# Scotland Deanery
# Quality Management Visit Report

| **Date of visit** | 13th-14th March 2024 | **Level(s)** | FY, GPST, IMT, ST |
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| **Type of visit** | Enhanced Monitoring | **Hospital** | Queen Elizabeth University Hospital |
| **Specialty(s)** | General (Internal) Medicine | **Board** | NHS Greater Glasgow and Clyde |

| **Visit panel** | |
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| Professor Adam Hill | Postgraduate Dean – Visit Chair |
| Dr Reem Al Soufi | Associate Postgraduate Dean – Quality |
| Dr Jane Rimer | Associate Postgraduate Dean – Medicine |
| Ms Kate Bowden | GMC representative |
| Mr Yatin Patel | Foundation Programme Director |
| Dr Duduzile Musa | College representative |
| Dr Aye Doris | Trainee Associate |
| Ms Sarah Chiodetto | Lay representative |
| Ms Gillian Carter | Quality Improvement Manager |
| **In attendance** | |
| Ms Patriche McGuire | Quality Improvement Administrator |
| Ms Fiona Black | GMC representative - shadowing |
| Ms Annie Gunner Logan | Non-executive Board member - shadowing |
| Ms Vhari Macdonald | Quality Improvement Manager - shadowing |

| **Specialty Group Information** | |
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| Specialty Group | Medicine |
| Lead Dean/Director | Professor Adam Hill |
| Quality Lead(s) | Dr Reem Al Soufi, Dr Alan McKenzie, Dr Greg Jones |
| Quality Improvement Manager(s) | Ms Gillian Carter, Ms Vhari Macdonald |

| **Unit/Site Information** | | | | | |
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| Trainers in attendance | 20 | | | | |
| Trainees in attendance | FY1: N/A | FY2: 8 | GPST: 5 | IMT: 11 | ST: 9 |

| Feedback session: Managers in attendance | Chief Executive | | DME | √ | ADME | | Medical Director | √ | Other | √ |
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| Date report approved by Lead Visitor | 2nd April 2024 |
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## 1. Principal issues arising from pre-visit review:

General (Internal) Medicine (GIM) at the Queen Elizabeth University Hospital (QEUH), Glasgow, has been under the General Medical Council (GMC) enhanced monitoring process since 2016.

The last visit to QEUH took place on 23rd-24th March 2023. The visit panel found improvements from the last Deanery visit and observed positivity and high morale despite the clinical pressures under which all staff were working. Ongoing concerns were noted in terms of patient safety – particularly in terms of implementation of the GlasFLOW continuous flow model – staffing for workload and access to local teaching and clinics.

The visit identified 5 requirements which were:

- The effectiveness of measures, including the introduction of the 'traffic light' system, implemented to address the patient safety concerns reported in association with the continuous flow (GlasFLOW) must be demonstrated to ensure the safety of care of unwell patients transferred to wards under this system.
- The scope of the ward cover and the associated workload for Foundation trainees at weekends (in the wards in 'the stack') must be reduced as currently they are perceived to be very demanding.
- Work must be undertaken to ensure that FY1, FY2, GPST and IMT trainees are supported to attend an average of approximately 2 hours per week of local teaching opportunities without compromise because of service needs.
- Work must be undertaken to ensure that GPST trainees are supported to attend sufficient clinics without compromise because of service needs.
- Work must continue to ensure sufficient staffing including medical staffing is available for the workload and to ensure trainees have access to quality training.

Following this visit the GMC confirmed that 3 requirements would remain attached to the enhanced monitoring case which were:

- R1.7 – All trainees reported that when they were able to access supervision they felt well supported. However, due to workload at the site Foundation trainees and GPSTs reported that

supervision could be hard to find, specifically out of hours. As work still needed to be undertaken in this area this requirement remained part of the enhanced monitoring case.

- R1.14 – There was evidence of improvement to some handover arrangements, specifically post-receiving handovers which had been used as an educational tool. However, trainees reported several areas where the lack of robust handovers affected quality and safety of care. In addition, new concerns were raised regarding handover of patients transferred as part of the GlasFLOW model. As work still needed to be undertaken in this area this requirement remained part of the enhanced monitoring case.
- R5.9 – Foundation trainees, GPSTs and IMTs reported that service needs often prevented them from accessing educational opportunities such as attending teaching and clinics. As work still needed to be undertaken in this area this requirement remained part of the Enhanced Monitoring case.

This visit aimed to review progress against the previous visit requirements as well as to review progress towards the GMC's outstanding requirements for enhanced monitoring. The areas explored during the visit were reflective of these aims. The visit also aimed to take the opportunity to gain a broader picture of how training is carried out within the department visited and to identify any points of good practice for sharing more widely.

Unfortunately the visit panel were unable to meet with FY1 trainees due to technical issues. The results from the pre-visit questionnaire have therefore been used to compile the responses for this cohort.

The panel thanked Dr Neil Ritchie, Clinical Director, for the detailed and informative presentation shared at the start of the visit.

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

### 2.1 **Induction (R1.13)**: Not covered

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

**Trainers:** Not asked.

**FY1:** Trainees described teaching available to them as regional FY1 teaching, departmental teaching and grand rounds. Trainees reported they could attend 0-4 hours of local teaching per week with most reporting 1-2 hours. In terms of regional teaching, trainees could attend at least 10% with most reporting 30-70%. Most stated that teaching was not bleep free and they could be prevented from attending by workload, staffing or lack of support to attend from colleagues.

**FY2:** Trainees described their regional teaching as a being a full day of teaching approximately every two months. This was online and recorded and they were able to access a day off in lieu to watch it if not able to attend live. Trainees reported departmental teaching was available in some departments such as Rheumatology and Gastroenterology, although this was mostly trainee-led. They noted it could be difficult to attend due to workload and felt there was not an expectation amongst the team that trainees would be released to attend teaching. Trainees stated there was no departmental teaching in Cardiology. Trainees were aware of grand rounds, but felt it was not realistic for them to attend as there was nowhere to watch online on the wards and the Teaching and Learning Centre was too far away. Trainees felt they would struggle to meet their non-core teaching requirement in this post.

**GPST:** Trainees reported that they get study leave to attend GP teaching. Some trainees had been able to attend departmental teaching, for example in Respiratory Medicine, however availability of this was variable and trainees could be prevented from attending by workload and staffing. Trainees noted that it could be difficult to join Microsoft Teams sessions when at work due to lack of access to appropriate space and technology.

**IMT:** Trainees reported that they get study leave to attend IMT teaching. They stated departmental teaching was available in some departments such as Gastroenterology and Acute Medicine, but not in others such as Cardiology. Trainees described departmental teaching as often trainee-led and felt

some consultant-led teaching would be beneficial. Trainees struggled to attend teaching due to workload.

**ST:** Trainees reported that they can attend GIM teaching and can get study leave to watch this back if unable to attend live. They were also aware of grand rounds.

**2.3 Study Leave (R3.12):** Not covered

**2.4 Formal Supervision (R1.21, 2.15, 2.20, 4.1, 4.2, 4.3, 4.4, 4.6):** Not covered

**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 all specialties have their own systems for escalation during the day and this is detailed at induction. A consultant is always available and in some departments the 'consultant of the week' model is used. Out of hours the GIM app details escalation processes and there is a single consultant contact for GIM overnight if trainees are unsure of a specific contact. Trainers reported that grades of trainee are clearly differentiated in the hospital and role cards can also be found on the GIM app. Trainers felt it was likely that everyone had to deal with problems beyond their competence or experience on occasion due to the nature of the work, however they felt this was not a common problem as it was rarely raised during morning de-briefs. Trainers thought the large number of consultants and ST6/ST7 trainees at the site provided more junior trainees with good access to support.

**FY1:** Most trainees knew who was providing their clinical supervision all or most of the time and felt the supervision they received was good or very good. Just over half of trainees felt they needed to deal with problems beyond their competence or experience due to being alone on the ward, not knowing who to contact for support, high workload or staffing gaps.

**FY2:** Trainees felt confident that they knew how to escalate concerns out of hours but sometimes struggled to know how to escalate during the day. Trainees reported that they were sometimes unable to find someone more senior than an FY2 during the day as consultants could be busy and registrars were not always readily accessible. When they found someone to help, trainees felt the support they received was generally good, although some consultants could be less approachable.

Ward 6D (GIM and boarders) was highlighted as an area where trainees did not know how to escalate beyond FY2 level. Trainees reported various incidents of having to deal with problems beyond their competence or experience including; having to look after large numbers of patients alone on their first day or first few days in the post; working in the ARU5 which was described as twice the size of other ARUs with only 1 Foundation doctor allocated to the unit; carrying the Coronary Care Unit (CCU) phone; receiving Cardiology referrals from other hospitals.

**GPST:** Trainees reported that there is a named consultant for each ward who will advise how to contact them if needed. Out of hours they described support being provided by registrars. Trainees reported that they sometimes had to deal with problems beyond their competence or experience due to staffing. Like FY2 trainees, GPSTs described feeling out of their depth when having to see large numbers of patients on their first day with only an FY1 to support them.

**IMT:** Trainees reported they generally knew who to contact for supervision except in the boarders' space where sometimes they were unsure and ARU5 where they felt support was variable. They reported that signs and role cards were widespread which was helpful. Trainees did not feel they needed to cope with problems beyond their competence or experience.

**ST:** Trainees were confident in accessing support and would call the switchboard if they were unsure. They did not feel they needed to cope with problems beyond their competence or experience.

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

**Trainers:** Trainers felt collectively confident in the portfolio requirements for different grades as the large size of the team allowed different individuals to have different expertise. The College and Deanery staff on site were described as helpful in ensuring requirements were understood. The department has a pre-Annual Review of Competence Progression (ARCP) process for IMT trainees to ensure they are meeting their requirements. Some specialties already have clinic rotas, but a project is currently underway to improve clinic access by using an app for trainees to register for clinics. Priority will be given to STs then IMTs then all other grades including clinical fellows. Currently morning clinics are under-utilised as learning opportunities and the department hopes to use cover from Advanced Nurse Practitioners (ANPs) in acute receiving to allow IMTs to attend clinics in the morning. Trainers felt trainees could struggle to practice pleural procedures due to insufficient

availability for the number of trainees wishing to complete them. Peripherally Inserted Central Catheters (PICC) lines could also be challenging as these are mostly done by nurses.

**FY1:** Trainees had mixed views regarding whether this post supported progress towards their curriculum competencies.

**FY2:** Trainees felt it was difficult to practice procedures as staffing was usually insufficient for them to leave their immediate tasks. Trainees did not have access to clinics due to workload and felt even if it was quiet enough they did not know when and where clinics were taking place or would often be pulled to another area to cover. Trainees felt this post was 90% service delivery, although they saw merit in practising existing skills to gain confidence.

**GPST:** Trainees reported some attendance at clinics, but felt this was difficult to achieve as there was no clinic rota. In general, they found it difficult to complete the GP-specific aspects of their curriculum as they do not do many consultations and find it difficult to leave the wards for other learning opportunities. Trainees felt working in the Immediate Assessment Unit (IAU) was helpful as it gave them the opportunity to see GP referrals, but felt they needed more consultant input to learn from the cases they were seeing. Overall, they felt this post was 70% service delivery. Whilst they felt they were learning passively through ward work, they felt their work was often very similar to an FY1 which was not beneficial for their learning.

**IMT:** Trainees reported difficulties attending clinics, although noted this was much improved in specialties with a clinic rota. Trainees commended the clinic rotas in Respiratory Medicine and Infectious Diseases and described being able to attend around 10 clinics per block in specialties with a clinic rota compared to around 2 clinics per block in specialties without. Trainees felt the percentage of their work which was service delivery varied depending upon the speciality in which they were working with some being up to 50% educational. Acute receiving was described as 70-80% service delivery.

**ST:** Trainees felt this post was 80% service delivery, although educational content was higher in the High Dependency Unit (HDU).

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

**Trainers:** Trainers reported that trainees could obtain their assessments very easily as there was a wide variety of cases in the department including rare cases.

**FY1:** Most trainees reported no difficulty completing their workplace-based assessments, however some had difficulties due to workload and a related lack of access to senior colleagues.

**FY2:** Trainees found it difficult to complete workplace-based assessments on the wards as they often saw patients independently and did not receive feedback, however they found it easier to complete assessments in acute receiving.

**GPST:** Trainees found it easy to have supervised learning events (SLEs) completed on the wards. As part of the GP curriculum they are required to have examinations of all systems signed off and find this difficult as they do not work directly with registrars and call them for advice only.

**IMT:** Trainees reported that some colleagues struggled to have assessments completed as they tend to work on a variety of different wards so don't know consultants well enough to receive meaningful feedback.

**ST:** Trainees felt it could be difficult to complete Acute Care Assessment Tools (ACATs) as their on-call is rarely at the front door. Some trainees described volunteering to do extra shifts at the front door to obtain sufficient ACATs. Trainees noted that there are 3 types of on-call shift for registrars and the allocation of these was last-minute and seemed to be random.

### 2.8 Adequate Experience (multi-professional learning) (R1.17): Not covered

### 2.9 Adequate Experience (quality improvement) (R1.22): Not covered

### 2.10 Feedback to trainees (R1.15, 3.13)

**Trainers:** Trainers felt there were good opportunities for trainees to receive feedback during the day in the IAU as consultants were present between 8am and 8pm to discuss patients and complete

workplace-based assessments. They felt feedback could be more variable out of hours, partly due to rapid turnover of patients, but noted more trainees seemed to be taking advantage of the opportunity to receive feedback between 8am and 9am following night shifts. Consultants try to give feedback during this time and complete ACATs, but accepted this could be better. During IMT Stage 2, trainees have an opportunity to spend 2 weeks in ARU5 as part of the 'SpR of the week' model which was felt to be beneficial for feedback and completion of ACATs.

**FY1:** Most trainees described receiving feedback less frequently than weekly.

**FY2:** Trainees reported that they received feedback in acute receiving following night shifts, but generally not on the wards as they do not see the same patients regularly. The exception to this was ward 7C where trainees noted that there were regular discussions about patients involving the whole team which was an opportunity for feedback. Trainees reported they did not usually receive any feedback during the day.

**GPST:** Trainees reported a lack of feedback out of hours as they do not see senior colleagues unless they contact them for support. They felt they were more likely to receive negative feedback than positive feedback.

**IMT:** Not asked.

**ST:** Trainees reported that they received feedback from consultants in the mornings in acute receiving, but in general it could be difficult to receive feedback out of hours as they see patients in various parts of the hospital including in the HDU so it is not always clear who to ask for feedback.

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

**Trainers:** Not asked.

**FY1:** Trainees described opportunities to provide feedback as including surveys, supervisor meetings and the trainees' forum. Most trainees were aware of the trainees' forum.

**FY2:** Trainees were only aware of the Scottish Trainee Survey (STS) as a means of giving feedback.

**GPST:** Trainees were aware of a trainees' forum which they thought took place regularly, but believed this was poorly attended as trainees are too busy to leave the wards.

**IMT:** Trainees had received emails about opportunities to attend a monthly trainees' forum and were aware that this was attended by a representative of hospital management. They found this difficult to attend due to workload, but knew they could also contribute to the forum by email. They were also aware of rota drop-in sessions being scheduled but thought most of these sessions had been cancelled.

**ST:** Trainees described opportunities to give feedback as including surveys and the trainees' forum, however they noted that the forum was never comprehensively attended due to workload. Registrars did not attend the trainees' forum and did not feel it addressed issues pertinent to them.

### 2.12 Culture & undermining (R3.3)

**Trainers:** Trainers reported that trainees are advised to contact their educational supervisor regarding any concerns relating to bullying or undermining, however all trainers would be happy to provide support. Some departments have pastoral leads and changes are made proactively to improve culture, for example in Diabetes and Endocrinology the team has moved to an intensive ward system with a consultant presence every day and instigated a team huddle at 9am. Trainers were aware of cultural issues which had been raised regarding handover. These were escalated to the clinical director and changes have been made to the process in light of this. GMC guidance has also been sent as a reminder to all consultants. Trainers felt non-clinical management have been supportive in these situations.

**FY1:** Some trainees reported bullying and undermining from nursing staff including; pressure to complete tasks; undermining of clinical decisions and priorities; speaking to FY1s in a rude or confrontational manner.

**FY2:** Trainees described undermining at acute receiving handover whereby specific consultants would make unpleasant, critical comments about trainees' management of patients. Trainees felt these comments were embarrassing and upsetting for the trainees concerned. This was described as

a long-standing issue. Trainees also noted poor culture on the 8th floor where ward staff were described as bullying trainees leading to some becoming unwell. Trainees knew some of these issues had been raised and were being investigated. They knew they could raise concerns with their educational supervisor but found this difficult if the allegation concerned someone in the same team as they worried they would be treated differently as a result of raising the concern. Trainees were unsure how else they could raise concerns if they did not feel comfortable doing so with their educational supervisor.

**GPST:** Trainees generally found their colleagues approachable and had not witnessed bullying or undermining although they had heard allegations from colleagues. If they witnessed bullying or undermining they would speak to their clinical supervisor or the nurse in charge.

**IMT:** Trainees echoed the concerns raised by FY2 trainees regarding a long-standing negative culture at acute receiving handover where they described feedback given as accusative. Trainees described being criticised for their speed of clerking and clinical decisions which led to anxiety during night shifts. Trainees reported that the handover process had been changed in response to concerns raised, however following a trial the new system had been found to be unsuitable and the original process had been reinstated. Allegations were also made of consultants shouting and swearing at trainees in the acute medicine department. Trainees were positive about the culture in specialty departments including Rheumatology, Respiratory Medicine, Cardiology, Infectious Diseases, Gastroenterology and the HDU. Good support was also identified from supervisors who had supported trainees following the above-mentioned undermining incidents.

**ST:** Trainees echoed the concerns raised by other grades regarding the acute medicine department as well as the concerns relating to poor culture on the 8th floor. Trainees reported that every weekend they supported junior colleagues who were upset due to being undermined. Undermining was alleged in relation to both nursing staff and consultants. Trainees felt the morale of junior medical staff was very low because of these incidents and because their workload felt unmanageable.

### 2.13 Workload/Rota (1.7, 1.12, 2.19)

**Trainers:** Trainers were aware that trainees had concerns about workload and capacity, but felt the causes were often outside their control. Trainers reported that measures had been taken to reduce

workload where possible, for example auditing patient reviews in Diabetes and Endocrinology to reduce the number of reviews needed at the weekend. Trainers also highlighted the current pilot whereby medical students are employed as healthcare support works in Gastroenterology at the weekends. This pilot has allowed trainees to focus more on tasks appropriate for their grade and to get their required breaks. Trainers felt trainees with occupational health recommendations had been accommodated well.

**FY1:** Most trainees described the intensity of their work during the day as busy or very busy. Most felt their education and training was adversely affected by their rota due to their being too busy to attend teaching and being exhausted. Half of trainees felt the workload or its intensity had an impact upon patient safety due to work being rushed, delays in treatment and tiredness of staff.

**FY2:** Trainees felt that the shift pattern where they worked a 7-day stretch in acute receiving - comprising 5 12.5-hour shifts and 2 9-hour shifts – then had 1 zero day before going back to work was exhausting. It was reported that this rota pattern featured once or twice in each block. Trainees described incidents of becoming unwell after periods of intense working.

**GPST:** Trainees echoed the concerns of FY2s regarding the 7-day stretch in acute receiving, but felt the rotas on the wards were better. Trainees felt they sometimes had a poor work-life balance due to their rotas.

**IMT:** Trainees reported that in their current block they spent about 6 weeks in their specialty and the rest of the time in acute receiving. They felt the high number of hours in acute receiving impacted their wellbeing. Trainees also felt their rota did not provide sufficient exposure to the intensive care unit compared to other hospitals as most of their time in intensive care was spent at Gartnaval General Hospital where they were frequently asked to cover downstream wards instead.

**ST:** Trainees felt their heavy commitment to GIM was adversely affecting their training and reported that they had to do their assignments in their spare time.

### 2.14 Handover (R1.14)

**Trainers:** Trainers noted that there was a 'Situation, Background, Assessment, Recommendation' (SBAR) plan for handover and sick patients were identified to be handed over doctor-to-doctor. Other patients were handed over electronically between nurses. Trainers felt this system worked well. Trainers reported that the GlasFLOW model requires a different handover process as under the model patients are moved throughout the day and have variable levels of acuity. They noted that a traffic light system exists to identify patients at higher risk, however those identified as 'red' can still be moved under GlasFLOW. Trainers felt acute receiving handover provided learning opportunities as it was well-attended and there were opportunities to discuss cases with consultants.

**FY1:** Most trainees thought all handovers were satisfactory. Some concerns were raised regarding lack of dedicated space for handover on the wards, poor attendance at handover due to workload and information coming from too many different sources. Most trainees reported that no electronic record was kept of handover and all reported that there was no consultant leadership of handover. Most felt handover was not used as a learning opportunity.

**FY2:** Trainees reported that acute receiving handover followed a script and worked well, however the cultural issues described under section 2.12 were discussed. Trainees felt sometimes acute receiving handover could be slow due to a lack of clarity regarding handing over phones. On the wards trainees reported a lack of clear handover process and location in the morning, with FY1s having to walk around looking for people to whom they could hand over. The exception to this was the 7$^{th}$ floor which was described as having a set process and location for handover. Trainees felt evening handovers on the wards worked better. Trainees reported there was no set system for handover from acute receiving to the wards and it could be hard to keep of track of which patients had moved.

**GPST:** Trainees reported that in the morning there is an acute receiving handover covering specific patients who need to be handed over. Trainees reported that their wards had systems for handover although echoed the comments regarding FY1s walking around to find someone to whom they could hand over. Transfer of patients was described as usually being done by nursing handover, but trainees could receive a phone call if a sick patient was arriving or if a patient had results needing to be chased. Trainees reported it could be difficult to contact colleagues by phone as the phones were not always covered which could lead to lack of awareness of patients being transferred.

**IMT:** Trainees reported that morning acute receiving handover utilised a checklist and then covered any individual patients who needed to be discussed. The cultural issues described under section 2.12 were also discussed.

**ST:** Trainees reported that morning acute receiving handover happened in the IAU and involved all grades of doctor. Trainees echoed the comments made by other grades regarding the culture of this handover as described in section 2.12. Ward handover was described as informal and, like other grades, they described FY1 trainees walking around looking for someone to whom they could hand over. In acute receiving in the evening trainees described a brief informal handover between registrars in the early evening followed by a formal 9pm handover. In the wards trainees described a handover taking place in one of the seminar rooms, however some floors did not attend this. There was then a formal 9pm handover in the stack.

**2.15 Educational Resources (R1.19):** Not covered

**2.16 Support (R2.16, 2.17, 3.2, 3.4, 3.5, 3.10, 3.11, 3.13, 3.16, 5.12):** Not covered

**2.17 Educational governance (R1.6, 1.19, 2.1, 2.2, 2.4, 2.6, 2.10, 2.11, 2.12, 3.1):** Not covered

**2.18 Raising concerns (R1.1, 2.7)**

**Trainers:** Trainers reported that trainees have daily contact with consultants in acute receiving and can raise concerns with any member of staff including the Training Programme Directors (TPDs) who work at the site and the Director of Medical Education (DME). Trainers noted that raising concerns forms part of the standard operating procedure for acute receiving handover. Other avenues for trainees to raise concerns were described as morbidity and mortality (M&M) meetings and trainee forums. Dr Neil Ritchie, Clinical Director, was commended for reviewing all Datix reports in real time and escalating them as needed. The department was described as having 2-3 service leads meetings per month with at least 1 dedicated to trainee issues. It was also noted that the senior management team do a lot of work regarding safety and incidents involving trainees.

**FY1:** Trainees reported that they would raise concerns with their supervisor, their Foundation Programme Director (FPD) or another consultant, however some were unsure how to raise concerns and some expressed a lack of confidence that issues raised would lead to improvement.

**FY2:** Trainees felt their consultants in specialty wards were approachable and they would have no issues seeking support from them, however they were unsure how to escalate concerns in acute receiving. Trainees noted they had raised concerns regarding lack of handover of sick patients who had arrived on their ward through the GlasFLOW model, however they did not feel they had seen any improvement.

**GPST:** Trainees felt their colleagues were approachable and would contact their clinical supervisor if they wished to raise a concern. Trainees had experience of raising a concern with a consultant, however the issue raised was a long-term issue and they did not feel it was something that could be easily resolved. A positive experience was reported whereby a trainee raised a patient safety concern to the nurse in charge who made a plan to resolve the issue. Trainees would appreciate more transparency about changes being made in response to feedback.

**IMT:** Trainees reported that there was an opportunity to raise concerns as part of acute receiving handover. They noted that concerns about capacity are raised every morning as there are often over 30 patients waiting to be seen, but no improvements had been seen.

**ST:** Trainees had experience of raising concerns relating to capacity and staffing, but did not have confidence that raising these concerns would lead to improvement. Trainees felt that clinical concerns were dealt with well, but general or systemic concerns were not addressed.

### 2.19 Patient safety (R1.2)

**Trainers:** Trainers felt that the site was very safe when not struggling with capacity issues. Compared with other sites, the department has a large number of consultants and senior trainees representing a variety of specialties which trainers felt was beneficial for patient safety. The site has a boarders team comprising 1 substantive consultant and 1 locum consultant as well as non-training grade doctors. Trainers reported that this team sees boarded patients every day and their interactions with the team had been positive.

**FY1:** Some trainees had concerns about patient safety for reasons including; low staffing and gaps being unfilled; delays in seeing patients due to workload; lack of awareness of patients who have been moved under the GlasFLOW model.

**FY2:** Trainees had patient safety concerns relating to ward 6D and the IAU. Trainees reported that on ward 6D the most senior doctor on the ward was usually an FY2 and there was not a clear escalation process. In the IAU trainees were concerned that patients were waiting a long time to be seen and were often accommodated in a corridor. Trainees were also concerned about patients being moved without their awareness leading to unwell patients not being seen in a timely manner. Trainees reported they were sometimes asked to cover the boarders team, particularly when working on ward 6D as half of this ward was boarders. Out of hours, trainees described being asked to identify patients who were suitable for boarding, however this was often amongst groups of patients they had never met which they felt was unsafe.

**GPST:** Trainees had patient safety concerns relating to staffing, including insufficient nursing staffing, and the GlasFLOW model. Trainees felt that GlasFLOW led to pressure for them to discharge patients unsafety and to patients being kept in undignified accommodation such as in corridors. In terms of boarding, trainees felt the pace of care was slower and patients were not always seen regularly by consultants. Trainees reported that they would not wish their friend or relative to be cared for in this department.

**IMT:** Trainees felt the department was safe during the day, but not always during the night. Trainees had concerns about the implementation of the GlasFLOW model in terms of lack of handover of unwell patients transferred under the model. Whilst trainees supported the concept of the model to prevent patients waiting in ambulances, they felt that changes to the system had been made without consultation or sufficient notice. Trainees described completing a ward round and finding several additional patients in the corridor who they did know were arriving on the ward. Care in some of the downstream medical wards was described as excellent, however trainees felt care was poorer in GIM wards.

**ST**: Trainees felt that patients admitted to a specialist team received good care, however they had patient safety concerns relating to staffing, capacity in the IAU and boarding. Trainees felt the trainee

and nursing staffing in the department were insufficient compared to other hospitals and felt the medical admissions pathway was unsafe, particularly for patients admitted to the IAU where waiting times could be 12-15 hours. Trainees felt the boarding team was utilised as well as it could be. Trainees reported that they would not wish their friend or relative or to be cared for in this hospital and would advise them to present elsewhere.

**2.20 Adverse incidents & Duty of Candour (R1.3 & R1.4):** Not covered

**2.21 Other:** N/A

## 3. Summary

| Is a revisit required? | Yes | No | Dependent on outcome of action plan review |
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Overall, the panel commended the ongoing engagement of service leads and trainers in supporting trainees and seeking evidence-based improvements in the department whilst noting the persisting concerns across all cohorts of trainees relating to patient safety, access to educational opportunities and alleged Dignity at Work concerns. The panel also observed a relatively low rate of engagement from trainees and heard comments from trainees which suggested that workload and low morale may have affected attendance at the visit. The panel acknowledged that the findings of the visit would have been more robust if trainee numbers had been higher and would hope to see improved attendance on any future visit.

Strengths:

- Service leads remain enthusiastic and dedicated to enacting improvement in the department. The use of data to inform improvement was commendable and it was clear that evidence-based solutions are sought to address issues within the department.
- Trainers were highly engaged in promoting training and creating a positive learning environment for trainees.
- The panel noted several examples of innovative improvement projects including; measures to improve clinic access for trainees; measures to reduce the weekend workload - an example demonstrated in Diabetes and Endocrinology; employing medical students as healthcare

support workers; creation of a boarders team not involving trainees; use of ANPs to support the medical workload; use of the GIM app to provide rapid access to resources such as escalation processes and role cards.

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Weaknesses:

- Trainees remained concerned about patient safety in the department, specifically relating to handover of patients under the GlasFLOW system and handover from the front door to downstream wards.
- Access to educational opportunities for all training grades was reported to be limited, largely due to workload.
- The panel heard alleged Dignity at Work concerns which were discussed with the DME and Medical Director following the visit.

**Progress against 2023 visit requirements**

| Requirement | Status |
|---|---|
| The effectiveness of measures, including the introduction of the traffic light system, implemented to address the patient safety concerns reported in association with the continuous flow (GlasFLOW) must be demonstrated to ensure the safety of care of unwell patients transferred to wards under this system. | Partially met |
| The scope of the ward cover and the associated workload for Foundation trainees at weekends (in the wards in 'the stack') must be reduced as currently they are perceived to be very demanding. | Met |
| Work must be undertaken to ensure that FY1, FY2, GPST and IMT trainees are supported to attend an average of approximately 2 hours per | Partially met |

| | |
|---|---|
| week of local teaching opportunities without compromise because of service needs. | |
| Work must be undertaken to ensure that GPST trainees are supported to attend sufficient clinics without compromise because of service needs. | Partially met |
| Work must continue to ensure sufficient staffing including medical staffing is available for the workload and to ensure trainees have access to quality training. | Not yet met |

## 4. Areas of Good Practice

| Ref | Item | Action |
|---|---|---|
| 4.1 | The panel noted several examples of innovative improvement projects including: measures to improve clinic access for trainees; measures to reduce the weekend workload - an example demonstrated in Diabetes and Endocrinology; employing medical students as healthcare support workers; creation of a boarders team not involving trainees; use of ANPs to support the medical workload; use of the GIM app to provide rapid access to resources such as escalation processes and role cards. | |

## 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 | The panel recommends the department review and clarify the clinical supervision arrangements to ensure a clear understanding of who is providing supervision and how the supervisor can be contacted. | |

| 5.2 | The process for providing feedback to doctors in training on their input to the management of acute cases should be reinforced and extended. This should also support provision of workplace-based assessments. | |
|---|---|---|

## 6. Requirements - Issues to be Addressed

| Ref | Issue | By when | Trainee cohorts in scope |
|---|---|---|---|
| 6.1 | Handover arrangements must be reviewed, particularly for patients moved under the GlasFLOW system and handover from the front door to downstream wards. | 14th September 2024 | FY, GPST, IMT, ST |
| 6.2 | Work must continue to ensure sufficient staffing, including medical staffing, is available for the workload and to ensure trainees have access to quality training; this includes ensuring FY1, FY2, GPST and IMT trainees are supported to attend an average of around 2 hours per week of local teaching opportunities, and ensuring GPST and IMT trainees are supported to attend sufficient clinics without compromise because of service needs. | 14th September 2024 | FY, GPST, IMT |
| 6.3 | All staff must behave with respect towards each other and conduct themselves in a manner befitting Good Medical Practice guidelines. Specific examples of undermining behaviour noted during the visit will be shared outwith this report. | 14th September 2024 | FY, GPST, IMT, ST |