Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	18th July 2024	**Level(s)**	FY, ST
Type of visit	Site Triggered visit	**Hospital**	Ninewells Hospital
Specialty(s)	Urology	**Board**	NHS Tayside

Visit panel	
Reem Al Soufi	Visit Lead/Associate Postgraduate Dean - Quality
Nadeeka Rathnamalala	Foundation Programme Director
Sarah Summers	Lay Representative
Sanju Vijayan	Trainee Associate
Helen Pratt	Quality Improvement Manager
Ashley Bairstow-Gay	Quality Improvement Administrator

Specialty Group Information	
Specialty Group	Surgery
Lead Dean/Director	Professor Adam Hill
Quality Lead(s)	Dr Reem AlSoufi, Dr Kerry Haddow, Mr Phil Walmsley
Quality Improvement Manager(s)	Helen Pratt
Unit/Site Information	
Non-medical staff in attendance	Nil
Trainers in attendance	5
Trainees in attendance	1 x FY1, 2 x ST3, 1 x ST5

Feedback session: Managers in attendance	Chief Executive		DME		ADME	✓	Medical Director		Other	Trainers, Trainees

Date report approved by Lead Visitor	16th August 2024

1. Principal issues arising from pre-visit review:

The Director of Medical Education at Ninewells Hospital was aware of challenges that the site had faced and tried to address, but due to only a small number of returns from trainee surveys, it was unclear whether any issues had been successfully resolved.

The visit team will also take the opportunity to gain a broader picture of how training is carried out within the department and to identify any points of good practice for sharing more widely.

NTS Data

Foundation Trainees – FY1s

Red flags	Adequate Experience; Overall Satisfaction
Pink flags	Supportive Environment

Red flags	Adequate Experience; Clinical Supervision; Handover; Overall Satisfaction; Reporting Systems; Supportive Environment
Pink flags	Teamwork

Specialty Trainees

Pink flags	Clinical Supervision Out of Hours; Handover; Regional Teaching

STS Data

Specialty Trainees

Green flags	Clinical Supervision
Red flags	Handover; Induction; Team Culture; Workload

All Trainees

Green flags	Team Culture; Workload
Red flags	Clinical Supervision; Handover; Induction;

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.

The visit team would like to thank the local site, for an informative presentation that was delivered by Mr Martindale and Mr Nandwani at the beginning of the visit. The presentation included information on the local staffing levels, particularly at consultant level in the department versus the significant service demands that they are faced with. The consultants felt they are using their own SPA time to meet the increased service demands and that they did not have adequate numbers of consultants in the department to cope with the workload.

2.1 Induction (R1.13):

Trainers: The trainers said they aim to ensure that the departmental induction is thorough and comprehensive as trainees have commented that the hospital induction is sometimes lacking in information. They are aware there can sometimes be an issue with IT passwords not being issued in a timely manner, however that is out with the scope and management of the urology team.

All trainee cohorts: The trainees said they received an induction which was held mostly on Teams. They said they had no issues getting IT passwords or access badges but felt that some training on IT systems such as Trakcare would have been useful, as there seemed to be an assumption that all trainees would already be familiar with the systems used. They also said that induction could be improved by clarifying guidance on types of scans frequently requested and providing further details on OPD referral pathways.

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

Trainers: One of the trainers has created a pastoral group that meets weekly on Teams to enable trainers and trainees to discuss the management of urology patients and clinical scenarios that trainees may not have been able to discuss elsewhere.

All trainee cohorts: The trainees said that there is no local urology teaching for either FY or STs. They said that there is regional teaching once a month which STs can usually attend. They also said that there are Morbidity & Mortality meetings held as part of clinical effectiveness meetings every 8 weeks, which they can usually attend. Not all the trainees were aware of the pastoral group created by one of the trainers. No concerns regarding FY Deanery teaching were raised during the visit or in the pre-visit questionnaire.

2.3 Study Leave (R3.12)

Trainers: Specialty trainees are given mandated study leave to allow them to attend regional teaching. If required, trainees' on-call duties are moved to facilitate their attendance at the teaching sessions. The site has also asked the training providers to provide hybrid teaching in order to reduce the requirement for trainees to maximise their attendance at training.

All trainee cohorts: The trainees said it is easy for them to get study leave when required.

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

Trainers: The reduced number of trainers at the site has had a significant impact. At one point last year only 2 trainers who could act as educational supervisors were available, and then due to sick leave that was reduced to only 1. It meant that some trainees had to change their educational supervisor midway through the year. Consultants are under constant pressure to balance their educational supervision and clinical responsibilities. This has proved very difficult; however, the Consultants have done a remarkable job of continuing to provide a clinical service despite the challenges they face.

All trainee cohorts: All the trainees had educational supervisors and had met with them. However, one trainee said that both educational supervisors had been on leave for most of the academic year but no arrangement to provide cover had been made, and the trainee felt this had subsequently affected their ARCP outcome. Another trainee said that in order to meet with their educational supervisor, they had to come into the hospital on their days off.

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: The Consultants carry out a ward round every day and ensure that the FY trainees are part of it to enable the trainees to understand the context surrounding patients' conditions and situations. The FY trainees also attend a pre-ward round MDT discussion. If difficult discussions need to be held with patients and/or their families, then a suitable time will be arranged with the Consultant and the rest of the team to have that discussion. While FY trainees will be part of that discussion, the Consultants try to ensure that they are not given responsibility for either breaking bad news to patients or obtaining consent from them for treatment.

A clear escalation procedure is in place for all FY trainees. The trainers advised that as part of their service design, no services are provided by trainees or registrars only, and that all services are supervised by a consultant. The only exception is flexible cystoscopies, which are sometimes carried out by trainees as long as they are fully qualified to do so.

All trainee cohorts: The trainees felt that the Consultants were generally approachable but said it could sometimes be hard to get hold of them as they were often in theatre. They felt that the availability and quality of supervision depending on which Consultants were on duty. One trainee said it could be especially difficult to get clinical supervision for the Monday flexible cystoscopy list and explained that after finding a bladder tumour during a cystoscopy, had been unable to get a Consultant to come and had had to break the news of the cancer diagnosis to the patient by themselves. They also feel there are presumptions made around what skills and experience trainees of certain grades have, and that no Consultants have watched them carry out flexible cystoscopies to verify their competence.

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

Trainers: The trainers were not aware of any difficulties for trainees in getting adequate experience to complete their logbooks. They advised the only issue could sometimes be if a specific operation happened the week that a trainee was on holiday.

All trainee cohorts: Some of the trainees felt they had not learned as much about urology as they had hoped and had not got as many opportunities to practice certain skills or procedures as they had expected. One

trainee felt they were being scheduled for clinics and flexible cystoscopies for service provision reasons rather than training, and missed out on theatre time as a result, however they felt this had recently improved.

Trainees said that access to elective theatre lists had been an issue due to numerous cancellations, but that it had improved over the past few months. However, they said that patients scheduled for theatre who have not had their general anaesthetic by 3.30pm will be cancelled by the nurse manager to ensure that the theatre list is finished by 5pm. Trainees felt this limited their access to cases and that they are not getting adequate experience. They also said that more advanced surgical procedures are now being used in preference to traditional procedures such as TURPs, which means that while ST6s and ST7s are getting experience in the advanced procedures, the ST3s and ST4s are not getting adequate experience in performing core urological procedures such as TURPs.

Some of the trainees felt they were spending a significant amount of their time doing non-educational tasks. For example, they noted that on-call shifts generate a huge amount of paperwork. They said that one of the issues is that there is no middle tier between the FY1s and the STs, which means that the STs must carry out the role of a middle grader as well as their own ST role. They said that on average they are bleeped once every 18 minutes and that most bleeps are for administrative reasons rather than from people needing expert urological advice.

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

Trainers: The trainers were not aware of any issues for trainees in getting their logbooks completed.

All trainee cohorts: The trainees said they are able to complete their workplace-based assessments, but that the Consultants do not usually have time to discuss them to the level they felt was required. They said that they will fill out a WPBA form and then it will be signed off without any discussion which means that any educational purpose or benefit is lost.

2.8 Adequate Experience (multi-professional learning) (R1.17) – Not asked.

2.9 Adequate Experience (quality improvement) (R1.22) – Not asked.

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: Consultants are encouraged to give feedback to trainees at the time rather than waiting until later. The return to a base ward on site has helped with this as trainees tend to work with the same people more of the time.

All trainee cohorts: The trainees felt that feedback on their performance was very limited, and if they did get any feedback, it was very informal. Handovers and ward rounds are done quickly due to high workload resulting in restricted opportunities for feedback. They felt that there is limited time for discussions with consultants because the department is understaffed and as consultants stretch themselves to cover service needs, they are exhibiting signs of burnout. The trainees stated that they hold the Consultants in the highest regard, but also stated that morale in the department is very low and they had concerns about the mental health and welfare of the Consultants due to the pressure on them caused by the understaffing.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: Trainees are strongly encouraged to raise any issues at the time. They can do this through their Lead Trainee or the Clinical Lead. Trainees are involved in Clinical Governance meetings, and lead on quality improvement projects, and trainers advised that trainees' voices have been instrumental in many of the service improvements that have been made. There is no specific trainee forum as trainees are already heavily involved in the department.

All trainee cohorts: The trainees said there is no trainee forum and no Chief Registrar for them to raise any issues with and did not mention any other methods of how they can give feedback on their training.

2.12 Culture & undermining (R3.3)

Trainers: The trainers advised that historically there have been issues however these have been addressed and they are not aware of any current issues.

All trainee cohorts: The trainees said that there had been issues in the past, however the culture in the department had since improved and they were not aware of any current issues with bullying, harassment, or

undermining.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Not asked.

All trainee cohorts: The trainees said that their rota is non-compliant due to missed breaks and exceeding the maximum limit on working hours during on-call weeks. They said that weekends should be non-resident, but one trainee did not leave the building for 48 hours.

2.14 Handover (R1.14)

Trainers: Trainers said that Consultants and trainees meet at 8.30am to discuss the CEPOD lists and then do a ward round at 9am. They said that Consultants are always present at the morning handover but cannot always join other handovers if they are doing other tasks. They said that feedback they had had from trainees was that handovers are felt to be robust.

All trainee cohorts: Some trainees said that FY trainees are expected to update the handover lists, however the morning urology handover sometimes clashes with the Hospital at Night handover elsewhere in the building, so FY trainees often only get to attend half of the urology handover. This makes FY trainees' role in handover unclear. Trainees felt that the quality of the handover depended on which registrar was doing it. They also said that there could be problems accessing the shared drive where the handover document is stored. They explained that IT access is computer specific, not user specific, so access to the handover document depends on which computer is available at the time.

2.15 Educational Resources (R1.19)

Trainers: Trainers felt that there were good rest facilities available for trainees, including reclining sofas and food in the doctors' mess. They said that trainees have 24/7 access to Dundee University library, as well as urology books and guidance documents in the registrar's office. A simulator is also available.

All trainee cohorts: The trainees said that they have to pay £40 a month to access the doctors' mess, and that based on the facilities available in the mess, they do not feel it is good value for money. They said that there are no other eating facilities available out of hours, so they have no option but to pay to access the mess. Not all the trainees knew about

the Dundee University library and said there was no information in their induction about that. Other trainees said that they do not automatically get access to the library and that they have to pay if they wish to access the library.

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 said that if a trainee needed reasonable adjustments they would be put in place with the support of Occupational Health.

All trainee cohorts: Not asked.

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

Trainers: Trainers said that there is no local trainers' forum within the Board, however all surgical trainers are members of the Surgical Training Committee for Urology in the East of Scotland, which holds meetings twice a year. There are also local Clinical Governance meetings 6 times a year which trainees are encouraged to attend. Trainers try to ensure that these meetings are held at times when trainees can attend but noted their disappointment at low attendance rates from trainees.

All trainee cohorts: Trainees said they knew how to raise concerns but did not detail how they would do so.

2.18 Raising concerns (R1.1, 2.7)

Trainers: The trainers said that trainees can raise concerns at the Clinical Governance meetings, or directly with the Clinical Governance lead for surgery.

All trainee cohorts: The trainees said they had had raised some concerns about patient safety, which resulted in a local investigation. Trainees had found this distressing and felt the support they had received during the investigation was minimal.

2.19 Patient safety (R1.2)

Trainers: Registrars will update the ward lists which ensures that Boarders are not lost. A traffic light system is

also in place on the ward.

All trainee cohorts: The trainees admitted that they would have concerns if a relative or friend was admitted to the ward, and one trainee admitted they had advised a relative to travel to another Health Board for treatment. They feel that communication is generally poor among staff and between staff and patients. They noted incidents where doctors had changed patients' treatment plans but not informed the patients, so that patients who were expecting to go to theatre for surgery suddenly discovered they were being discharged instead. They also said that on-call duties were so busy they were concerned that urgent cases may not be seen in a timely manner. Understaffing was felt to be contributing significantly to perceived poor communication.

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

Trainers: SAERs are held when required. If a trainee is involved in an incident, their educational and clinical supervisors will support them and meet with them for a debriefing. M&M and Clinical Governance mechanisms have been improved to help make these discussions as open and supportive as possible.

All trainee cohorts:

See section 2.18.

2.21 Other

Trainees described their overall training experience as being inadequate and felt it could be improved, however they did highlight the knowledge and experience they have gained from two particular Consultants has made their time at Ninewells worthwhile. Trainees had extremely high praise for Mr Benedict Rajendran and Mr Amit Kalpee, who they named as excellent, enthusiastic, and inspiring trainers.

Therefore, for the purpose of this report, no overall satisfaction scores have been included.

3. Summary

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

Positive aspects of the visit:

- Trainees hold the Consultants in high esteem and are very appreciate of what they do despite the challenges they face. The trainees had especially high praise for Mr Benedict Rajendran and Mr Amit Kalpee, who they named as enthusiastic and inspiring trainers.
- Access to clinical supervision in clinics and theatre is generally good.
- Trainees have adequate access to regional training and study leave.
- The MDT meetings at the start of ward rounds have been very beneficial to FY trainees as it helps involve them in the care of patients and better understand their training needs.

Less positive aspects of the visit:

- Consultant staffing has been an issue.
- There was reported limited local urological teaching for either FYs or STs
- The registrars' rota is reported to be non-compliant and their workload following on-calls consists mainly of admin tasks that are deemed non-educational".
- Clinical supervision for trainees running the Monday flexible cystoscopy list is variable. Consultants are not always available for advice if trainees come across unusual pathology. There is reported no assessment of whether trainees are competent to carry out the flexible cystoscopy procedure by
- themselves."
- The role of FY trainees in handover is unclear, and access to the shared drive where the handover document is stored is problematic as access to IT systems is computer specific not user specific.
- Access to theatre for elective cases particularly for core urological competences is affected by list cancellations and there is a concern amongst STs regarding ability to meet their learning needs.

4. Areas of Good Practice

Ref	Item	Action
4.1	Nil	

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	Nil	

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	Establish departmental teaching for all grades of trainee.	Dec 2024	FY, ST
6.2	Ensure those undertaking the role of Educational Supervisor are given adequate time to engage with the process.	Dec 2024	FY, 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.	Dec 2024	ST
6.4	Trainees must not undertake clinics without an appropriate Clinical Supervisor co-located in the clinic to refer to.	Dec 2024	ST
6.5	The handover process must be clear to all those involved in handover.	Dec 2024	FY
6.6	Core and Higher Surgical trainees must have more access to emergency and elective theatre opportunities.	Dec 2024	ST