% of their time undertaking tasks that are of little of no benefit to their training or education. They described requesting bloods, sorting bloods for the next day, discharge letters, scribe at ward round which are not educational and often can start without the F1. They stated there is no formality to ward rounds, they are quick, and more than one ward round can be taking place at the same time, unfortunately, there are not enough trainees to attend both, and no verbal catch up offered. They gave an example of general surgery and upper gastrointestinal ward rounds as taking place at the same time. Often nurses compile lists of task or trainees must hope for

good written notes in the patient records this can however lead to tasks being missed which can happen a few times a week. They find the receiving shift useful as they are the first person to see the patient and the urology ward round better as they know more about patients beforehand, they also feel comfortable in asking questions if there is something they do not understand.

Core and ST Trainees: Trainees reported difficulties in achieving numbers for wound closures. They commented that there are occasions when consultants do not have time to watch therefore, they cannot use that case as an assessment. They also described difficulties if allocated to the colorectal team as opportunities are fewer as there may only undertake 1 or 2 procedures a day. Trainees confirmed being allocated to a lot of clinics which can sometime feel like service provision instead of training. The other task they find to be of little or no benefit to their education are dictation and discharges for patients they have never seen. They agreed that the post allows them to develop skills in managing the acutely unwell patient.

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

Trainers: Trainers reported no concerns in trainees achieving portfolio requirements. Formal meetings are held at the start, middle and end of post.

F1 Trainees: Trainees reported no difficulties in completing workplace-based assessments. Clinical fellows and CT trainees are approachable and happy to help. They do not interact with consultants or specialty doctors on the ward to allow them to be ticketed for assessments.

Core and ST Trainees: Trainees reported mixed experience in getting procedures signed off by consultants, some have had no issues and others have struggled.

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

Trainers: Not asked.

F1, Core and ST Trainees: Not asked.

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

Trainers: Not asked.

F1, Core and ST Trainees: Trainees reported that they can undertake quality improvement projects while in post.

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: Trainers stated that providing feedback is an area they can always improve on. They consider feedback as being provided continuously and they encourage trainees to ask questions at ward rounds to promote discussion. Formal supervision meetings are also a good place to discuss how trainees are getting on.

F1 Trainees: Trainees reported receiving constructive and meaningful feedback in urology however in general surgery feedback is very informal.

Core and ST Trainees: Trainees stated that if they ask for feedback, they will receive it. Ongoing feedback is provided in theatre.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: Trainers advised of a WhatsApp group managed by an ST trainee which allows trainees to provide feedback on their learning experience within the department. Trainees are also given the opportunity to provide any feedback with Friday meetings.

F1, Core and ST Trainees: Not asked.

2.12 Culture & undermining (R3.3)

Trainers: Trainers stated that Friday team meetings are used to promote a good team culture. They are not aware of any instances of bullying or undermining and referred to an incident in the last year which was dealt with and resolved through the appropriate channels.

F1 Trainees: Trainees reported no concerns relating to bullying or undermining in post. Should they have any concerns they would raise these with their educational supervisor.

Core and ST Trainees: Core trainees reported issues with some specialty doctors which they believe affect team dynamics. They confirmed that these issues have been raised with consultants. CT trainees commented that they would find it easier raising any concerns with a consultant rather than ST trainees.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Trainers reported that clinic and theatre sessions are scheduled within the rota. CT trainees have timetabled endoscopy lists along with scheduled clinic and theatre sessions. It can be difficult for F1 trainees to attend clinic or theatre sessions due to staffing shortages however if the opportunity presents, they can attend to observe a procedure. F1s are encouraged to undertake a taster week. Mr Kallachil also provides one-to-one teaching and mentoring for an hour on a Friday when not on-call which has been well received. ANPs provide cover to allow attendance. Trainers stated that there is a gap at F1 level, but they do not believe that trainees are affected by this as ANPs are assisting with any additional workload. They are not aware of any aspects of the post that are compromising trainee wellbeing and feel that trainees enjoy the post.
F1 Trainees: Trainees reported a long term F1 gap in the rota which has not been filled. The commented that the rota co-ordinator does a good job and tries to be open however communication between urology and general surgery is poor and agreed actions are not always adhered to which can cause friction. They also commented on difficulties in managing the long-term gap as the rota co-ordinator is far to stretched to give general surgery the attention is requires. There have been multiple instances that gaps in the rota have not been filled and trainees are informed of this within handover.

Core and ST Trainees: Trainees confirmed that there are currently 2 gaps in the rota with no plan to recruit. Shifts are mostly picked up internally as locum shifts. They do not believe that the rota is affecting their wellbeing. They did however comment that shift intensity can be great particularly the first on-call and after 5 on-call then going straight into theatre sessions.

2.14 Handover (R1.14)

Trainers: Trainers stated there are 3 handovers per day at 9am, 5pm and 9pm. 9am handover is mainly for on-call patients and sick elective patients. It is consultant lead, teaching orientated and includes the F1, ANP, CT and ST trainees. This is followed by a teaching ward round from 12.30pm – 1pm. 5pm handover is between a senior trainee and the rest of the team. 9pm is the handover from the day to night team. Again, trainees are in constant contact through the WhatsApp group.

F1 Trainees: Trainees reported being aware of 2 handovers in general surgery taking place each day. Urology also handover in the morning and talk through each patient. In general surgery there is an F1-F1 handover. The F1 starting on day shift must seek out people to talk to prior to attending the 9am medical handover. There is morning handover on the receiving ward which includes the F1. They stated that there is no 9am, 5pm and 9pm handovers in surgery and handovers that do take place do not have a formalised structure. Trainees do not consider handover to provide safe continuity of care for new admissions or for patients in downstream wards. They commented on finding out about patients as they go throughout the day. They spoke highly of ANP support and stated they are proactive and look at notes and update themselves, so they are prepared for ward rounds.

Core and ST Trainees: Trainees reported formal morning handover is between the consultant, night shift person and receiving F1, they discuss all patients and then undertake a ward round. Occasionally at 5pm there can be a short rundown for those patients that are of concern however this is not formal. At 9pm there is a formal dayshift to nightshift handover. Weekends are easier to get support as seniors are not in theatre. They commented that if handover is done properly then it does provide safe continuity of care. They believe there is an element of teaching at morning handover and there can be some good discussions.

2.15 Educational Resources (R1.19)

Trainers: Not asked.

F1, Core and 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: Not asked.

F1, Core and ST Trainees: Trainees reported they are aware of support being available to them should they be struggling with the job or their health. They believe the site does accommodate requests for reasonable adjustments to training.

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

Trainers: Trainers reported that anaesthetic colleagues at University Hospital Crosshouse, the Director of Medical Education and Deputy Director of Medical Education for NHS Aryshire and Arran oversee the management and quality of postgraduate medical education and training on site. Trainers commented that on occasion the balance between service and medical education can be compromised. For education purposes it is important for F1s to attend ward rounds however they can be pulled from these to complete tasks if there are shortages or to complete discharge letters.

F1 Trainees: Trainees stated that there is no formal forum for raising concerns regarding the quality of training in post. They are told that consultants are always approachable should they wish to raise any concern. They commented on weekend shifts for F1s being very difficult and unsafe. They are aware of efforts to raise such concerns where suggestions were made for improvements however these were not listened to. They commented on a meeting arranged by the clinical director where it was presented to trainees that they were welcome to raise issues and speak freely. Trainees felt uncomfortable and commented on the meeting being an unpleasant experience and not a safe place to raise any issues. They again raised concerns with weekend shifts, the heavy workload and volume of discharge letters with one F1 covering 3 wards plus urology. They believe there is a lack of recognition from seniors on what is expected of an F1 and the list of responsibilities they have.

Core and ST Trainees: Trainees stated that there is no formal forum to raise concerns relating to the quality of training in post. If they had any concerns, they would raise these with their TPD or chief resident. CT trainees described a meeting that took place recently where they did not feel listened to, they found the meeting uncomfortable and unhelpful.

2.18 Raising concerns (R1.1, 2.7)

Trainers: Trainers reported that trainees are encouraged to raise concerns relating to patient safety via robust M&M meetings. The morbidity part is explained in detail at induction, the meeting also looks at near misses and any problems in management should a patient be admitted after discharge along with all mortality cases being discussed. Trainees are also encouraged to raise any concerns with seniors.

F1 Trainees: Trainees stated that they have raised concerns with the CT trainee regarding patient safety when on receiving. They gave an example of 5 general surgery patients needing to be seen with only one room available which is very cold. They also raised concerns about the length of time these patients were having to wait to be seen because of this.

Core and ST Trainees: Trainees stated that they would raise any concerns relating to patient safety with a consultant or member of the on-call team.

2.19 Patient safety (R1.2)

Trainers: Trainers reported no concerns in the quality and safety of patient care. They consider the department to have good governance structures and robust systems in place. The datix process is also very good and trainees are encouraged to use the system. Trainers commented that boarded patients are managed by the parent department, who will come to the ward to review the patients. ANPs liaise with teams to ensure patients are reviewed. Daily lists are provided which detail where all patients are.

F1 Trainees: Trainees stated that they would have concerns if a friend of relative were to be admitted to the ward. They commented on escalating patients who have been admitted with surgical problems that are now medical to the CT trainee or CF as surgeons refuse to see these patients and state, they should be referred to the medical team. These patients are not properly handed over to the medical team and can wait 2-3 days to be reviewed. Lack of note keeping is also a big issue, if there is a F1 present at ward rounds then they become the scribe however there are instances where some specialty doctors review on their own and relay the management plan to a nurse, but no record is

made in the patients notes. This is an ongoing issue with senior staff. Often after ward rounds F1s and CTs are spending a lot of time trying to find out what the plan is for some patients. They also raised concerns with boarders in that a lot of these patients are very ill with complex medical problems but have F1 surgical trainees trying to look after them who are not familiar with these problems. They are unaware when medical patients will be reviewed by the medical team and there have been instances where trainees know nothing about these patients. A trainee described carrying out CPR on a patient they were unaware had a DNR which was a very traumatic experience. Often patients are boarded to surgical wards without the medical team's knowledge due to medical wards being full and other departments needing to move patients on. Trainees are not aware of any systems to monitor or track boarders. Trainees commented that medicine hold a list of boarders which they review at handover. There are no such lists in surgery wards, instead trainees look at the ward board to see if the consultant looking after the patient is a Dr, Mr or Ms.

Core and ST Trainees: Trainees stated they would have no concerns if a friend or relative were to be admitted to the department. Trainees stated that medical boarders are more of a problem for F1s as they are ward based. CT and ST trainees spend very little time in the ward setting.

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

Trainers: Trainers reported that adverse incidents are reported via the datix system and M&M meetings. Should the datix involve a trainee the clinical director would meet with them to discuss the matter and take a statement. They will look at the situation in detail, how it could have been avoided and what could have been done better. The trainee is also encouraged to add a reflection to their portfolio on the datix.

F1 Trainees: Trainees reported being aware of the datix system however most have not had to use the system and therefore were unable to provide comment. A trainee who had been involved in a datix described a debrief where they went over what went wrong and what could have gone better. There was a further check up to ensure they were ok a few days after. The trainee found it a good learning experience and noted an audit that is now taking place by the resus team on cardiac arrest calls.

Core and ST Trainees: Trainees reported being aware of the datix system and M&M meetings however have had no experience of using the system.

2.21 Other

Overall Satisfaction:
F1 Trainees - 4/10
Core and ST Trainees – 6.16/10

3. Summary

Is a revisit required? **(please highlight the appropriate statement on the right)**	**Yes**	**No**	**Dependent on outcome of action plan review**

The panel commended the engagement of the site, trainers, and medical education team in supporting the visit. An immediate concern was raised for action in relation to documentation of clinical decision. No serious concerns were identified within this visit. The panel noted a good training environment for specialty trainees however some issues were raised regarding the experience of the foundation trainees. The key areas for improvement noted at the visit relate to induction, non-educational tasks, handover, discontinuity of ward placements, assessments, management of medical boarders, feedback, and team culture. Overall, the visit was positive, the panel noted a committed group of trainers with a supportive DME team who are keen to make improvements.

Positive aspects of the visit:

- Excellent engagement from site and department pre visit with an informative presentation delivered on the day.
- Friday lunchtime departmental teaching is well received by all training grades.
- Trainees confirmed being able to attend a good proportion of regional teaching.
- All training grades confirmed having an allocated educational supervisor with initial meetings completed.
- A wide range of experiential learning opportunities are available to middle and higher-grade trainees including endoscopy.

- Good variety of teaching opportunities offered including informal opportunities within clinics and theatre.
- F1s commented on a very supportive and helpful cohort of CT trainees, who are also happy to undertake assessment requests.
- F1s provided positive feedback on development days which have allowed attendance in theatre. They also appreciated that development days are rescheduled if there is a requirement for these to be cancelled.
- All training grades reported good opportunities to undertake quality improvement projects and audits.
- Consistent flow of informal constructive and meaningful feedback provided to CT and ST trainees. F1s commented on a more cohesive team within Urology where constructive feedback is provided.
- Trainees commended the work put in by the rota co-ordinator and appreciate difficulties faced.
- F1s commented on a good morning and evening handover system in Urology.
- CT/ST described morning handover as effective, structured with an element of teaching, this includes the receiving F1 who also consider this handover to work well.
- F1 described a positive experience relating to an adverse incident which was well debriefed, followed up and used as a learning opportunity. This has also led to a hospital wide audit.

Less positive aspects of the visit:

- F1s report no formal departmental induction. They received a brief chat which did not equip them to work in the department. Trainees would appreciate a more detailed and thorough induction providing an understanding of teams, escalation within each team, introductions, and expectations of roles and responsibilities.
- CT/ST trainees commented that induction to IT systems is lacking and should be improved to include more than HEPMA.
- F1 trainees believe a high percentage of their working day is spent carrying out tasks that are of little or no benefit to their education or training.
- F1 trainees have no opportunity for direct interaction with consultants therefore advised that none of their workplace-based assessments are signed off by a consultant.

- No formal mechanisms for F1 trainees to receive feedback on their day-to-day decision making. They consider the experience out of hours to be slightly better with some informal feedback provided.
- Ward based versus team-based structure for F1s. Discontinuity of ward placements for F1s is a concern, trainees are moving wards every few days and have no consistency of working within a team. There is also no flexibility in the rota for any gaps.
- F1s report simultaneous ward rounds are still being undertaken. Opportunities for ward rounds to be utilised to promote learning are being lost as trainees are used as scribes and struggle to keep up with the flow and have no opportunity to engage.
- Formal structured handovers were described by management and trainers as taking place at 9am, 5pm and 9pm. This was not reflected in the trainee sessions. Handovers do not appear to be working well for F1s. 5pm handover is informal and has no structure. F1s are conducting a separate peer to peer handover either face to face or via WhatsApp. Again, these are lost learning opportunity for trainees.
- F1 reported feeling unsafe on weekend shifts due to volume of work and IDLs. Suggestions for improvements were made to seniors however these were not taken forward.
- Second on registrars (non-training) are actively discouraging trainees from contacting them at home. This is becoming embedded in the team culture. Concerns have been raised by trainees however as a result has led to a poorer culture.
- Concerns were raised by all training grades regarding management meetings. Trainees felt they have no forum or safe space to raise concerns without fear of retaliation.
- The WhatsApp group Trainers believe is used by all training grades as a platform to raise concerns is in fact used for handover or seeking support on clinical matters.
- F1 trainees believe there is a significant lack of recognition and understanding on the role of the F1 and duties they undertake.
- Concerns with medical boarders were raised due to lack of management and communication. Trainees are often unaware of management plans which can lead to things being missed. A concerning example was provided relating to a DNR and CPR.

4. Areas of Good Practice

Ref	Item	Action
4.1	A wide range of experiential learning opportunities are available to middle and higher-grade trainees including endoscopy.	n/a
4.2	F1s commented on a very supportive and helpful cohort of middle grade trainees, who are also happy to undertake assessment requests.	n/a
4.3	F1s provided positive feedback on development days which have allowed attendance in theatre. They also appreciated that development days are rescheduled if there is a requirement for these to be cancelled	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	Concerns were raised by all training grades regarding management meetings. Trainees felt they have no forum or safe space to raise concerns without fear of retaliation.	
5.2	F1 trainees believe there is a significant lack of recognition and understanding on the role of the F1 and duties they undertake.	

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	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. Handbooks or online equivalent may be useful in aiding this process but are not sufficient in isolation	November 2023	F1
6.2	All trainees must have timely access to IT passwords and system training through their induction programme.	November 2023	CT/ST
6.3	Tasks that do not support educational and professional development and that compromise access to formal learning opportunities for all cohorts of doctors should be reduced.	November 2023	ALL
6.4	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	November 2023	F1
6.5	A process for providing feedback to Foundation doctors in training on their input to the management of acute cases must be established and feedback provided from incidents recorded on the Datix system. This should also support provision of WPBAs.	November 2023	F1
6.6	The discontinuity of ward placements for F1 trainees must be addressed as a matter of urgency as it is compromising quality of training, feedback, workload, and the safety of the care that doctors in training can provide. The duration of ward attachments of Foundation doctor must be increased to be for at least 4 weeks.	November 2023	F1

6.7	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.	November 2023	F1
6.8	The scope of the ward cover and the associated workload for F1 trainees at weekends must be reduced as currently they are not manageable and safe.	November 2023	F1
6.9	Staff providing clinical supervision out of hours must behave professionally and be easily accessible. The culture should encourage liaison and joint working	November 2023	ALL
6.10	There must be robust arrangements in place to ensure the tracking of all boarded patients includes information for ward based FY1. In addition, for boarded patients, there needs to be clarity which Consultant and clinical care team are responsible, how often patients are reviewed and what the escalation policy is.	November 2023	F1