Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	27th February 2020	**Level(s)**	FY/GP/ST1-8
Type of visit	Enhanced Monitoring Revisit	**Hospital**	Princess Royal Maternity Hospital/Glasgow Royal Infirmary
Specialty(s)	Obstetrics & Gynaecology	**Board**	NHS Greater Glasgow & Clyde

Visit panel	
[redacted]	Visit Chair - Postgraduate Dean
[redacted]	GMC Visits & Monitoring Manager
[redacted]	GMC Visits & Monitoring Manager
[redacted]	GMC Associate
[redacted]	College Representative
[redacted]	Foundation Programme Director
[redacted]	Assistant GP Director
[redacted]	Trainee Associate
[redacted]	Lay Representative
[redacted]	Quality Improvement Manager
In attendance	
[redacted]	Quality Improvement Administrator

Specialty Group Information	
Specialty Group	Obstetrics & Gynaecology and Paediatrics
Lead Dean/Director	[redacted]
Quality Lead(s)	[redacted] & [redacted]
Quality Improvement Manager(s)	[redacted]
Unit/Site Information	

Non-medical staff in attendance	6									
Trainers in attendance	5									
Trainees in attendance	5 x FY2,11 x ST1-7									
Feedback session: Managers in attendance	Chief Executive		DME	x	ADME	x	Medical Director		Other	x

Date report approved by Lead Visitor	

1. Principal issues arising from pre-visit review:

The Princess Royal Maternity Hospital has been under the GMC's Enhanced Monitoring process since May 2018. The requirements from the visits of 5th February 2018 (prior to Enhanced Monitoring) and 24th January 2019 (on Enhanced Monitoring) are listed below. At the 2019 visit, the panel found trainees experience of training had improved.

Requirements from visit on 5th February 2018:

- All clinics must be supervised by a Consultant.
- There must be protected bleep free local teaching for Foundation and General Practice doctors supported by the Consultant team
- A unit induction must be available to all trainees including those who start their post on nightshift.
- There must be provision on the rota to ensure GPSTs can attend clinics relevant to their training needs.
- The department must ensure that there are clear systems in place to provide supervision, support and feedback to trainees working in clinics.
- Foundation and General Practice trainees must be included in Clinical Risk Meetings to have access to learning from clinical adverse events
- The department must work with the Board in implementing changes to improve the educational environment for all grades of doctors in training.
- All references to "SHO's" and "SHO Rotas" must cease. The "Say No to SHO" programme must be adopted, with all staff involved.
- GPSTs must have the opportunity to have assessments completed by another team member of appropriate grade to do this.

Requirements from visit on 24th January 2019:

- Educational and clinical supervisors must understand curriculum and portfolio requirements for the cohorts of trainees training in the unit.
- Tasks that do not support educational and professional development and that compromise access to formal learning opportunities for GP and Foundation doctors must be reduced.
- The department must develop and sustain a local teaching programme relevant to curriculum requirements of the ST3+ trainees including a system for protecting time for attendance.

- Trainees must be given protected study leave to attend mandatory regional teaching.
- Doctors in training must have access to appropriate resources to support their training - office space for doctors in training is an issue.
- Assignment of STs undertaking ATSMs must be within the unit's capacity to provide training.
- The department must support ST3+ trainee attendance at regional teaching days.

The site provided an update against the previous visit requirements in December 2019, which suggested there had been progress against and/or resolution of the previous requirements.

The visit commenced with a session with training leads from within the department, the NHS GG&C Director of Medical Education and the CD for maternity services that included a presentation highlighting the main challenges within the department since the last visit:

- Maternity Immediate Discharge Letters: plans in place to train midwifery staff to complete.
- Lack of consistent acute Gynaecology consultant cover for doctors in training: – there is a proposal to reconfigure consultants' job plans from May 2020 to ensure consultant cover Mon-Fri 09:00-17:00 on the gynaecology ward.
- 'Gynaecology blood round': an ongoing issue. An 06:30 blood round must be completed to allow patients to be discharged at 12:00, no phlebotomy service is available at this time.
- Gynaecology boarders: service pressures have increased the specialty spread (now 6 different specialties) of boarded patients. Junior doctors received no medical handover for patients however were expected to complete medical tasks. This led to some confrontation within the team which has now been resolved.
- Overall numbers of doctors in training: several issues were noted - the late awareness that a reduced number of GP trainees were coming in February, the number of LTFT trainees, the high number of trainees seeking similar ATSM training opportunities.

A number of successes were reported: the ability to provide access to ATSM opportunities (albeit the number seeking this was high) including in Gynaecological cancer, provision of administration session for trainees, provision of learning sessions, provision of days-off before & after nights, use of rota-management software over the last 2yr, appointment of clinical fellows to support the rota, provision of consultant-led gynaecology clinics, availability of experienced locums.

Several challenges were also noted: the reduction in WTE staffing by doctors in training, the absence of academic trainees, the training needs of some ATSMs meant they were not be on the oncall rota, sickness absence among doctors in training,

The panel were unable to meet with any GP trainees at the visit.

2.1 Induction (R1.13):

Trainers: Trainers felt the induction provided was effective for preparing trainees to work in the department. Induction was a full day session which included departmental presentations and an orientation tour. Rotas and timetables were distributed in advance although, trainers noted the timeframe to be variable. Trainees who are out of sync or can't attend the main induction are provided with a mini one-to-one session.

FY2: Not all trainees interviewed received a hospital induction. All trainees received a departmental induction and felt this adequately prepared them for their roles. Trainees felt that the laminated prescribing cards they were issued with were very useful and helped to minimise prescribing errors. They suggested providing a speculum examination tutorial, would further improve the induction.

ST: The majority, of trainees received departmental induction. Inductions were provided to obstetrics and to gynaecology; trainees felt the obstetrics induction was well delivered but highlighted inadequacy of the gynaecology induction. due to the consultant delivering not being a gynaecologist and unable to answer related queries. Trainees did not receive a rota until a few weeks into the role. Trainees commented on the new O&G app that has been created but highlighted this is in its infancy, but noted valuable content.

Nursing and Non-Medical Staff: Staff felt induction was effective in preparing trainees to work both during the day and out of hours, nursing staff participate in induction.

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

Trainers: The panel were advised there are postgraduate teaching sessions which were delivered on Friday afternoons, 1 to 3 times per month. Trainers highlighted challenges in ensuring trainees attend sessions due to the nature of the rota and clashes with the deanery teaching sessions. Trainers reported that there is weekly cardiotocography (CTG) teaching sessions and highlighted various other educational opportunities available to trainees, these include:

- 1st on call tutorials

- Obstetrics risk management meetings and,
- Gynaecology risk management meetings.

Trainers felt that clinical commitments were given priority over training needs.
Trainers flagged concerns about the organisation of regional teaching and the late sharing of the dates of these sessions.

FY2: Trainees reported that there is scheduled teaching on Thursdays but noted these sessions are frequently cancelled at short notice. Trainees noted service pressure and rota allocation are also a barrier to attending. Some trainees discussed concerns with not achieving the required teaching sessions for their curriculum with [redacted]. The majority, of trainees were able to attend regional teaching with no barriers: there is one full day F2 scheduled regional teaching day per block.

ST:

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Departmental teaching is meant to be delivered on Friday afternoons although the frequency is variable and it is poorly attended. Trainees reported being able to attend only 3 sessions in 6 months. Their average weekly attendance at local teaching sessions was zero hours. Teaching time is not protected and trainees noted acute service pressure as the main reason they are unable to attend. Trainees were able to attend the CTG teaching on Monday afternoons however, since November these sessions had not been run. Trainees confirmed the Thursday 1st on-call teaching sessions covered basics and are well run and well organised. CTG teaching was held on Monday afternoons but stopped around November or December.

Trainees detailed multiple locations that regional teaching is delivered. They highlighted challenges in attending sessions due to the majority, of the cohort of trainees being of the same seniority. Trainees also noted that they did not receive regional teaching dates in advance and that training is frequently cancelled but, when able to attend the sessions are useful and targeted.

Nursing and Non-Medical Staff: Staff acknowledged the ongoing challenges faced by trainees in attending teaching sessions. Senior nursing staff are engaged with clinical directors to help identify and resolve issues.

2.3 Study Leave (R3.12)

Trainers: Trainers did not feel there were any challenges in supporting study leave for trainees.

FY2: Trainees reported that due to current gaps on the rota, obtaining study leave has become more challenging than at the start of their post. Trainees must take study leave for mandatory FY training and noted that generally there is no issues around this.

ST: Trainees not asked.

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

Trainers: Trainers confirmed that not all have allocated time in their job plans for supervising trainees. Local training sessions are delivered 4-6 times per year, supervisors would be expected to attend a proportion to ensure knowledge is kept current.

All trainees: Trainees present had all been allocated Educational Supervisors, had met them at the beginning of their current block and had learning plans in place. Some trainees experienced good engagement with their supervisor but, others felt this was variable, and were concerned their needs were not being met.

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 they can differentiate between the different cohorts of trainees. Within the gynaecology department, there is always a consultant on call, however, 2days per week they may not be based at the site. Due to the pressures on the consultant body, clinical duties are not cancelled when on-call. The panel were advised of a proposal to alter consultant job plans to provide ‘hot week cover’ which would ensure consultant cover Mon-Fri,09:00-17:00. Trainers reported they were not aware of any instances where a trainee had been left to cope with a situation beyond their competence. If a trainee reported concerns, they would provide appropriate support.

FY2: Trainees reported that they feel well supervised clinically and always know who to contact for support both in and out of hours. Some trainees felt pressured to complete speculum

examinations in the maternity assessment unit without senior support. Trainees felt that their senior colleagues are very approachable and accessible whenever they ask for support.

ST: Trainees were aware who provides clinical supervision within the obstetrics department and this is done well. However, they reported that in the gynaecology department they are not always appropriately supervised. Emergency day time gynaecology consultant cover posed significant concern to the trainees. The consultant on call may be at clinic, theatre, or some days of the week off-site. leaving the registrar without accessible on-site senior support. Trainees noted this would happen 2-3 days per week. Trainees are concerned that the delay in contacting the consultant and lack of immediate support available on site has resulted in compromise to patient care. Trainees informed the panel of 2 events when they perceived patient care was compromised due lack of on-site consultant. Trainees were unaware of plans to introduce the consultant 'hot week' to ensure on-site consultant cover during the day.

Nursing and Non-Medical Staff: Staff felt that they learnt each level of trainees competency through discussions with the trainees.

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

Trainers: Trainers confirmed that some supervisors maintained responsibility for the same cohorts of trainees and this provided them with familiarity of specific curricula. Some trainers reported they rely on trainees to inform them of the requirements of their curricula to allow them to tailor training to their needs. Trainers felt the department capable of delivering all curricular needs for specialty trainees but noted difficulties in ensuring trainees are able, to access the experience and opportunities they need. Trainees spend a lot of their on-call shifts at night, limiting their availability during the day. Trainers also advised the rota coordinator aims to schedule 2 ATSM sessions per week for specialty trainees but that trainees must be proactive and organised to access the sessions required. Sub-specialty trainees meet weekly with their supervisors and plan out their needs that feed into their weekly rota.

FY2: Trainees felt the loss of 'green days', which allowed them access to learning in clinics, has compromised their learning opportunities. They reported they thought they would achieve the required learning outcomes, but the majority of FYs felt that their workload was dominated by routine tasks of little to no benefit to training. Their gynaecology 'blood rounds' typically comprise taking 20-25 blood samples.

ST: Obstetrics opportunities were generally satisfactory although some trainees reported that the rota had resulted in some accessing relatively few labour ward sessions in favour of substantially greater numbers of gynaecology sessions. Access to core curriculum theatre opportunities was limited both in range and in number of sessions. Outpatient learning opportunities were also limited, made more so by loss of 'green days' but also varied depending on how the clinics were run. All trainees reported they were struggling to meet curriculum goals; this included all of the trainees undertaking ATSMs. Service provision was the key barrier to accessing learning opportunities, but lack of continuity of ward base and lack of on the job feedback contributed.

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

Trainers: Trainers reported that due to the new portfolio and curriculum for O&G trainees there has been some challenges. Trainers indicated that they had received training in completing workplace-based assessments but had not had the opportunity to benchmark their assessments with each other.

All trainees: All trainees noted significant issues in obtaining of workplace-based assessments from senior staff, with trainees having to send several invitations and multiple reminders in the hope that they will receive the required responses. Specialty trainees highlighted that their educational supervisors were unable to access the portfolio for months due to unfamiliarity with the new eportfolio system.

Nursing and Non-Medical Staff: Staff advised they complete multi-source feedback assessments for the trainees.

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

Trainers: Trainers described a variety of multi-professional learning opportunities available to the trainees, including:

- Practical obstetric multi-professional training (PROMPT)
- Simulation in emergency gynaecology (SinErGy)
- Various risk management meetings

FY2: Trainees had the opportunity to attend a multidisciplinary training day at the start of their post but were unaware of any other sessions available to them.

ST: ST1 trainees appreciated the willingness to train from the midwifery staff on the labour ward. Sub-specialty trainees have multiple opportunities to work and learn alongside multi-professional staff.

Nursing and Non-Medical Staff: Staff reported there are a variety of risk management meetings that trainees can attend.

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

Trainers: Trainers reported there is a QI team based at the Queen Elizabeth University Hospital and trainees who wished to undertake a project would receive suitable support.

FY2: Trainees reported that they have the opportunity, to undertake quality improvement projects during their post.

ST: Trainees not asked.

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: Trainers reported that feedback is provided to trainees in real time face to face discussions. Significant event cases would be discussed at risk management meetings and feedback would be provided directly to the trainee or via there supervisor. The labour ward utilises a Greatix system which allows staff to record when something has gone well. Once reviewed, the form acknowledging this is delivered to the recipient.

FY2: The trainees felt they generally do not receive day to day feedback. Quiet nights can provide learning opportunities with feedback from the registrars. When it happens, the feedback is useful.

ST: Trainees do not routinely receive feedback. Some trainees noted they will seek consultant advice after creating a patient care plans and noted the feedback can be variable. All trainees highlighted their lack of continuity in ward working affected their learning and acquisition of

technical skills due to trainers not allowing them to complete specific skills that they themselves had not witnessed them previously perform.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: Trainers receive feedback via informal and formal discussions with the trainees. There is a FY/GPST trainee forum which is led by [redacted] and the department have a chief resident who attends, where possible, the senior staff meetings.

FY2: FY trainees confirmed they had attended meetings with [redacted] to provide feedback on their training experience. These were informal sessions which were incorporated into their teaching time. Trainees reported they are aware of who the chief resident is and that they had informal feedback discussions.

ST: Trainees advised there is no routine trainee forum however, they can feedback on the quality of training by completing the GMC and other surveys. The chief resident is able, to feed into the management structure although is not always updated on the outcome.

2.12 Culture & undermining (R3.3)

Trainers: Trainers advised there is a bullying and undermining champion and any concerns could be raised this way or through the chief resident. Trainers were aware of instances where trainees may have received less than supportive comments, these were addressed and, the trainees were supported throughout.

FY2: Overall the trainees interviewed felt they worked in a very supportive environment. Trainees felt there were issues within the gynaecology department with tendency to blame and to respond to questioning about why things were being asked to be done with escalation on the basis of refusal to do things. This was raised through the chief resident and the trainees hoped this would be adequately resolved.

ST: Trainers felt they worked in a very supportive environment and the clinical team are always approachable. Trainees had witnessed junior doctors being subjected to undermining behaviours whilst in the gynaecology ward that they understood have been escalated.

Nursing and Non-Medical Staff: Staff reported they have a good team working culture with the departments and noted they would be promoting the positive culture campaign that had been implemented at the Queen Elizabeth University Hospital. Staff were aware of instances of undermining that had been raised and dealt with.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Trainers reported gaps on the junior rota which had resulted in each trainee losing approximately 10 ‘green days’ from their rota. It is a busy department and the workload is high. Trainers acknowledged that since August, sick leave and conditions requiring people not to work nights had dramatically affected the rota. Trainers flagged their concerns about the late awareness (3weeks before changeover) of 3 gaps among 6 GP trainees. Trainers felt more registrars and consultants on the rota would improve the training environment. Trainees can raise concerns about their rota through the chief resident.

FY2: There is currently 3 gaps on the rota which has resulted in the loss of the ‘green training days’. Trainees felt the department were trying to manage the gaps but, had been unsuccessful. All trainees were concerned the high volume of workload was affecting their wellbeing. Trainees felt pressured to cover shifts on their non-working days.

ST: Trainees confirmed there has been gaps on the junior rota since August which had dramatically affected training opportunities. The loss of ‘green days’ had meant ATSM sessions had been pulled from the rota. There is a high volume of less than full time trainees on the rota which had not been accounted for. Trainees felt overburdened to cover shifts.

Nursing and Non-Medical Staff: Staff reported that they were not aware of any rota concerns that could impact on training or a trainee’s wellbeing.

2.14 Handover (R1.14)

Trainers: Trainers advised the obstetric handover has been changed to create a more robust system ensuring all at risk patients including post-natal patients are discussed. The gynaecology handover takes places at 08:30 and is multidisciplinary; all patients are discussed.

FY2: Both the obstetrics and gynaecology handovers take place at 08:30 and 20:30 on the wards. Gynaecology have a shared access handover file which details patient information and can be updated throughout the day/night. Trainees reported handover was not used as a learning opportunity.

ST: Trainees not asked.

Nursing and Non-Medical Staff: Handover is good in all wards/units within the department. Each ward/unit had their own handover process and there was non-medical input to these.

2.15 Educational Resources (R1.19)

Trainers: Trainers described a variety of resources available to trainees to support their learning, including:

- Library
- Computer access
- O&G guideline app

Trainees also have the opportunity, to attend PROMPT and SinErGy simulation courses to further enhance their learning.

FY2: There is a Doctors' Room in the Gynaecology unit but this is a very small room with only 2 computers for all trainees. Trainees found it challenging to access computers in the obstetrics department.

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: Concerns regarding a struggling trainee would be raised through the trainees' educational supervisors and escalated to TPD if required. Doctors in difficulty would be further supported by the consultant group and appropriate guidance provided. Trainees returning from maternity leave are given extra support and protected from intense on call shifts until they feel competent.

FY2: Trainees felt confident that support would be provided to them if they were struggling. 1 trainee had childcare issues and felt the department adaptable. The additional training needs of academic trainees are accommodated.

ST: Trainees not asked.

Nursing and Non-Medical Staff: Staff would discuss any concerns with a trainee individually or through their supervisor.

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

FY2: Some trainees were aware who the Director or Associate Director of Medical Education is but were unclear as to their role within managing the quality of education and training they receive. Trainees are aware of who the chief resident is but were unaware of any trainee forums.

All trainees:
The feedback from trainees suggests that many of the issues raised at the last QM visit have not been addressed (see section 3), and there is limited understanding among them of progress to address a number of these concerns.

2.18 Raising concerns (R1.1, 2.7)

Trainees: Trainers reported that they encourage trainees to submit a datix report if they have a patient safety concern but would also encourage trainees to first raise any concerns with a consultant. Concerns can also be discussed at the obstetric and at the gynaecology risk management meetings.

All trainees: Trainees reported that they would raise patient safety concerns to a senior trainee or consultant. They would use the datix system to report a clinical incident and provided an example of an issue raised and feedback given.

Nursing and Non-Medical Staff: Staff reported there is a clear escalation policy. All incidents are recorded through the datix system and reviewed at monthly governance meetings.

2.19 Patient safety (R1.2

Trainers: Trainers felt the department provided an extremely safe environment for patients and trainees. Patient safety is prioritised, sacrificing trainee education. Consultants have regularly given up admin time to ensure the rota is adequately staffed.

Concerns were noted with medically unwell patients being boarded into the gynaecology unit and the increased workload this created for the junior tier. This issue has been discussed at a hospital-wide consultant meeting and going forward boarding policy criteria should be followed.

FY2: Trainees shared their concern around patient care due to inadequate medical staffing levels. There was also felt to be a lack of consultant continuity in the gynaecology department which trainees felt could lead to things being missed. Despite trainees reporting concerns, issues remain ongoing.

Patients are boarded into the gynaecology ward, these patients can come from a mix of specialties and on occasions are not suitable boarders. Trainees noted concern around the responsiveness when escalating concerns to the appropriate department. Trainees described occasions when boarded patient care was delayed by up to 48hrs but, highlighted that this had no adverse outcome for the patients.

The lack of consistent access to consultant input to support trainees managing gynaecology emergencies left trainees feeling under pressure and was perceived to compromise the safety of patient care.

ST: Trainees expressed similar concerns to those of their FY2 colleagues in regard to lack of consistent access to on-site consultant support for the management of emergency gynaecology cases.

Although trainees feel comfortable raising concerns, they feel issues are not addressed, this has resulted in low morale amongst the group.

Nursing and Non-Medical Staff: Staff felt the environment was as safe as it can be for patients. Staff discussed concerns raised by the junior doctors around the completion of discharge letters for boarders but felt that this issue had been resolved.

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

Trainers: Trainers reported that adverse incidents are recorded through the datix system. If a trainee has been involved in an adverse incident, feedback and reflection about the incident are provide directly to the trainee. Obstetric and Gynaecology risk management meetings provide the opportunity for shared learning from adverse events. There are also perinatal mortality meetings.

Trainees: All trainees reported that adverse incidents are recorded through the datix system. Those that had submitted a datix had received feedback. Trainees were aware of departmental obstetric and gynaecology risk management meetings and reported that summaries of the learning gained from the reviews of cases are distributed via email.

Some trainees had received greatix letters and all trainees were aware of the system.

2.21 Other

Trainees were asked to rate their overall satisfaction experience of working within the department from a range of 0 (very poor) to 10 (excellent). The scores are listed below:

- Foundation – Range: 4 – 6, Average 5.2 out of 10
- ST - Range: 4 – 8, Average: 5.5 out of 10

3.Summary

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

The visit panel found an approachable and supportive group of trainers who were focused on the care and safety of their patients whilst aiming to improve the training experience for trainees. Despite their efforts, significant educational challenges remain. Due to the remaining and ongoing concerns around the delivery of postgraduate medical training not meeting the GMC's standards despite enhanced monitoring, there will be a discussion with the GMC following finalisation of the report as to whether they might wish to consider imposing conditions upon the ongoing enhanced monitoring. A revisit will be required within 12 months' time.

<u>Positive aspects of the visit</u>

- The effective governance structure around risk management within both obstetrics & gynaecology including feedback and sharing of learning.
- The awareness and appreciation of the 'greatix' system
- Generally, very supportive and approachable consultants both in and out of hours
- Multi-disciplinary simulation training for both obstetrics and gynaecology
- The introduction of the O&G mobile app
- The concept of 'green days' is commendable however, these have been sacrificed due to rota gaps and service delivery

Less positive aspects of the visit

- Lack of consistent on-site Gynaecology Consultant on call cover Mon-Fri; this is a 'known, known' and we heard that this would be addressed through the next round of Consultant job planning that is imminent. However, the current escalation plan appears vague and we heard that current arrangements resulted in delays in patients getting to theatre
- Lack of access to a formal local teaching programme with protected time
- Responsiveness to education and training concerns with a number of last year's visit requirements unaddressed. Doctors in training have little awareness of the plans to address and resolve issues they have raised.
- All trainees highlighted difficulty in achieving workplace-based assessments
- Access to learning opportunities for all level of trainees including those on ATSMs are compromised by service delivery. There is universal concern that trainees will struggle to achieve the required competencies by end of post
- Discontinuity of ward base for trainees which is a barrier to developing supervisory and feedback relationships and to accessing learning opportunities
- There continues to be a burden of non-educational tasks impacting on the junior trainees' experience.
- We heard of some instances of allegations of undermining but we understand these have been escalated and are being addressed
- Morale of all the doctors in training is low

Progress against previous requirements: recorded as 'addressed', 'significant', 'some progress', 'little or no progress'

Ref	Item	Progress
7.1	Educational and clinical supervisors must understand curriculum and portfolio requirements for the cohorts of trainees training in the unit.	Some progress. See new requirement 6.4
7.2	Tasks that do not support educational and professional development and that compromise access to formal	Little or no progress. See new requirement 6.7

	learning opportunities for GP and Foundation doctors must be reduced.	
7.3	The department must develop and sustain a local teaching programme relevant to curriculum requirements of the ST3+ trainees including a system for protecting time for attendance.	Little or no progress See new requirement 6.2
7.4	Trainees must be given protected study leave to attend mandatory regional teaching.	Some progress
7.5	Doctors in training must have access to appropriate resources to support their training - office space for doctors in training is an issue.	Little or no progress
7.6	Assignment of STs undertaking ATSMs must be within the unit's capacity to provide training. ***This is a deanery requirement for the training programme director****	Little or no progress See new requirement 6.5
7.7	The department must support ST3+ trainee attendance at regional teaching days.	Little or no progress
7.8	Foundation and General Practice trainees must be assigned to a ward/unit for a minimum of a 4-week continuous period.	little or no progress see new requirement 6.8

4. Areas of Good Practice

Ref	Item	Action
4.1	The introduction of the GGC wide O&G guideline app	
4.2	Laminated prescribing cards for common prescriptions. This was highly thought of by FY2 and GP trainees as it supported patient safety and reduced the risk of prescribing errors.	

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		Efforts should be made to support and value trainees to improve their morale

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	Clinical supervision must be available at all times to support trainees working in acute gynaecology.	27th December 2020	ST
6.2	There must be a protected formal teaching programme for doctors in training.	27th December 2020	FY, ST
6.3	The department must respond to concerns about education and training and provide feedback on this.	27th December 2020	FY, ST
6.4	Educators must be supported to deliver the assessments required of trainees' curricula.	27th December 2020	FY, ST
6.5	The Board must design rotas to provide learning opportunities that allow doctors in training to meet the requirements of their curriculum and training programme.	27th December 2020	FY, ST incl ATSM
6.6	Staffing levels in wards must be reviewed to ensure that workload is appropriate and does not prevent access to learning opportunities including outpatient clinics.	27th December 2020	FY, ST
6.7	Tasks that do not support educational and professional development and that compromise access to formal learning opportunities for all cohorts of doctors must be reduced.	27th December 2020	FY, ST
6.8	The discontinuity of ward placements 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.	27th December 2020	FY, ST

6.9	The department must have a zero tolerance policy towards undermining behaviour.	27th December 2020	FY, ST

7. DME Action Plan: to be returned to QIM on [INSERT DATE]

Ref	Issue	By when	Owner	Action(s)	Date Completed
7.1	Clinical supervision must be available at all times to support trainees working in acute gynaecology.	27th December 2020			
7.2	There must be a protected formal teaching programme for doctors in training.	27th December 2020			
7.3	The department must respond to concerns about education and training and provide feedback on this.	27th December 2020			
7.4	Educators must be supported to deliver the assessments required of trainees' curricula.	27th December 2020			
7.5	The Board must design rotas to provide learning opportunities that allow doctors in training to meet the requirements of their curriculum and training programme.	27th December 2020			

7.6	Staffing levels in wards must be reviewed to ensure that workload is appropriate and does not prevent access to learning opportunities including outpatient clinics.	27th December 2020			
7.7	Tasks that do not support educational and professional development and that compromise access to formal learning opportunities for all cohorts of doctors must be reduced.	27th December 2020			
7.8	The discontinuity of ward placements 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.	27th December 2020			
7.9	The department must have a zero tolerance policy towards undermining behaviour.	27th December 2020			

Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	23rd March 2022	**Level(s)**	FY/GP/ST
Type of visit	Enhanced Monitoring Revisit	**Hospital**	Princess Royal Maternity Hospital/Glasgow Royal Infirmary
Specialty(s)	Obstetrics & Gynaecology	**Board**	NHS Greater Glasgow & Clyde

Visit panel	
[redacted]	Visit Chair - Postgraduate Dean
[redacted]	GMC Visits & Monitoring Manager
[redacted]	GMC Associate
[redacted]	Associate Postgraduate Dean – Quality
[redacted]	Training Programme Director
[redacted]	Foundation Training Programme Director
[redacted]	Trainee Associate
[redacted]	Lay Representative
[redacted]	Quality Improvement Manager
In attendance	
[redacted]	Quality Improvement Administrator

Specialty Group Information	
Specialty Group	Obstetrics & Gynaecology and Paediatrics
Lead Dean/Director	[redacted]
Quality Lead(s)	[redacted] & [redacted]
Quality Improvement Manager(s)	[redacted]

Unit/Site Information		
Trainers in attendance	6	
Trainees in attendance	2x FY2, 6x GPST, 8x ST1-7	

Feedback session: Managers in attendance	Chief Executive		DME	X	ADME	x	Medical Director		Other	x

Date report approved by Lead Visitor	7th April 2022

1. Principal issues arising from pre-visit review:

The Princess Royal Maternity Hospital has been under the GMC's Enhanced Monitoring process since May 2018 due to escalating concerns about the training environment. The last visit to the unit on 24 February 2021 indicated that significant progress had been made across several areas of previous concern. The overall training experience had improved for most cohorts, the exception being the FY trainees who did not feel as embedded in the team culture. Some challenges remain and have been reflected in the requirements.

Requirements from visit on 24th February 2021:

- The department must increase relevant training opportunities for FY trainees.
- There must be a protected and accessible formal local teaching programme appropriate for the learning needs of doctors in training (in particular for FYs & ST1-3s). There must also be more consistent and regular scheduling of the formal teaching for senior trainees with more advanced notice of topics.
- Foundation trainees must be given the opportunity to be an effective member of the multi-professional team by promoting a culture of learning and collaboration between specialties and professions.
- Tasks that do not support educational and professional development and that compromise access to learning opportunities for FY/GP doctors must be reduced.
- A process must be put in place to ensure that any trainee who misses their induction session (hospital or departmental) is identified and provided with an induction.

The visit commenced with [redacted] delivering an informative presentation to the panel which provided an update regarding progress against the previous visit requirements, along with supporting evidence/documentation and detailed the impact of COVID-19 on the unit.

2.1 Induction (R1.13):

Trainers: Trainers told us that all trainees receive induction to the site. Prior to starting trainees are sent an online induction package for Greater Glasgow & Clyde and advised to download the GGC wide O&G app which provides clarity of on-call duties, roles and expectations with links to supporting protocols and guidance. Trainees receive a protected full day on site induction to the unit which includes, departmental presentations and orientation tour. Trainees who are unable to attend the

main induction are sent details of their rota and educational supervisor in advance and a condensed one-to-one induction is scheduled at the earliest opportunity.

FY2 & GP: All trainees present received induction to both the hospital and department. Trainees who were unable to attend the on-site induction due to shift pattern were provided with online materials prior to starting, had an initial brief induction with a fuller induction provided to them the following week. All trainees felt the induction adequately prepared them for working in the unit. We were told some trainees experienced a delay in receiving their security access badges.

ST: Trainees reported a comprehensive induction which equipped them well to work in the department. Special arrangements and a catch-up induction are made for trainees who are starting on nights or unable to attend the induction.

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

Trainers: Trainers reported that there is 1st on call training delivered on Thursday afternoons, there is a general awareness within the unit that trainees should not be interrupted during this time. Trainees are encouraged to inform staff when they are leaving to attend teaching sessions which has helped to reduce interruptions. Feedback is sought on the teaching programme at the end of each rotation and changes have been made based on trainee suggestions.

To enable attendance at the FY2 regional teaching days, the rota coordinator will mark all available trainees as being on study leave, with the exception of those on nights or annual leave. GP trainees must inform [redacted] and the rota coordinator to organise attendance at their specific teaching days. FY and GP trainees 'cover' each other so that each group can attend their own specialty teaching. Specialty teaching takes place on Friday afternoons, when there is typically reduced clinical activity which allows the majority, of trainees to attend.

All teaching sessions are recorded using MS Teams and attendance is tracked. If a trainee was regularly missing sessions, trainers would meet with them and encourage attendance. Attendance certificates reflecting their engagement are provided as evidence for their portfolio. Trainers estimated that on average a trainee would be able attend 2 hours per week of teaching sessions.

FY: Trainees reported that there is scheduled 1st on-call teaching on Thursday afternoons and FY specific learning (provided across NHS GG&C) on Tuesdays. They felt the departmental teaching

was of a high standard however attendance had been variable due to the workload. Trainees estimated they can attend 1-2 hours per month of teaching but this is not interruption free.

GP: GPST's confirmed weekly teaching on Thursday afternoons, these sessions are not bleep free and similar, to their FY2 colleagues they noted the burden of clinical service pressure as the main barrier to attendance. The sessions provide valued and relevant content. They felt able to attend between 10-50% of these sessions. Trainees found it challenging to attend their regional teaching days as they must be on a 'green' day on the rota to allow access or, organise a shift swap with a colleague. COVID-19 absences has added to the service and rota pressures. Trainees anticipated being unable to attend any regional teaching sessions during this placement.

ST1-7: Local and regional teaching sessions are delivered on Friday's when service commitments are reduced. Trainees highly commended the rota coordinator [redacted] for maximising training opportunities by rostering their attendance into the rota. ST1-2 trainees attend the first on call teaching sessions and reported no barriers in attending. They are also invited to participate in the specialty teaching however, no provision is in place on the rota to facilitate attendance. The trainees told us that teaching is working well but COVID-19 had impacted on opportunities such as Practical Obstetric Multi-Professional Training (PROMPT) and Cardiotocography (CTG) teaching. A new simulation lead has been identified within the department and trainees were aware of plans to restart PROMPT.

2.3 Study Leave (R3.12):

Trainers: Not asked

ALL: The system of 'green days' was valued as a principle, but there were too few of them to achieve real benefit to accessing learning opportunities. 'Green days' are used to enable trainees' access to annual leave and study leady and what is left over can be used to support access to learning opportunities such as getting to clinics; there are insufficient 'green days' to support access to the requisite learning opportunities. 'Green days' had been compromised also by rota and staffing pressures and the need to provide back-fill, but this was perceived to exacerbate what was a fundamental issue.

FY2 & GP: Trainees reported no issues accessing study leave on these days however, noted it was more challenging to take on non-standard days.

ST1-7: Trainees reported that it was easy to get study leave approved.

2.4 Formal Supervision (R1.21, 2.15, 2.20, 4.1, 4.2, 4.3, 4.4, 4.6): Not covered, no concerns raised in pre-visit information

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 told us that they were not aware of any instances where a trainee had been left to cope with a situation beyond their competence. When working in the Maternity Assessment Unit (MAU) trainees are supported by 2 on-call consultants. The escalation policy is clear and detailed at induction.

FY2 & GP: Trainees advised they feel well supported in all clinical areas and have not worked beyond their competence levels. The MAU can be challenging initially for more junior trainees; it does present potential for more clinical autonomy but there is always someone to call for senior support, although the senior support can be committed to other duties. On occasions, when the registrar has been called to theatre, trainees have felt pressured by the midwives to discharge patients from MAU.

ST 1-7: None of the trainees present had felt left to cope with a situation beyond their competences and described their consultants as supportive and approachable. Trainees recognised 2nd on-call support may be variable at times but felt the consultants are always accessible when required. They suggested a specific MAU induction detailing common presentations would be beneficial for the junior doctors.

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

Trainers: To ensure consistency and familiarity with curricula, allocated trainers maintain responsibility for trainees in either the FY-, GPSTs or specialty trainee cohort. Junior doctors have ‘green weeks’ scheduled into their rota providing them with opportunities to attend sessions that they find most useful to their learning but ‘green weeks’ are also to be used for study leave and annual leave. Trainers said that ‘green’ weeks may be pulled to provide clinical care when there are shortages on the rota but despite this, they felt access to training opportunities would be equal for all

training cohorts. [redacted] actively seeks feedback and encourages trainees to highlight any required training needs.

[redacted] coordinates the ST3-7 rota and tailors learning opportunities based on grade of training. Through the trainee forum trainees have the opportunity, to review theatre lists and select specific cases based on their individual learning needs. Trainers have implemented the 'What matters to you' initiative during on call shifts, which allows trainees to highlight required learning outcomes.

It was felt that trainees' access to sonography scanning sessions and elective gynaecological surgery has been limited due to the pandemic.

The introduction of a 2nd on call consultant has increased core activity learning for trainees as trainers now have more time for on the job learning such as ward rounds and case discussions.

FY2: Trainees reported they could achieve the majority, of their learning outcomes and reported a wide breadth of experience across the two specialties, but the relative balance between gynaecology & obstetrics varies among the cohort. There were opportunities to clerk acute Gynaecological admissions first and to run their findings past the registrars. There were opportunities to assist in Gynaecology theatre sessions and in emergency sections. The MAU, particularly for those new to this environment could be challenging, in that is present the greatest opportunities for clinical autonomy; MAU can be busy and there is always someone senior to call, although they may not be available immediately. Exposure to clinics had been very limited. They felt well supported by their senior colleagues when escalating concerns.

Trainees, however felt that their workload was dominated by routine tasks considered to be of little to no benefit to training. After Gynaecology night shifts they are required to do a gynaecology 'blood rounds' typically that takes ~2hours. Trainees reported that they had recently been advised of a proposal to implement a phlebotomy service to cover this role.

GP: This post has potential to provide good training opportunities in MAU, the labour ward and in Gynaecological emergencies – in practice access to these is hindered by the reality that 70-95% of their work is carrying out tasks with little or no educational benefit. There is good exposure to acutely unwell patients. Some consultants within Gynaecology do ask the GPSTs what would be of benefit to them. Access to learning opportunities was reported to vary depending on their 'column' on the rota and while 'green days' were welcomed in principle, the absolute number of these available to support

clinic attendance and other learning opportunities such as Gynaecology theatre lists was in practice very limited. They were able to project forward as to their likely clinic attendance in this post – these numbers were very limited. Clinic attendance provided valuable learning opportunities and they suggested more gynaecological clinic experience would enhance their learning for their future roles as GPs providing insights into the GP referral path and management of common complaints. Trainees reported challenges in achieving sign-off for speculum examination when on night shifts due to the paucity of direct supervision. The opportunity to do this during the day had not presented itself.

ST1-7: These trainees acknowledged the perception that MAU could feel like being 'in at the deep end' for those new to specialty, but that there were 1st on and 2nd on consultants and a registrar available, although none might be immediately available. They noted plenty of access to ante-natal work and to Obstetric opportunities in the 'busy labour ward'. The range of Gynaecological operative procedures had been significantly limited by COVID-19, with oncological work continuing but substantial reduction in elective Gynaecological theatre sessions; there were plenty of opportunities in relation to acute Gynaecology. The already noted limited availability of 'green days' also impacts on the access to clinics for ST1-3 trainees; ST3 trainees told us they had lots of opportunities to attend antenatal clinics but limited gynaecology sessions. The added compromise to accessing 'green days' because of COVID-19 was again noted. Access to scanning opportunities for high risk patients for senior trainees continues but access to 'basic scanning' training opportunities led by sonographers was a current and ongoing issue, for reasons that were not clear. A large proportion of the ST1-2s' time was spent completing non educational tasks such as immediate discharge letters (IDLs) however, after raising this, their rota was amended to reduce time on the obstetrics ward. The first on-call rota coordinator was reported to be supportive of the trainees' needs.

ST6-7 trainees were positive about their learning opportunities. Trainees highly commended the work of the senior rota coordinator in ensuring learning needs are matched to opportunities.

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

Trainers: Trainers reported that there are plenty of educational opportunities for trainees to achieve their assessments.

FY2: Trainees reported no issues in completing their work-place based assessments (WPBAs) and appreciated the supportive nature of the senior trainees.

GP: Trainees reported difficulties in gaining access to educational opportunities whilst working in the gynaecology department. They described a 2-week rotation in the department which was dominated by non-educational tasks. Opportunities to review patients prior to the registrar were unable to be accomplished due to service pressures. A minority of trainees had managed to achieve WPBAs required for their portfolios.

ST1-7: Trainees stated that in general they were able to complete WPBAs and have them signed off easily.

2.8 Adequate Experience (multi-professional learning) (R1.17): Not covered, no concerns raised in pre-visit information

2.9 Adequate Experience (quality improvement) (R1.22): Not covered, no concerns raised in pre-visit information

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: Trainers advised that due to the high level of consultant involvement in patient care, informal feedback was regularly provided to trainees. Good practice identified at risk management meetings is fed back to the trainee by the department lead and areas of concern would be shared with the trainees' educational supervisor for further discussion.

FY2: Trainees reported they receive good levels of feedback particularly, when on-call from both senior trainees and some consultants.

GP: Trainees reported that they do not routinely receive day to day feedback. Some trainees noted that if they requested feedback this would be provided however limited direct supervision affected this. Some trainee review patient plans on badger net to ensure that correct had been made however it is not possible to do this for all due to service needs.

ST1-7: Trainees advised they receive regular feedback which is constructive and meaningful.

2.11 Feedback from trainees (R1.5, 2.3) Not covered, no concerns raised in pre-visit information

2.12 Culture & undermining (R3.3)

Trainers: Trainers felt that they had worked hard to continue to promote a positive culture within the department. They have introduced various measures to ensure trainees feel part of the team such as the 'what matters to you' initiative, theatre briefs clarifying roles and ward round introductions. At induction trainees are informed how to report any bullying or undermining concerns and are encouraged to raise any issues. Trainers were aware of an instance where a trainee had raised a concern with another department, this was resolved.

FY2: Trainees reported that they work within a very supportive team. None of the trainees had witnessed or experienced any undermining or bullying behaviours but would be comfortable in raising any concerns.

GP: Trainees told us that overall, they worked in a supportive environment. There was awareness of occasional inappropriate communications among staff. They were able to report and escalate these although it was not apparent at this time that any action had been taken.

ST1-7: Trainees reported that they work within a very supportive unit. None of the trainees had experienced or witnessed bullying or undermining behaviours. If they were to, trainees stated they could raise through various channels.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Trainers acknowledged the challenging demands of the rota which have been exacerbated due to COVID-19. The middle grade rota is currently running with an additional 2.5 WTE which has increased access to study leave and ATSM sessions.

FY2: Trainees were aware of the rota coordinator and provided examples of their rota being amended to reflect need. They reported that they find the rota challenging with a high burden of on-call and night shifts. COVID-19 had generated the need for a lot of extra cover of shifts.

GP: Trainees were concerned the high volume of workload and rota structure was affecting their wellbeing. They described the rota as tight and felt it limited their opportunity to engage in educational learning. A rota pattern of 4 long days, 7 on-call, followed by 5 long days can leave them feeling very tired. The phlebotomy round at the end of a night shift was felt to be an additional burden.

ST1-7: Trainees once again commended [redacted] for tailoring the rota to their learning needs. They acknowledged rota pressures due to COVID-19 which had resulted in them covering extra shifts but felt this had been split equally amongst the group. ST1 trainees echoed the concerns of the GP cohort regarding the run of long days into nights.

2.14 Handover (R1.14): Not covered, no concerns raised in pre-visit information

2.15 Educational Resources (R1.19):

Trainers: Not asked

All Trainees: Each cohort of trainees reported a lack of available space to complete administrative tasks on the wards, this was raised through the trainee forum and is being addressed.

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, no concerns raised in pre-visit information

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, no concerns raised in pre-visit information

2.18 Raising concerns (R1.1, 2.7):

Trainers: Trainers felt they encouraged trainees to raise concerns through the open culture of the department.

Trainees: Not asked

2.19 Patient safety (R1.2) Not covered, no concerns raised in pre-visit information

2.20 Adverse incidents & Duty of Candour (R1.3 & R1.4) Not covered, no concerns raised in pre-visit information

2.21 Other

Trainees were asked to rate their overall satisfaction experience of working within the department from a range of 0 (very poor) to 10 (excellent). The scores are listed below:

- Foundation – Range 4-8, Average 6
- General Practice Range 3-7, Average 4.8
- ST1-7 – Range 8-9, Average 8.3

3. Summary

Is a revisit required?	Yes	No	Highly Likely	Highly unlikely

Throughout the visit all levels of trainees emphasised the approachability and supportiveness of the consultant team. The panel would like to acknowledge the amount of work that has gone into sustaining and improving the training experience for trainees, despite staffing difficulties and the service pressures created by the COVID-19 pandemic. Over the course of this visit, the panel asked questions which related to previous visit requirements and have highlighted in the table below where we think current progress is with each, categorised into addressed, progress noted, or little progress noted.

Review of previous requirements from 2021:

Ref	Visit requirement from 2020	Progress in 2021 visit
7.1	The department must increase relevant training opportunities for FY trainees.	Progress noted
7.2	There must be a protected and accessible formal local teaching programme appropriate for the learning needs of doctors in training (in particular for FYs & ST1-3s). There must also be more consistent and regular scheduling of the formal teaching for senior trainees with more advanced notice of topics.	Little progress noted
7.3	Foundation trainees must be given the opportunity to be an effective member of the multi-professional team by promoting a culture	Addressed

	of learning and collaboration between specialties and professions.	
7.4	Tasks that do not support educational and professional development and that compromise access to learning opportunities for FY/GP doctors must be reduced.	Little progress noted
7.5	A process must be put in place to ensure that any trainee who misses their induction session (hospital or departmental) is identified and provided with an induction.	Addressed

The positive aspects of the visit were:

- The culture within the department feels right, providing a very supportive training environment with a potentially good range of training opportunities.
- Foundation trainees were very positive about the feedback received from more senior trainees and consultants on their clinical contributions.
- We commend the ST3-7 rota coordinator who is a facilitator of excellent training opportunities for the senior run-through trainees. Also, we note the valuable contribution of the rota coordinator for the junior tier.
- ST3-7 trainees highly value the positive training experience within the unit.
- The post equips all cohorts of trainees well to deal with acutely unwell patients in both specialities.
- Induction is working well including for those starting on nights who receive a catch-up session to ensure they are fully prepared for work in the unit.

The less positive aspects of the visit were:

- The proportion of time spent on non-educational tasks by first on-call trainees, especially FY2 and GP that prevents access to learning opportunities.
- We commend the concept of ’green days’ but operationally as these days are also used for AL/SL and gap cover its guarantee of access to training opportunities is compromised.
- The first on-call rota is inflexible and burdened with a heavy and very demanding work pattern.
- Lack of access to formal teaching opportunities and lack of protected time to attend.
- Lack of CTG teaching.
- GP training opportunities are not fully meeting their training needs.

4. Areas of Good Practice

Ref	Item	Action

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		Guidance to support the trainees' management of common presentations they will encounter when based in the Maternity Assessment Unit would be beneficial.
5.2		CTG teaching should resume.
5.3		The number of 'green days' available to all trainees should be expanded if this is the means of enabling access to learning opportunities such as clinics. Other solutions may, however, be available to achieve the required outcome.

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	The training opportunities provided to GPSTs must be tailored to their learning needs including relevant gynaecology and obstetrics clinic experience, feedback on their clinical decisions and access to WPBAs including training towards competence in procedures such as use of the speculum.	23/12/2022	GP
6.2	Ensure that service needs do not prevent trainees from attending clinics and other scheduled local learning opportunities.	23/12/2022	FY/GP/ST1-2
6.3	There must be a protected and accessible formal local teaching programme appropriate for the learning needs of doctors in training, in particular for FYs & GPSTs.	23/12/2022	FY/GP
6.4	The first on call rota structure is perceived to be too demanding because of a lack of down time between nights and long days and this must be addressed.	23/12/2022	FY/GP/ST1-2

Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	16th & 18th May 2023	**Level(s)**	FY/GP/ST
Type of visit	Enhanced Monitoring Revisit	**Hospital**	Princess Royal Maternity Hospital/Glasgow Royal Infirmary
Specialty(s)	Obstetrics & Gynaecology	**Board**	NHS Greater Glasgow & Clyde

Visit panel	
[redacted]	Visit Chair - Postgraduate Dean
[redacted]	GMC Visits & Monitoring Manager
[redacted]	GMC Associate
[redacted]	Associate Postgraduate Dean – Quality
[redacted]	Training Programme Director
[redacted]	Foundation Training Programme Director
[redacted]	General Practice Training Programme Director
[redacted]	Trainee Associate
[redacted]	Lay Representative
[redacted]	Quality Improvement Manager
In attendance	
[redacted]	Quality Improvement Administrator

Specialty Group Information	
Specialty Group	Obstetrics & Gynaecology and Paediatrics
Lead Dean/Director	[redacted]
Quality Lead(s)	[redacted] & [redacted]
Quality Improvement Manager(s)	[redacted]
Unit/Site Information	
Non-medical staff in attendance	2

Trainers in attendance	5	
Trainees in attendance	FY2 x 3, GP x 4, ST1-7 x 9	

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

Date report approved by Lead Visitor	26th May 2023

1. Principal issues arising from pre-visit review:

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

2.1 Induction (R1.13):

Trainers: To ensure trainees have timely access to IT systems all trainee information is sent to the relevant departments for set up. System training sessions are delivered at induction.

FY: Prior to starting all trainees were emailed log in details for most IT systems, Badgernet access was provided at induction and a comprehensive training session delivered**.**

GP: Trainees told us that there was a delay in receiving log in details for the Badgernet system. They confirmed they received a short training presentation at induction but were unable to put into practice any of the information until they received access 2-3 weeks later.

ST: Trainees all received system access in a timely manner.

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

Trainers: Trainers described a variety of teaching sessions available to trainees which included the reinstated Cardiotocography (CTG) session. All teaching sessions are detailed on the GGC O&G app which trainees are asked to download. Throughout departments there are posters which state teaching times and encourage interruption free teaching. Trainees are told at induction that teaching is bleep free, trainers acknowledged some junior trainees do not feel comfortable handing bleeps to senior staff but hope that the culture will soon become embedded in the unit. When attending trainees can scan a QR code which tracks their attendance, provides a certificate, and seeks feedback. Department sessions are recorded using MS Teams which allows trainees to access the sessions at a more suitable time. Attendance at regional teaching is facilitated and if required service reduced or

time back to review recorded sessions given. There are 3 laparoscopic simulation kits available, and we were told trainers hope to run more formal sessions going forward.

FY: 1 hour of 1st on call departmental teaching and FY2 teaching is available to trainees weekly. Attendance was variable and dependent on shift pattern. Department teaching is very good and relevant to their curriculum. Core FY2 teaching is recorded and if unable to attend trainees are given time in lieu to catch up. Teaching is not bleep free and they were unaware of any process to facilitate this.

GP: Attendance at teaching was variable with some trainees stating they had not yet managed to access any sessions whilst others told us they had attended 3-4 hours since starting in February. We heard that service pressures and rota allocations limited their availability to attend. They were unsure who they would give their page to when attending teaching and told us that this was not encouraged. Those that had attended teaching reported good quality sessions which were useful to their role. The majority, of trainees were able to attend their regional teaching and organise their keeping in touch days at their practice.

ST: Weekly CTG teaching has been reinstated and trainees estimated they had attended 3 sessions in the past 2 months. Friday afternoon departmental teaching can be difficult to access due to clinical commitments but those able to attend are scheduled on the rota. They told us that GG&C wide O&G sessions would benefit from improved planning and direction. All teaching is relevant however trainees suggested more gynaecology sessions would enhance their learning. Regional teaching is recorded so trainees who are unable to attend can catch up when they have time.

2.3 Study Leave (R3.12)

Trainers: There are no issues supporting study leaves, the department is now better staffed which helps support requests.

FY: Trainees reported no issues in accessing study leave for singular days, but some had experienced difficulties in securing leave to accommodate taster weeks.

GP: The rota coordinator is very approachable and accommodating. At times it can be challenging to get study leave approved if multiple trainees wish to attend the same course.

ST: Trainees told us this was the best unit for access to study leave. Rota gaps can at times affect approval, but overall trainees were happy with accessibility.

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

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 told us that they were not aware of any instances where a trainee had been left to cope with a situation beyond their competence. Some trainees had raised concerns over the presence of medical boarders within the gynaecology ward, they were unsure of their role and who they should escalate to. In response, a meeting was organised with the Clinical Director for medicine and the trainees to discuss their concerns, a detailed escalation plan was created and trainees are now comfortable with the boarding arrangements. Consultants confirmed trainees would not be asked to consent a patient unless competent to do so.

FY: Trainees are aware who to contact and have never worked beyond their level of competence. They work closely with their seniors and always feel supported.

GP: Escalation policies are detailed at induction and trainees were aware who they should contact for support both during the day and out of hours. When there is a gap on the senior rota, it can be challenging to get timely support within the Maternity Assessment Unit (MAU) as trainees escalate to the main obstetrics registrar who may be in theatre or have other duties. When seeking support for acutely unwell patients, they are responded to in a timely manner.

ST: Clinical supervision is always available and consultants were described as being accessible and approachable.

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

Trainers: Trainers reported it can be challenging to keep up to date with the different requirements for each trainee group, to help ensure familiarity allocated trainers maintain responsibility for each cohort.

Specialty trainees are asked to highlight priorities and learning needs at the start of their post these are then built into the rota where possible. Trainees are encouraged to raise any concerns with their educational opportunities with the rota coordinator. A record of who has attended which clinics/surgeries is kept, ensuring equity.

Since the pandemic, gynaecology operating has been significantly reduced. Senior trainees completing their Advanced Training Skills Modules (ATSMs) each have regular operating lists and ST2-5 trainees have 1 day surgery list per week.

The implementation of the phlebotomy service has greatly reduced the burden of tasks on junior doctors.

FY: Trainees felt it was quite easy to achieve most of their learning outcomes as they see a range of patients. They had lots of exposure in their post to developing their skills in managing acutely unwell patients, particularly when working in the MAU. Trainees do not attend clinics however theatre opportunities provide valuable learning experiences receiving on the job feedback. When working on the wards learning is limited by the burden of non-educational tasks such as immediate discharge letters (IDL) or electrocardiograms (ECG). Phlebotomy services were good.

GP & ST1: It can be difficult to complete some aspects of the GP curriculum such as community orientation reflections due to the repetitive nature of presentations within the unit. Clinics are scheduled on the rota however trainees told us this would be the first activity to be pulled should there be staff shortages or an increase in clinical pressure. Trainees described limited learning within their roles and estimated that up to 85% of their work is carrying out tasks with little or no educational benefit. At times when medical students are on site they have been turned away from clinics as educational priority is given to students. They were able to maintain their skills in looking after acutely

unwell patients but felt these were skills gained in previous roles with no further learning. Access to gynaecology patients/clinics for ST1 trainees was perceived to be inadequate.

ST2-7: ST2-5 Trainees reported plenty of access to obstetrics work but noted reduced gynaecology clinic and operating opportunities. Similar, to their GP & ST1 colleagues the repetitive patient case load limits their portfolio reflections. Trainees are frequently pulled from learning events such as scan lists to provide consultant cover at antenatal clinics.

Senior trainees completing their ATSMs were happy with their learning opportunities and have received regular gynaecology operating lists.

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

Trainers: Recent survey feedback suggests there are no problems for trainees to complete their assessments. Trainees on the junior rota are told at induction that the 6 weekly feedback meeting is an opportunity to complete case-based discussions (CBD's) or workplace-based assessments (WPBA's).

FY & GP: Trainees stated that in general they were able to complete WPBAs and have them signed off easily. The MAU provides the greatest potential as they can assess patients and complete a CBD with their seniors. At the start of their post, FY trainees received an email offering them the chance to complete speculum examinations as a mini-CEX assessment but as yet none of managed to complete this. Occasionally, due to the rota the registrar is not senior enough to sign off assessments for the GP trainees.

ST: ST1 trainees told us they can struggle to get to learning events that can be used for assessment. ST2-7 trainees reported no issues completing their WPBAs.

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

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

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: Trainers advised they provide regular constructive informal feedback to trainees.

FY: Trainees reported they receive good levels of both formal and informal feedback from their senior colleagues.

GP: Trainees felt their role had limited opportunity for clinical decision making unless working in the MAU. When received, feedback was fair and consistent.

ST: Trainees reported they receive good levels of feedback and described approachable consultants who deliver constructive and meaningful feedback.

2.11 Feedback from trainees (R1.5, 2.3) Not asked

2.12 Culture & undermining (R3.3)

Trainers: The team have worked hard to create a positive culture within the unit, running Civility Saves Lives initiatives and incorporating trainee educational objectives into the daily handovers. After feedback from trainees the rota was amended to provide enhanced continuity with 1 trainee and 1 consultant on the gynaecology ward per week. At induction they emphasise the culture and approachability of the multidisciplinary team and escalation pathways are shared.

FY: Trainees told us they work in a very supportive, approachable multidisciplinary team. They would raise any concerns with their supervisor or Training Programme Director. When working as a team they feel listened to and that their opinion matters.

GP: No issues with undermining or bullying, they felt well supported by their senior colleagues. The midwifery staff are very supportive and reliable. They were informed at induction how to raise any concerns.

ST: Trainees feel well supported at all times and work collaboratively on decision making with the wider team. Some trainees had witnessed occasional undermining behaviours from the senior gynaecology nursing staff to their junior colleagues but told us this was not representative of the overall culture.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: There is 1 gap on the senior rota, the on-call shifts are covered by trainees at locum pay or time in lieu. To address gaps on the junior rota, the health board have funded a clinical fellow (CF) post. Efforts are made to fill any remaining gaps with locums or the current trainee group. Workload pressures can have a negative impact on training opportunities that can be allocated to the junior rota. The department plan to develop a standard operating policy for rota gap management to ensure transparency across the board.

FY: Trainees can discuss their rota and make suggestions for improvements. They commended [redacted] on the management of the rota. It can be challenging at times with trainees working additional night shifts to provide cover. FY trainees told us this was no worse than any previous rota they had worked in other departments.

GP & ST1-2: They described a very tight rota with frequent gaps uncovered which had resulted in delayed patient care. The workload is extremely high and impacts on access to learning opportunities. [redacted] is receptive to suggestions of improvement, but the majority of issues relate to staffing levels which are out with her control.

ST3-7: Trainees were aware of gaps on their rota. They described an intense working period from January-March of this year which was alleviated in April when the ST2 trainees stepped up onto the senior rota. This had a knock-on effect on the junior rota. The burden of night shift provision can leave trainees feeling stretched and provides limited educational experiences within the gynaecology department. Senior trainees completing their ATSM's were happy with learning opportunities on their rota.

2.14 Handover (R1.14)

Trainers: Trainers felt that handover arrangements were robust and provided safe care for patients. They have further developed the gynaecology handover to include boarded patients. Additional departmental safety briefs supplement the structure.

All trainees: There are multidisciplinary effective handovers which are good for continuity of care.

2.15 Educational Resources (R1.19)

Trainers: Trainees described a variety of educational resources available to trainees including:

- Laparoscopic Simulation
- Doctors room
- Library
- Recorded teaching sessions, and
- O&G mobile app.

FY: Trainees reported that they are satisfied with the IT and educational resources available to them on site.

GP: There is a lack of available space for trainees to access.

ST: Trainees reported adequate facilities and resources to support their learning. The implementation of the doctor's room provides further space for learning.

2.16 Support (R2.16, 2.17, 3.2, 3.4, 3.5, 3.10, 3.11, 3.13, 3.16, 5.12) – Not asked

2.17 Educational governance (R1.6, 1.19, 2.1, 2.2, 2.4, 2.6, 2.10, 2.11, 2.12, 3.1) – Not asked

2.18 Raising concerns (R1.1, 2.7)

Trainers: Escalation pathways are detailed at induction and the college tutor sends an email to trainees detailing who to speak to. Trainees can also raise concerns at the 6 weekly feedback meeting.

FY: Trainees advised they would raise any patient safety concerns with their senior or consultant on call.

GP & ST: Trainees told us they are encouraged to raise patient safety concerns through Datix and or via the consultant in charge. Effective risk management meetings are in place and a culture of learning from incidents.

2.19 Patient safety (R1.2) – Not asked

2.20 Adverse incidents & Duty of Candour (R1.3 & R1.4) – Not asked

3. Summary

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

Once again, we would like to commend the ongoing engagement of the local team and DME in addressing these issues. Throughout the visit all levels of trainees emphasised positive working relationships across the multidisciplinary team. Despite the site's progress, some concerns remain around the learning opportunities for GP trainees. Discussions will now take place with the GMC around whether or not the site has reached the threshold for removal of its Enhanced Monitoring status.

Review of previous requirements from 2022:

Ref	Visit requirement from 2022	Progress in 2023 visit
7.1	The training opportunities provided to GPSTs must be tailored to their learning needs including relevant gynaecology and obstetrics clinic experience, feedback on their clinical decisions and access to WPBAs including training towards competence in procedures such as use of the speculum.	Little progress noted
7.2	Ensure that service needs do not prevent trainees from attending clinics and other scheduled local learning opportunities.	Progress noted
7.3	There must be a protected and accessible formal local teaching programme appropriate for the learning needs of doctors in training, in particular for FYs & GPSTs.	Progress noted
7.4	The first on call rota structure is perceived to be too demanding because of a lack of down time between nights and long days and this must be addressed.	Addressed

The positive aspects of the visit were:

- There is an excellent supportive culture within the department despite considerable service pressures
- There are excellent working relationships with nursing and midwifery colleagues
- The introduction of technology to support education and learning (for example the GGC app and IT room facilities) has been well received
- Efforts have been made to reduce time spent on non-educational tasks (e.g. phlebotomy)
- The foundation doctor experience is positive, particularly relating to induction, supervision, support and teaching
- The Rota coordinators are viewed very highly, being approachable and making active efforts to accommodate requests fairly and equitably.
- Handovers are effective, multidisciplinary, and supportive

- Feedback is valued by trainers and trainees
- There are effective and collaborative clinical risk management processes with a culture of learning from events.

The less positive aspects of the visit were:

- Training opportunities for trainees on the junior rota are not fully meeting their curricular needs.
- Access to a clinical system (Badgernet) was not provided in a timely manner for General Practice Specialty trainees, although it was for other trainee groups.
- Gynaecology operating theatre experience and gynaecology clinic access is limited for O&G specialty trainees.
- Trainees sometimes are required to cover clinics when the usual consultant is on leave, although none felt they were working outwith their competence
- Teaching is not consistently bleep free
- Teaching for specialty trainees could benefit from further coordination and planning

4. Areas of Good Practice

Ref	Item	Action
4.1	Culture. There is a very high quality of workplace culture shown by all staff. This promotes effective, insightful and collaborative approaches to a range of activities, including feedback, handover and clinical risk management.	

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	Induction	Ensure all trainees have timely access to IT systems and passwords.
5.2	Rota	Consultant absences should be staggered to ensure the burden of covering antenatal clinics does not solely fall to trainees
5.3	Adequate experience	Consideration should be given to ensure learning opportunities for GP and junior specialty doctors are not compromised when hosting medical students
5.4	Teaching	Forward planning of the specialty teaching programme could be enhanced, including more advance notice and alignment of the programme with curricular requirements.

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	The department must review and optimise training opportunities for specialty trainees on the junior rota.	18th February 2024	GP/ST1
6.2	All trainees must have timely access to IT passwords and system training through their induction programme.	18th February 2024	All
6.3	Access to appropriate gynaecology clinic & theatre opportunities and experience must be provided for ST2-5 Trainees which aligns with curriculum requirements.	18th February 2024	ST2-5
6.4	There must be prospective support of attendance of doctors in training at teaching events to ensure that workload does not prevent attendance. This includes bleep-free / bleep minimised teaching attendance.	18th February 2024	All

Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	24th February 2021	**Level(s)**	FY/GP/ST
Type of visit	Enhanced Monitoring Revisit	**Hospital**	Princess Royal Maternity Hospital/Glasgow Royal Infirmary
Specialty(s)	Obstetrics & Gynaecology	**Board**	NHS Greater Glasgow & Clyde

Visit panel	
[redacted]	Visit Chair - Postgraduate Dean
[redacted]	GMC Visits & Monitoring Manager
[redacted]	GMC Associate
[redacted]	Associate Postgraduate Dean – Quality
[redacted]	Training Programme Director
[redacted]	Trainee Associate
[redacted]	Lay Representative
[redacted]	Quality Improvement Manager
In attendance	
[redacted]	Quality Improvement Administrator

Specialty Group Information		
Specialty Group	Obstetrics & Gynaecology and Paediatrics	
Lead Dean/Director	[redacted]	
Quality Lead(s)	[redacted] & [redacted]	
Quality Improvement Manager(s)	[redacted]	
Unit/Site Information		
Non-medical staff in attendance	4	
Trainers in attendance	7	
Trainees in attendance	5 x FY2, 3 x GPST, 13 x ST1-7	

Feedback session: Managers in attendance	Chief Executive		DME	X	ADME	x	Medical Director		Other	

Date report approved by Lead Visitor	09/03/2021

1. Principal issues arising from pre-visit review:

The Princess Royal Maternity Hospital has been under the GMC's Enhanced Monitoring process since May 2018 due to escalating concerns for the training environment. The last visit to the unit on 27 February 2020 indicated that progress made from the 2019 visit had not been sustained and significant educational challenges remain.

Requirements from visit on 24th January 2019:

- Educational and clinical supervisors must understand curriculum and portfolio requirements for the cohorts of trainees training in the unit.
- Tasks that do not support educational and professional development and that compromise access to formal learning opportunities for GP and Foundation doctors must be reduced.
- The department must develop and sustain a local teaching programme relevant to curriculum requirements of the ST3+ trainees including a system for protecting time for attendance.
- Trainees must be given protected study leave to attend mandatory regional teaching.
- Doctors in training must have access to appropriate resources to support their training - office space for doctors in training is an issue.
- Assignment of STs undertaking ATSMs must be within the unit's capacity to provide training.
- The department must support ST3+ trainee attendance at regional teaching days.
- Foundation and General Practice trainees must be assigned to a ward/unit for a minimum of a 4-week continuous period.

Requirements from visit on 27th February 2020:

- Clinical supervision must be available at all times to support trainees working in acute gynaecology.
- There must be a protected formal teaching programme for doctors in training.
- The department must respond to concerns about education and training and provide feedback on this.
- Educators must be supported to deliver the assessments required of trainees' curricula.
- The Board must design rotas to provide learning opportunities that allow doctors in training to meet the requirements of their curriculum and training programme.

- Staffing levels in wards must be reviewed to ensure that workload is appropriate and does not prevent access to learning opportunities including outpatient clinics.
- Tasks that do not support educational and professional development and that compromise access to formal learning opportunities for all cohorts of doctors must be reduced.
- The discontinuity of ward placements 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 department must have a zero tolerance policy towards undermining behaviour.

The visit commenced with [redacted] delivering an informative presentation to the panel which provided an update regarding progress against the previous visit requirements, along with supporting evidence/documentation and detailed the impact of COVID on the unit.

2.1 Induction (R1.13):

Trainers: Trainers advised all trainees receive induction to the site. The rota is coordinated to ensure trainees are not scheduled for on-call shifts when transferring from other units or coming off night shift. Trainees who are out of sync or can't attend the main induction are provided with a mini one-to-one session. Prior to starting the role trainees are advised to download the GGC wide O&G app which provides clarity of on-call duties, roles and expectations with links to supporting protocols and guidance. Previous suggestions to improve the induction by including speculum examination tutorials for junior doctors had been actioned.

FY2: All trainees present received site induction except for those who had started on nights. Some trainees were contacted to organise a mini induction but 2 trainees did not receive the communication and had to seek out information on their own. Departmental induction was provided and was helpful. It was suggested that the content could be enhanced by provision of guidance on how to escalate and triage phone calls received when they held the on-call page; examples given related to calls from midwives in the hospital and in the community relating to insulin dosage in the management of gestational diabetes and symptoms experienced by a patient following methotrexate treatment of ectopic pregnancy.

GP: GPST trainees received both hospital and departmental induction which they felt adequately prepared them for their roles. They noted the usefulness of the O&G app which they were sent prior to starting.

ST: Trainees present had received induction to site and department. The department induction was comprehensive and targeted by training level. Trainees felt well prepared for their role and did not suggest any improvements required.

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

Trainers: Trainers reported that there is 1st on call training provided on Thursday lunchtimes and registrar training delivered on Fridays. Despite an awareness that the Thursday sessions are bleep free, they acknowledged the challenges of ensuring this happens due to the acute nature of the specialty. Since COVID restrictions, sessions are now recorded which enables trainees to access the teaching when suitable. Trainers also highlighted a number of other teaching opportunities available including:

- Weekly CTG teaching
- Weekly obstetric risk management
- Perinatal risk management – monthly
- Laparoscopic simulation training

FY: Trainees reported that there is scheduled 1st on-call teaching on Thursday afternoons but noted that this has been inconsistent. Attendance had been variable, but generally low. Some felt their clinical workload was not a barrier to attending the sessions although noted rota allocation could affect ability to attend. The sessions can be attended in-person or via MSTeams. All regional teaching has been cancelled due to the pandemic.

GP: GPST's confirmed 1st on call teaching is delivered weekly on Thursday afternoons, and was available via MS Teams. The trainees interviewed had only been in post since 3rd February 2021 and had been unable to attend any sessions due to rota allocation but felt there would be no barriers in attending sessions going forward. Regional teaching had been cancelled due to the pandemic.

ST1-3: Trainees confirmed weekly teaching sessions and estimated they had attended 3 sessions in 6 months. Their average weekly attendance at local teaching sessions was zero hours. ST1-3's felt clinical service pressure to be the main reason they are unable to attend.

ST4-7: The majority, of teaching sessions are now delivered via MSTeams which has increased accessibility to trainees. Trainees can attend CTG teaching and participate in the delivery of 1st on call training on a weekly basis. The 'Registrar teaching sessions' are sporadic and unstructured with limited advanced scheduling of topics.

To address the limited gynaecological operating exposure due to COVID, regular simulation teaching has been delivered. Trainees spend a lot of their on-call shifts at night, which has limited their availability to attend teaching during the day.

Trainees felt able to attend on average 55% of regional teaching although noted this time is not protected. Trainees once again highlighted the benefits of delivering training via MSTeams.

2.3 Study Leave (R3.12): Not covered, no concerns raised in pre-visit information

2.4 Formal Supervision (R1.21, 2.15, 2.20, 4.1, 4.2, 4.3, 4.4, 4.6): Not covered, no concerns raised in pre-visit information

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 escalation policy is detailed at induction and trainees are made aware that senior escalation is expected due to the potential high risks within the specialty. Previous concerns over a lack of on call consultant presence between Mon-Fri, 09:00-17:00 in the gynaecology department had been addressed with consultants now being rota'd to be on and available during 'Hot Weeks' to support the management of acute gynaecological presentations. Trainers reported they were not aware of any instances where a trainee had been left to cope with a situation beyond their competence since thjs new work pattern was introduced.

FY: Trainees felt they knew who to contact for support both during the day and out of hours. Although they had never been left to deal with a situation out with their level of competence, they noted

occasional challenges in contacting the on-call registrar but all felt comfortable in escalating to consultants when required. When seeking support from senior trainee colleagues, trainees felt the majority to be approachable although on occasions, the response was less positive. Trainees reported the need to include within departmental induction guidance as to whom they should escalate calls they receive when holding the on-call page, when the subject of these calls related to issues beyond their knowledge or competence (see section 2.1).

GP/ST1-7: Trainees always felt well supported by their senior colleagues. They did not feel they had to work beyond their level of competence and reported no instances when they were required to do so.

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

Trainers: Trainers confirmed that successive FY & GP trainees are allocated to the same consultants acknowledging the different curricular needs compared to those of specialty trainees. [redacted] and [redacted] keep up to date with the changes to the specialty curricula and maintain a close relationship with the training programme director. Trainers felt there has been a cultural shift in the recognition in value of being a supervisor and noted all trainers now have allocated time in their job plan. To ensure trainees meet the satisfactory number of clinics and learning experiences, trainees are asked to highlight their learning needs to the rota coordinator. Due to the pandemic, there has been limited gynaecological operating exposure for trainees, and this has impacted in particular on the Gynaecology – Oncology subspecialty trainees. To help address this the department now have a new laparoscopic simulator which allows trainees to gain gynaecological competencies. Trainers felt highlighted other competencies they thought trainees may struggle to achieve were around mid-trimester surgical evacuations and scan training.

COVID has allowed for a review and change in processes which has resulted in fewer non-educational tasks for trainees. Immediate discharge letters continue to be challenging although steps have been taken to improve the efficiency of the IDL-completion process.

FY2: COVID has reduced the opportunities for FY2 trainees to attend clinics and the rota has been altered to reflect this. They reported spending much more time on wards. Trainees reported that since December they have attended on average, 2 clinics and 1 theatre session. As first responding

doctors, trainees can participate in the management of acutely unwell patients. Due to the nature of the specialty this is a whole team event and trainees felt their skills have not developed as fully as in other posts. All described a lot of time being spent on non-educational tasks. They advised whilst working in obstetric wards they could spend 80% of their time completing IDL's and prescriptions.

GP: Trainees felt they were receiving enough exposure to meet their curricular requirements. Opportunities to attend the Sandyford clinic for sexual health experience has been halted due to the pandemic. Trainees have scheduled clinic days on their rota however, current social distancing rules impacts on the number of trainees able to participate. Trainees have been able to assess acutely unwell patients particularly in the gynaecology wards. Due to rota structure the trainees we met with felt less confident in dealing with unwell obstetrics patients due to a lack of exposure but felt this may improve with more time in post. Similar to their FY colleagues when working on an obstetrics ward they spend approximately 90% of time completing IDL's, phlebotomy and inserting cannulas.

ST1-2: Trainees acknowledged the impact of COVID on their learning opportunities and operating exposure. Priority has been given to more senior trainees who require competencies signed off at ARCP's. Trainees are encouraged to speak with the rota coordinator should they require specific educational opportunities. They described the balance of non-educational tasks vs medical work as variable.

ST3-7: Gynaecological operating exposure has been significantly reduced during the pandemic. Trainees discussed proactive rota management that ensured those requiring procedural sign off were able to attend sessions. Trainees commended highly the work of the rota coordinator. ATSM trainees have been able to continue training throughout the pandemic averaging 3 operating lists per week. Although the volume of clinics has decreased, educational opportunities whilst attending clinics have improved and have enabled trainees to complete work placed based assessments (WPBA's). Trainees who had worked in the department previously highlighted the significant shift in focus in their rota over the past 2 years to incorporate their training and learning needs.

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

Trainers: Trainees communicated an issue with the completion of assessments at a senior management meeting, once highlighted this issue was addressed, no further issues have been raised.

All trainees: Trainees confirmed that in general they were able to complete Workplace Based Assessments and have them signed off easily. They felt they were assessed fairly and consistently.

2.8 Adequate Experience (multi-professional learning) (R1.17): Not covered, no concerns raised in pre-visit information

2.9 Adequate Experience (quality improvement) (R1.22): Not covered, no concerns raised in pre-visit information

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: Trainers felt informal feedback was regularly provided to trainees. Formal feedback is delivered through review of significant event cases at risk management meetings. The labour ward utilises a Greatix system which allows staff to record when something has gone well. Once reviewed, the form acknowledging this is delivered to the recipient.

FY: Trainees felt they have had limited day to day feedback, when received it has been constructive and meaningful.

GP: Trainees have the opportunity, to get informal feedback whilst working in the Maternity Assessment Unit by creating a management plan and discussing with a senior.

ST1-7: Trainees reported they receive good levels of feedback and described pro-active consultants who deliver constructive and meaningful feedback.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: Trainers highlighted the trainee forum, chief resident and survey results as avenues for trainees to feedback on concerns about their training.

FY: Trainees were not aware of any opportunities to feedback to the trainers about their experience in the post. Trainees were not aware of the chief resident and their role in the department. They were aware of a trainee forum however, felt this was to address specialty level training concerns only.

GP: There was a lack of awareness of opportunities for trainees to feedback on their experience in the department. One trainee was aware they could raise any concerns with their educational supervisor.

ST1-7: Trainees reported multiple effective routes for feedback to be shared including via the chief resident and trainee forum.

2.12 Culture & undermining (R3.3)

Trainers: Trainers reported that from induction they embed the positive culture of the department, highlighting the openness of the multidisciplinary team. Trainees are informed how to report any bullying or undermining concerns and areencouraged to raise any issues with consultants, senior nurses or midwives. On the labour ward each person introduces themselves stating their name and role for the shift, trainees then have the opportunity, to highlight any learning needs. Trainers detailed a previous instance where there was friction between disciplines, this was addressed and has not presented again.

FY: Trainees felt they worked in a generally supportive environment and felt all consultants were approachable. However, some trainees interviewed reported they had witnessed occasional inappropriate conversations between registrars about a fellow trainee's clinical decisions.

GP: Trainees reported that they worked in a very supportive team. None of the trainees interviewed had experienced or witnessed any bullying or undermining behaviours but would raise this with their Clinical Supervisor if they did.

ST1-7: All trainees felt they worked in a very supportive department. They described a valued relationship between the midwifery and nursing staff who take time to teach and highlight learning opportunities. There are posters throughout the department which provide information on how to report any concerns relating to bullying and undermining. Trainees who had previously worked in the unit commented on the improvements to clinical supervision with consultants now being more familiar with their individual skill sets and efforts that had been made to make the rota more training focused.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Trainers reported that there are no gaps on the current rota. The health board have funded clinical fellows who have been beneficial in covering gaps and enhancing trainees' training opportunities. ST2 trainees are supernumerary on the rota to allow them access to more educational opportunities and experiences before transitioning to the more senior on-call rota.

FY2: There are currently no gaps on the rota. Trainees raised concern over a lack of a 'rolling' rota and perceived a disparity between obstetrics and gynaecology shifts. They also felt there to be an unfair discrepancy between the amount of night shifts with some trainees completing 25 compared to others at 14.

GP: Trainees were not aware of any gaps on their rota. They had only been in post for about 3 weeks. Trainees felt their rota is tailored to curricular requirements but noted there are a lot of on call shifts which can leave them feeling tired.

ST1-2: Trainees reported their current rota accommodates access to learning opportunities. They can raise any learning requirements such as access to scan lists or operating procedures with the rota master or supervisor and requests are accommodated.

ST3-7: Trainees were aware of a vacancy on their rota, which was being covered by a locum. They described their rota as tailored to individual learning needs and ST7 trainees noted they have good access to ATSM sessions. There is an online calendar which enables trainees to select their annual / study leave. Trainees described the volume of night shifts as 'overwhelming' although they were keen that any solution to this should not compromise their valued day-time learning.

2.14 Handover (R1.14): Not covered, no concerns raised in pre-visit information

2.15 Educational Resources (R1.19): Not covered, no concerns raised in pre-visit information

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, no concerns raised in pre-visit information

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

Trainees: All trainees would raise concerns about the quality of training in the post through their Educational Supervisor, Training Program Director or Clinical Supervisor.

2.18 Raising concerns (R1.1, 2.7):

Trainers: Trainers felt they encouraged trainees to raise concerns through the open culture of the department. Risk management meetings provide the opportunity to formally review cases and share learning from incidents.

2.19 Patient safety (R1.2)

Trainees: All trainees interviewed felt the department provided an extremely safe environment for patients and reported they would not have any concerns about the quality of care if a family member was admitted to the department.

2.20 Adverse incidents & Duty of Candour (R1.3 & R1.4) Not covered, no concerns raised in pre-visit information

2.21 Other

Trainees were asked to rate their overall satisfaction experience of working within the department from a range of 0 (very poor) to 10 (excellent). The scores are listed below:

- Foundation – Range 4-6, Average 4.6

- General Practice – Average 7
- ST1-2 – Average 8
- ST3-7 – Range 7-9, Average 8.4

3. Summary

Is a revisit required?	Yes	No	Highly Likely	Highly unlikely

This was a very positive visit to the department and there have been significant improvements made across several areas of previous concern. We would like to commend the ongoing engagement of the DME and local team in addressing these issues. The pandemic has limited certain training opportunities however, it has also allowed for a more focused training and educational approach to service. The overall training experience has improved for most cohorts, the exception being the FY trainees who did not feel as embedded in the team culture. This is reflected in their overall satisfaction scores. Some challenges remain and have been reflected in the requirements.

The positive aspects of the visit were:

- Significant progress in addressing concerns was noted in particular for run-through trainees.
- Very supportive, caring and accessible consultants who value contributions from trainees and ensure no one is working beyond their level of competence.
- Positive impact of the rota coordinator on senior trainees' experience with greatly valued tailoring of opportunities to individual trainee's needs.
- ST2 trainees are supernumerary on the junior rota to enable their smooth transition to the more senior on call rota.
- The GGC app supports induction to O&G in PRMU and provides clarity of on-call duties, roles and expectations with links to supporting protocols & guidance.
- The wider multi-disciplinary team including midwives are supportive and contribute to the education and learning of the doctors in training.
- The culture ensuring the safety of patient care.

The less positive aspects of the visit were:

- The educational experience of Foundation doctors in training: a) the burden of non-educational tasks is a barrier to their education and training particularly in the obstetrics role, b) they struggle to access local formal teaching opportunities, & c) it appears this cohort are not as embedded in the positive team experience reflected by other cohorts.
- Significant burden of night shifts on senior trainees (although they were keen that solutions to that should not compromise their highly valued, tailored day time learning opportunities).

- The senior trainee formal education programme would benefit from more consistent scheduling and more advanced notice of topics.

Review of previous requirements from 2020:

Ref	Visit requirement from 2020	Progress in 2021 visit
7.1	Clinical supervision must be available at all times to support trainees working in acute gynaecology.	Addressed
7.2	There must be a protected formal teaching programme for doctors in training.	Partially met see requirement 6.2
7.3	The department must respond to concerns about education and training and provide feedback on this.	Addressed
7.4	Educators must be supported to deliver the assessments required of trainees' curricula.	Addressed
7.5	The Board must design rotas to provide learning opportunities that allow doctors in training to meet the requirements of their curriculum and training programme.	Addressed
7.6	Staffing levels in wards must be reviewed to ensure that workload is appropriate and does not prevent access to learning opportunities including outpatient clinics.	Largely addressed
7.7	Tasks that do not support educational and professional development and that compromise access to formal learning opportunities for all cohorts of doctors must be reduced.	Partially met see requirement 6.4 – specifically obstetrics ward
7.8	The discontinuity of ward placements 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.	Addressed
7.9	The department must have a zero tolerance policy towards undermining behaviour.	Largely addressed

4. Areas of Good Practice

Ref	Item	Action
4.1	The use of the GGC O&G app	

4.2	ST2 trainees are supernumerary on the rota allowing them to develop with appropriate support before transitioning to the senior rota.	
4.3	The use of MSTeams to record training sessions which can be accessed later by trainees.	

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	Departmental induction	Doctors who hold the on-call page should be made aware as to whom they should escalate queries whether from within the hospital or from the community relating to matters that are beyond their knowledge or competence to answer.
5.2	Trainee Engagement	Ensure all grades of trainees are aware of the trainee forum and chief resident as a way to raise concerns.
5.3	Senior rota	Review with senior trainees the pattern of night shifts on the senior rota as this is perceived to be heavy and demanding. In addressing this, it would be important not to compromise the educational benefits achieved for this cohort during daytime hours.

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	The department must increase relevant training opportunities for FY trainees.	24th November 2021	FY
6.2	There must be a protected and accessible formal local teaching programme appropriate for the learning needs of doctors in training (in particular for FYs & ST1-3s). There must also be more consistent and regular scheduling of the formal teaching for senior trainees with more advanced notice of topics.	24th November 2021	All
6.3	Foundation trainees must be given the opportunity to be an effective member of the multi-professional team by promoting a culture of learning and collaboration between specialties and professions.	24th November 2021	FY
6.4	Tasks that do not support educational and professional development and that compromise access to learning opportunities for FY/GP doctors must be reduced.	24th November 2021	FY/GP
6.5	A process must be put in place to ensure that any trainee who misses their induction session (hospital or departmental) is identified and provided with an induction.	24th November 2021	All

7. DME Action Plan: to be returned to QIM on 24th November 2021

Ref	Issue	By when	Owner	Action(s)	Date Completed
7.1	The department must increase relevant training opportunities for FY trainees.	24th November 2021	**DME**		
7.2	There must be a protected and accessible formal local teaching programme appropriate for the learning needs of doctors in training (in particular for FYs & ST1-3s). There must also be more consistent and regular scheduling of the formal teaching for senior trainees with more advanced notice of topics.	24th November 2021	**DME**		
7.3	Foundation trainees must be given the opportunity to be an effective member of the multi-professional team by promoting a culture of learning and collaboration between specialties and professions.	24th November 2021	**DME**		
7.4	Tasks that do not support educational and professional development and that	24th November 2021	**DME**		

	compromise access to learning vopportunities for FY/GP doctors must be reduced.				
7.5	A process must be put in place to ensure that any trainee who misses their induction session (hospital or departmental) is identified and provided with an induction.	24th November 2021	**DME**		

General Medical Council

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16 June 2023

Professor John Brown CBE
Chair
NHS Greater Glasgow and Clyde
[redacted]

GMC reference: QA10482

Dear Professor Brown,

Changes to Enhanced Monitoring status at Princess Royal Maternity Unit/Glasgow Royal Infirmary, NHS Greater Glasgow and Clyde

Following a recommendation from NHS Education for Scotland (NES), we are pleased to see that your organisation has satisfactorily resolved concerns in connection with training in obstetrics and gynaecology at Princess Royal Maternity Unit/Glasgow Royal Infirmary to the extent that it will no longer be part of our enhanced monitoring process.

We have asked NES to continue to monitor training in obstetrics and gynaecology at the site through their routine monitoring processes to make sure the solutions in place are sustained.

We will now update the information on our website to reflect the above. We would like to thank you and your teams for all your efforts to achieve this.

If you have any questions about this, please contact your Education Quality Assurance Programme Manager, [redacted] at [redacted]

Yours sincerely

[redacted]

Professor Colin Melville
Medical Director and Director of Education and Standards, GMC

Copied to:

Jane Grant, Chief Executive
[redacted]

Dr Jennifer Armstrong, Medical Director
[redacted]

Dr Colin Perry, Director of Medical Education
[redacted]

Professor Alan Denison, Postgraduate Dean, NES
[redacted]

Prof. Emma Watson, Executive Medical Director, NHS Education for Scotland
[redacted]

Prof. Karen Reid, Chief Executive, NHS Education for Scotland
[redacted]

Nicola Cotter, Head of the Scotland Office, GMC
[redacted]

Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	24th January 2019	**Level(s)**	FY/GP/ST
Type of visit	Revisit (ongoing concerns, including enhanced monitoring)	**Hospital**	Princess Royal Maternity Hospital/Glasgow Royal Infirmary
Specialty(s)	Obstetrics & Gynaecology	**Board**	Greater Glasgow & Clyde

Visit panel	
[redacted]	Visit Chair - Postgraduate Dean
[redacted]	GMC Visits & Monitoring Manager
[redacted]	GMC Associate
[redacted]	College Representative
[redacted]	Programme Representative
[redacted]	GP Representative
[redacted]	Foundation Representative
[redacted]	Trainee Associate
[redacted]y	Lay Representative
[redacted]	Quality Improvement Manager
In attendance	
[redacted]	Quality Improvement Administrator

Specialty Group Information		
Specialty Group	Obstetrics & Gynaecology and Paediatrics	
Lead Dean/Director	[redacted]	
Quality Lead(s)	[redacted], [redacted]	
Quality Improvement Manager(s)	[redacted]	
Unit/Site Information		
Non-medical staff in attendance	7 x Nursing and Midwifery Staff	
Trainers in attendance	6	

Trainees in attendance	3 x FY2, 3 x GPST2, 10 x ST(including 1 out of programme)	
Feedback session: Managers in attendance	DME, Clinical Director, ADME, Lead Clinician, Obstetrics and Gynaecology - North Sector; Clinical Service Manager, Obstetrics; Clinical Service Manager, Outpatient and Community Services; Clinical Director, Obstetrics (for part of session); and Chief of Medicine (for part of session).	

Date report approved by Lead Visitor	25th February 2019

1. Principal issues arising from pre-visit review

Following a Foundation led triggered visit on 5th February 2018, the department was placed under enhanced monitoring due to significant concerns about the educational environment and training being provided to all levels of trainees. The visit panel also found at that time, the GP trainee cohort were having a very negative experience in this post. The requirements to be addressed to meet the GMC's standards were as follows:

Ref	Issue
7.1	All clinics must be supervised by a Consultant.
7.2	There must be protected bleep free local teaching for Foundation and General Practice doctors supported by the Consultant team.
7.3	A unit induction must be available to all trainees including those who start their post on nightshift.
7.4	GP trainees must know who is providing their supervision when working in the Maternity Admissions Units.
7.5	There must be provision on the rota to ensure GPSTs can attend clinics relevant to their training needs.
7.6	The department must support ST3+ trainee attendance at regional teaching days.
7.7	The department must ensure that there are clear systems in place to provide supervision, support and feedback to trainees working in clinics.
7.8	The department must develop and sustain a local teaching programme relevant to curriculum requirements of the ST3+ trainees including a system for protecting time for their attendance.
7.9	Foundation and General Practice trainees must be assigned to a ward/unit for a minimum of a 4-week continuous period.
7.10	Foundation and General Practice trainees must be included in Clinical Risk Meetings to have access to learning from clinical adverse events
7.11	The department must review and reduce the volume of non-educational tasks the Foundation trainees undertake in order to maximise the potential to attend educational opportunities including teaching and clinics. In particular, efforts should be made to allow them to avail of "Green Days".
7.12	Zero tolerance of undermining behaviours must be promoted.
7.13	The department must review the rota structure and night shift allocation to ensure that daytime sub specialty training is not compromised.
7.14	The department must work with the Board in implementing changes to improve the educational environment for all grades of doctors in training.
7.15	All references to "SHO's" and "SHO Rotas" must cease. The "Say No to SHO" programme must be adopted, with all staff involved.
7.16	GPSTs must have the opportunity to have assessments completed by another team member of appropriate grade to do this.

NTS Data 2018

The 1 year post trend data shows the overall experience of all cohorts of trainees and is reflective of most areas of concerns highlighted at the Deanery triggered visit. For those that completed the NTS for Glasgow Royal Infirmary (GRI), this indicates an improving trend with a green flag for supportive environment, in addition to improvements with teamwork, educational governance and study leave.
Unfortunately, several areas remain poor with pink flags for:

- overall satisfaction,
- induction,
- adequate experience and,
- curriculum coverage.
- educational supervision

In addition, there is a deteriorating trend with pink flags for educational supervision and feedback.
The post trend for those in the Princess Royal Maternity Hospital does indicate an improving trend for regional teaching and educational governance, however several indicators remain poor for:

- Overall satisfaction – downward trend and red flag
- Curriculum Coverage – downward trend and red flag
- Educational Supervision – downward trend and red flag
- Induction – Red Flag
- Local teaching – red flag
- Adequate experience – downward trend and pink flag

FY2 NTS

The NTS data specific to Foundation suggests that although concerns remain, the post has improved moving from 6 red flags and 1 pink flag in 2017 to 6 pink flags in 2018. The pink flags are for:

- Adequate experience (previously red)
- Educational supervision (previously white)
- Feedback (previously white)
- Induction (previously red)
- Overall satisfaction (previously red)
- Curriculum coverage (previously red)

GPST NTS

The GPST experience has been poor for the past 3 years, with a significant deterioration in 2018 with only 5 out of 18 indicators not being red or pink. Of the 12 red flags and 1 pink flag, 3 areas have consistently remained as a red flag area, these are:

- Overall Satisfaction (red flag since 2013)
- Local teaching (red flag since 2013)
- Supportive environment (red flag since 2014)

ST NTS

The NTS data for ST trainees is reasonably consistent over the past 3 years. Most areas meet with the average trainee experience with white flags. Data indicates improvements to clinical supervision with a positive green flag. Local and regional teaching are the only negative outliers, with red flags, for the past two years.

Scottish Training Survey Data 2018

The RAG data from the STS also indicates that Foundation trainees are having a more positive experience within the department with light green and green flags for: clinical supervision, handover and workload. Similarly, the one negative outlier for ST trainees is teaching. This indicator is also a red flag on a downward trend for Foundation and GP trainees. In addition to teaching, GP trainees have 3 additional negative red flag outliers for: educational environment, team culture and induction.

At the time of the previous visit, 16 requirements were made for the department to address to meet the GMC's standards. An update on the progress being made to meet these requirements was provided prior to the visit.

The panel will seek to determine if the work undertaken by the department has now started to improve the training experience for all levels of trainee.

2. Introduction

Princess Royal Maternity Hospital, which is adjacent to Glasgow Royal Infirmary on Alexandra Parade, has 140 beds and provides maternity and special care baby unit/ITU facilities for neonates.

The panel met with the trainers and the following trainee groups:

Foundation Trainees

General Practice Trainees
Specialty Trainees

A summary of the discussions has been compiled under the headings in section 3 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.

3.1 Induction (R1.13)

Trainers: Trainers reported that changes made to the induction are working well and is effective in preparing trainees to work in the department. They advised that an abbreviated induction is provided to any trainees that are unable to attend the main departmental induction, with a tailored one to one induction for those returning from a career break, such as maternity leave. The department also request feedback from trainees to review if any further improvements are required. They were aware that there had been delays with issuing trainees with passwords and ID badges. Trainers reported that the time spent queueing for ID badges was a hospital wide issue and the concerns around this had been escalated.

FY2: Trainees reported that they received a hospital induction which provided them with the required IT training and access to database systems such as Badgernet. Trainees suggested that ID badge collection times should be staggered as they required to wait two hours to collect this. All interviewed felt they received an effective departmental induction which informed them of their roles and responsibilities in each department and during different shifts. Trainees felt that the laminated cards they were provided with common prescribing guidelines are very useful and help minimise prescribing errors. They could not suggest any improvements to the departmental induction.

GP: Trainees reported the received a hospital induction which included IT training for those new to the hospital. Trainees reported that rotas were sent to them in advance and passwords were provided at the start of their post. Trainees felt the department induction was very useful as it focussed on their roles and responsibilities and were introduced to relevant staff in the department. Trainees felt that the laminated cards provided, which listed key prescribing protocols, were very useful. Trainees reported the induction included clinical scenario simulation training, however those who required to attend IT training or were due to work night shift were unable to attend. They suggested that running an additional simulation training event, to allow all trainees to attend, would further improve the induction.

ST: Trainees reported that they received a comprehensive induction that prepared them for working in the department, this included:

- Information about their roles and responsibilities
- Who to escalate concerns to
- How to use TRAK system
- Tour of department
- Introduction to multi-disciplinary staff.

Trainees reported that there were some issues with the rota at the start of the post due to a new electronic system, but this was resolved within 3 weeks and works well. All trainees felt the induction worked well and could not suggest any improvements.

Non-Medical Staff: Staff reported that the induction had improved, with trainees arriving to the wards with a good understanding of their roles and responsibilities. Some suggested that a tour of the postnatal ward would be useful during induction as trainees will undertake a lot of work in the department.

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

Trainers: Trainers reported that efforts have been made to provide bleep free local teaching to FY2, GP and ST1 & ST2 trainees. They reported that trainees are informed at induction that they are expected to hand their page to the on-call middle grade ST or on-call consultant. Trainers reported that at the time of the visit there is no consultant led local teaching for ST3+ trainees. This was in part due to consultant staffing undertaking clinics in peripheral sites and not having sufficient time to travel and undertake teaching in the main hospital. However, trainers did report that there is weekly trainee led CTG teaching sessions. Trainers also highlighted various other educational opportunities available to trainees, these include:

- Obstetrics risk management meetings
- Gynaecology risk management meetings and,
- A variety of multi-disciplinary meetings.

Trainers reported that trainees are required to apply for study leave to attend regional teaching with a standard maximum of 4 trainees on leave (study and/or annual leave) at any one time.

FY2: Trainees reported they receive 1 hour of weekly formal teaching every Thursday. The sessions are led by a specialty trainee and have consultant support. Trainees reported they are expected to attend the teaching sessions and are required to submit a reason for non-attendance, unless working nightshift or on leave. Trainees felt it could be difficult to leave the department to attend teaching when it’s busy as they felt pressured to remain on the ward. They also indicated that although teaching should be bleep free, they may

not be able to find a senior trainee to pass the page to, but this would not prevent them from attending teaching. Trainees reported they have managed to attend 100% of their regional teaching.

GP: Trainees reported there is a 30-minute formal teaching session every Thursday afternoon which is normally provided by a senior ST trainee with consultant support but can be consultant led. They felt the teaching sessions were useful and cover a wide variety of relevant topics. Trainees reported that if they are rostered on to work, their ability to attend local teaching is very good, unless working in the labour ward as the work demands can be unpredictable. Trainees reported that teaching sessions had recently become bleep free, but they can find it difficult to find an ST trainee to hand the bleep to, however they will inform nursing and midwifery staff if attending teaching. Trainees felt the teaching was of good quality, but the room used was not ideal as it often had IT issues. Trainees reported they can attend regional teaching if they are on a green day or can swap their green day, however, this meant to some of the trainees had not been able to attend any regional teaching sessions during their post.

ST: Trainees reported that there is no consultant led local teaching provided to them but there are weekly trainee led CTG meetings. They believed that a Friday afternoon teaching session was due to be reinstated. Trainees also reported variability (some less than 50%, some more than 50%) in attendance at regional teaching as only two trainees are permitted study leave to attend regional teaching at one time.

Non-Medical Staff: Staff reported that they try to complete any clinical tasks before teaching sessions begin to minimise interruptions. They felt that due to the unpredictable nature of the labour ward, it was not always possible for trainees to attend but all staff indicated that they try to remind trainees when their teaching sessions are due to begin.

3.3 Study Leave (R3.12)

Trainers: Trainers reported that the only challenge to supporting study leave is where a number of trainees' request leave for the same date.

FY2: Trainees reported that it was easy to request and take study leave if the date of leave was on a green day of their rota. Trainees indicated that they need to swap shifts with trainees if their study leave date does not fall on a green day, but they felt the rota co-ordinator was accommodating when swaps are needed.

GP: Trainees reported it was easy to request and take study leave if they were on a green day.

ST: Trainees reported it was easy to request and take study leave unless several trainees request leave for the same event, such as regional teaching.

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

Trainers: Trainers reported that they are allocated to trainees at the start of the trainee post. The college tutor reviews the ST trainees' eportfolios to allocate supervisors most appropriate to the educational needs of trainees. Trainers confirmed that they have time in their job plan for supervising trainees but that this time is not sufficient to provide local teaching. All are recognised trainers and have their educational roles reviewed during appraisal.

FY2: Trainees reported they were informed of their allocated educational and clinical supervisor prior to starting in post. Not all trainees had managed to meet with their supervisor, but those who had confirmed that a personal development plan had been agreed during their initial meeting.

GP: Trainees reported they were emailed who their clinical supervisor would be. All reported that they had formally met their supervisor once and had agreed a personal development plan during the meeting. Some trainees felt their supervisor was not responsive to emails but other experienced good engagement from their supervisor.

ST: All trainees reported that they had met with their educational supervisor and agreed a personal development plan. Trainees felt that their meetings were useful and that they would get out what they put in.

Non-Medical Staff: Staff felt that trainees can always access senior support when required. They highlighted that the additional consultant cover which is now in place provides an additional contact for when support is needed.

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

Trainers: Not all trainers were aware of the curriculum requirements of Foundation and GP trainees but will ask trainees at their initial meeting what they need to do and their expectations from the post. Trainers reported that green days are built into the rotas for FY2, GP and ST1 & ST2 trainees to enable them to attend clinics. They also advised that trainees are provided with lists of clinics to enable trainees to highlight which ones the trainees would prefer to attend. However, it was acknowledged that trainees are supernumerary at these clinics and therefore can be at risk of being pulled from clinics to support the wards when they are busy or have unexpected absences. Trainers also advised that ATSM sessions are built into

the rota for senior ST trainees. Although trainers were aware that some trainees may struggle to achieve a specific procedural skill, they were unclear as to the reason for this. Trainers reported that they would expect the trainees to highlight to them if there are any curriculum competences that a trainee is struggling to achieve to ensure this is addressed. The trainers were aware that there remains a high volume as basic tasks, such as completing immediate discharge letters and phlebotomy, which the FY2, GTST and ST1/2 doctors are required to perform, and they are continuing to look at ways this can be reduced.

FY2: Trainees felt the variety of patients they are exposed to provides them with lots of opportunities to achieve their curriculum competences. Trainees did not feel there are any learning outcomes that will be difficult to achieved. They also reported that they are asked what clinics they are interested in attending and can attend out-patient clinics when rostered onto a green day. Trainees felt that the overall balance between educational and non-educational tasks was good but did indicate that they are required to complete high volume of IDLs when on the obstetrics ward.

GP: Trainees reported that the allocated green days and green weeks for attending out-patient clinics was very helpful to their training. They felt they are closely supervised by a senior ST and can always ask for advice. Trainees also felt they gained a positive training experience working on-call in gynaecology. They did not feel that any particular competences would be difficult to achieve as staff are willing to complete their workplace-based assessments. Trainees reported they had attended approximately 10 clinics since starting their post. However, they felt that some trainees had less clinic experience due to having to be pulled from their planned green day to support the department due to work demands or rota gaps. Trainees felt that although the green days were 100% educational, the overall balance of time spent developing as a trainee and time spent completing tasks of little to no educational benefit was 30:70. Trainees reported they complete an excessively high volume of immediate discharge letter in comparison to other posts they had worked in, as well as cannulation and taking bloods.

ST: Trainees felt the business of the unit provided them with a lot of variety to meet their curriculum requirements. Additionally, they feel the multi-disciplinary team are very approachable. Due to a few senior trainees specialising in surgical gynaecology, they felt it was difficult to achieve their benign gynaecology ATSM due to competing demands of other trainees. Trainees reported that whilst there is a lot of service provision in the post, the overall balance is good with lots of learning opportunities.

Non-Medical Staff: Staff reported that they will provide advice to trainees when the trainees ask and will also highlight to trainees if they feel senior support is required. Midwifery staff reported that will also support a trainee to undertake some of their tasks, if they are aware that a trainee has an interest in obstetrics, to gain more practical experience.

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

Trainers: Trainers reported that the trainees highlight to them what assessments they require to complete. They felt that trainees could easily complete their required assessments in the post. There is also a variety of staff, including a senior trainee, to ensure that GP trainees can be assessed by the required level of doctor. Trainers indicated that they had received training in completing workplace-based assessments but had not had the opportunity to benchmark their assessments with each other.

FY2: Trainees reported that it is easy for them to complete their assessments. They felt these were completed in a fair and consistent way as they are working with the same senior trainees. Trainees also felt that working in the maternity assessment unit was particularly useful as it provides them with lots of opportunities to complete workplace-based assessments.

ST: Trainees reported that, although they may have to chase some staff to complete the forms, overall it was easy for them to complete their required assessments. Trainees felt that their assessments were completed in a fair and consistent manner.

Non-Medical Staff: Staff reported that they are happy to complete formal assessments, such as 360 degree and multi-source feedback, if asked.

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

Trainers: Not asked

FY2: Trainees reported that the risk management meetings involve a multi-disciplinary team (MDT) and provide opportunities for multi-professional learning. If unable to attend, trainees reported that minutes of these meetings are shared via email.

GP: Trainees reported that there are obstetrics and gynaecology risk meetings which involve the multi-disciplinary team (MDT). In addition, they reported there are MDT meetings held every two months, all of which offer the opportunity for multi-professional learning.

ST: Trainees reported the clinical risk meetings provide opportunities for multi-professional learning but the rota can hinder their attendance at these meetings.

Non-Medical Staff: Staff reported there are a variety of multi-professional learning opportunities, these included:

- PROMPT (Practical Obstetric Multi-Professional Training) courses,
- REACT (Rapid Effective Assistance for Children) training and,
- Clinical risk meetings

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

FY2: Trainees reported that they have the opportunity to undertake quality improvement projects during their post.
ST: Trainees reported there are lots of opportunities for them to undertake quality improvement projects.

3.9. 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 they are able to differentiate between the higher specialty trainees but felt all staff find it challenging to differentiate among the more junior grades of doctors. They felt that discussions with junior trainees enables them to determine a trainee's competence. There are dedicated pages for on-call staff which everyone is made aware of which ensures trainees know who to contact in each department for support. Trainers reported they were not aware of any instances where a trainee had been left to cope with a situation beyond their competence and they would expect a trainee to ask for support if needed. The department also ensures that trainees have direct consultant support within the maternity assessment unit until they are competent to undertake assessments. In addition, where no consultant is available, clinics are cancelled (with the exception of antenatal clinics) to ensure senior trainees would always have access to consultant support when seeing patients in a clinic setting. Trainers would not expect a trainee to seek consent for a procedure th are not competent to undertake and would always seek and reconfirm consent with a patient if they had initially had consent taken by a trainee.

FY2: Trainees reported that they are provided with the pager number for the on-call doctor to contact for clinical supervision. Trainees reported that they had not been left to cope with a problem beyond their competence, but felt pressured at times by some midwifery staff in the maternity assessment unit, to make decisions rather than discussing the management plan with a senior trainee. Trainees reported that their senior colleagues are very accessible and approachable when support is requested.

GP and ST: Trainees reported they always have access to a supervising clinician and know who to contact for that supervision if needed. None of the trainees felt they had been left to cope with a situation beyond

their competence and that their senior colleagues are very approachable and accessible when support is required.

Non-Medical Staff: Staff reported the department utilises colour coded badge holders to differentiate between the different levels of trainee. They felt that they learned each trainees level of competency through discussions with the trainees. None of the staff that met with the panel were aware of instances where a trainee had to cope with a problem beyond their level of competency.

3.10. Feedback to trainees (R1.15, 3.13)

Trainers: Trainers reported that feedback is provided to trainees during one to one discussions and case discussions following the ward round.

FY2: Trainees reported they receive constructive feedback on their clinical decisions when working within the MAU, but not on the wards as they do not make clinical decisions.

GP: Trainees reported that they receive constructive feedback on their clinical decisions.

ST: Trainees reported a variety of opportunities in which they can receive constructive and meaningful feedback. This included during discussions with consultants following working out of hours and during the day when working with consultants.

3.11. Feedback from trainees (R1.5, 2.3)

Trainers: Trainers reported that in addition to trainees feeding back issues to them directly, there is a trainee forum from which the chief resident can feed back to them about any issues affecting trainees.

FY2: Trainees reported they can provide feedback on their training experience through the national GMC survey (NTS) and Scottish training survey (STS). Some trainees were aware of the trainee forum but there was a lack of awareness when these meetings were held.

GP: Trainees reported that they are regularly asked to provide feedback on their experience in the post. Trainees reported they are aware of who the chief resident is and are invited to attend the monthly trainee forum. Trainees felt that there may be more of a focus on O&G trainee issues but that FY2 and GP trainee concerns can be raised.

ST: Trainees reported that they can feedback on their experience in the post at the trainee forum. They advised that the forum is held approximately monthly following which the chief resident will discuss with consultants if any issues have arisen.

3.12. Workload/ Rota (1.7, 1.12, 2.19)

Trainers: The department has made changes to the senior trainee rota which provide trainees with an additional rest day before or after nightshifts and also allocates 2 ATSM sessions a week for them. Green days are built into the junior rota to enable their attendance at clinics and clinical risk meetings. In addition, the junior trainees now work in the same areas for a few days in a row to improve continuity for both staff and patients.

FY2: Trainees reported their workload was manageable but that there was variation in the rota resulting in them being exposed to either more gynaecology or more obstetrics (on an individual basis). Additionally, some felt that there was not an equal allocation of green days to attend clinics/take study leave. Traineesdid not feel that the rota raised any patient safety issues. Trainees suggested that the rota could be improved by providing an even share of green days for each FY2.

GP: Trainees felt that their workload and rota was manageable both during the day and out of hours. They did not feel the rota raised any patient safety concerns. It was perceived by trainees that, although they are on the same rota as ST1 and ST2 O&G trainees, the O&G trainees gained more educational experience to the detriment of FY2 and GP trainees. Trainees suggested that having more time in out-patient clinics and less time in theatre would be more beneficial to their future careers as GPs. Trainees reported that they work in the same area for a few days at a time. They felt this continuity provided an opportunity for more positive team working and an ability to build a rapport with staff in the department.

ST: Senior trainees reported that their rota and workload is manageable.. Junior trainees are on the same rota as Foundation and GP trainees and felt that having more green days to attend clinics would be useful to their training as these days also need to be used for taking annual and study leave. None of the trainees felt the rota raised any patient safety concerns. Trainees reported that their rota is monitored but at the time of the visit the results were not yet available to confirm that it is compliant with the European Working Time Regulations.

Non-Medical Staff: Staff reported that they were not aware of any rota concerns that could impact on training or a trainee’s wellbeing. Staff felt that trainees would seek additional help when busy.

3.13. Handover (R1.14)

Trainers: The trainers described an effective handover process which takes place in the morning. This includes a safety brief and there is an electronic sheet for gynaecology. There is a further handover from a consultant to a trainee at 5pm and from the trainee to the night team at 8pm. The obstetrics handover takes place every morning. Trainers reported they are constantly improving the rota and an audit is ongoing at present. Where possible, trainers will look to provide feedback on patient management plans at handover.

FY2: Trainees reported there is an effective, structured handover in place with consultant presence in the morning, with further handovers at 5pm and 8pm. The gynaecology handover includes a paper copy for information. Trainees felt that the 5pm handover may not be as thorough as staff may be called to an emergency resulting in delays with handover. Trainees reported that patient safety is the focus of the handover and it is not used as a learning opportunity as all staff are eager to get their rest after a long shift.

GP: Trainees reported there is an effective morning and evening handover in place with written records of handover information. Trainees reported they were aware of a 5pm handover but were not involved and had no concerns about this. Trainees felt that handover could be used as a learning opportunity if there had been any interesting cases to discuss.

ST: Trainees reported that there is a formal structured handover in place in the morning and evening which is consultant led in the morning. They advised that there is an additional handover in gynaecology at 5pm from the consultant to a senior trainee. Trainees reported that the morning handover is not used as a learning opportunity as those coming off night shift are keen to get home to rest.

Non-Medical Staff: Staff reported there is an effective handover in place which, in gynaecology, includes a written copy.

3.14. Educational Resources (R1.19)

FY2: Trainees reported they have access to adequate educational resources but would welcome more updated IT systems.

GP: Trainees reported they have access to adequate educational resources but would welcome more updated IT systems as it can take up to 40 minutes to log in to a computer.

ST: Trainees reported that facilities to support their learning needs are poor.

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

GP: Trainees reported that support is available to them if they were struggling personally or professionally. Trainees felt that the department are very accommodating if reasonable adjustments, such as changes or reduction in nightshifts, are requested.

ST: Trainees reported that support is available to them if they were struggling professionally or personally. Although specific examples were not provided, trainees reported that the department will accommodate reasonable adjustments where possible and are very supportive.

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

GP: Trainees were not aware of the educational governance structures within the hospital.

ST: Some trainees were aware who the Director or Associate Director of Medical Education is but were unclear as to their role within managing the quality of education and training they receive. Trainees are aware of who the chief resident is and will raise concerns about training to them at the trainee forum to discuss with the consultant team.

3.17 Raising concerns (R1.1, 2.7)

Trainers: Trainers reported that they encourage trainees to submit a datix report if they have a patient safety concern but would also encourage trainees to first raise any concerns with a consultant. Concerns can also be discussed at risk management meetings. If trainers had concerns about their education or training they would raise this at a specialty training committee meeting or seek support from the deanery.

FY2: Trainees reported that they would raise patient safety concerns to a senior trainee or consultant. Trainees reported that they have not had to raise any concerns about their training or education but would be happy to raise any concerns with their supervisor and felt confident these would be addressed.

GP: Trainees reported that they would raise patient safety concerns to a senior trainee who would escalate to a consultant if needed. If there was a concern related to training, the trainees reported they would discuss this with their clinical supervisor or the GP lead in the department.

ST: Trainees reported they would discuss any patient safety concerns to the consultant team and clinical director. If a concern related to their training, trainees reported they would be happy to raise this with the college tutor or another consultant.

Non-Medical Staff: Staff reported there is a clear escalation policy in place for raising concerns about patient safety. They advised that they can raise concerns with a trainee and escalate to a consultant to address any concerns.

3.18 Patient safety (R1.2)

Trainers: Trainers felt that there is very safe environment in gynaecology for both patients and staff as most work is planned. They felt the environment within obstetrics was as safe as it could possibly be due to the unpredictable nature of the specialty. Patients are not boarded out, but some may be boarded in to the gynaecology depart. Trainers advised that the day to day managements of boarded in patients is undertaken by the relevant specialty. Daily ward rounds, handover and weekly risk management meetings are in place to monitor the safety of patients.

FY2: Trainees reported they would have no concerns about the quality or safety of care if a friend or relative was admitted to the department. Trainees reported that patients are not boarded out, but some medical patients can be boarded in to the gynaecology wards. Some trainees felt that there needed to be more clarity as to who is responsible for the care and discharge of boarded in patients as there were variable expectations from different medical teams.

GP: Trainees reported they would have no concerns about the quality or safety of care if a friend or relative was admitted to the department. Trainees reported that there are boarded in patient within gynaecology wards, but they are not expected to be involved with their care unless the patient's condition was deteriorating.

ST: Trainees reported they would have no concerns about the quality or safety of care if a friend or relative was admitted to the department.

Non-Medical Staff: Staff reported there is a daily safety brief included in the morning huddle, where discussion around high risk patients takes place. Staff reported that there are also regular clinical risk meetings to discuss adverse incidents.

3.19 Adverse incidents (R1.3)

Trainers: Trainers reported that adverse incidents are recorded through the datix system. If a trainee has been involved in an adverse incident, feedback and reflection about the incident are provide directly to the trainee. Risk management meetings provide the opportunity for shared learning from adverse events.

FY2: Trainees reported that there are aware of the Datix system for reporting adverse incidents but had not received any training on how to use this. They reported that incident reports can go to risk meetings for discussion or escalated to the significant clinical incidents process but had no specific experience of this process.

GP: Trainees reported that they would speak with a senior nurse or submit a datix report for recording adverse incidents. They reported that risk management meetings include discussion of and learning points from significant incidents.

ST: Trainees reported that they would submit a datix report if an adverse incident occurred. They can also complete an incident review (IR1) form. Trainees were aware that reports are subsequently reviewed at clinical risk meetings. They advised that they receive written feedback with learning outcomes following submission of an incident report and also receive copies of the minutes from risk management meetings.

Non-Medical Staff: Staff reported that adverse incidents are reported through the Datix system. They advised that datix reports are discussed at risk management meetings and learning outcomes from these meetings are shared with all staff.

3.20 Duty of candour (R1.4)

GP & ST: Trainees felt that, as they work with an open and approachable team, they would be supported if involved in an incident where something went wrong.

3.21 Culture & undermining (R3.3)

Trainers: A zero tolerance culture of undermining behaviours is emphasised to all trainees at induction. Trainers highlight an open-door policy and would encourage trainees to raise any concerns. The department also ensure that all staff are aware of the local policy on bullying and harassment.

FY2: Trainees felt they worked in a very supportive environment. None of the trainees interviewed had witnessed or experienced any undermining behaviours from any colleague in the department. Trainees felt comfortable to raise any concerns about bullying or undermining with their supervisor or a senior trainee.

GP: Trainees felt they worked in a very supportive environment. None of the trainees interviewed had witnessed or experienced any undermining behaviours from any colleague in the department. Trainees reported that there are posters throughout the hospital with consultant contact details if they needed to raise a concern about bullying or undermining. Some trainees felt they would raise concerns with their clinical supervisor before contacting anyone else for support.

ST: Trainees felt they worked within a very supportive environment. No-one raised any concerns regarding bullying or undermining. Trainees reported that there are posters located across the hospital with named consultants for them to contact if they wanted to discuss any bullying or undermining concerns.

3.22 Other

Trainees were asked to rate their overall satisfaction with the training and education they have experienced in this post, with a rating from 0 (very poor) to 10 (excellent). The scores are provided below:

FY2 – 8 out of 10
GPST2 – Range: 5 – 8, Average: 6.3 out of 10
ST – Range: 3 – 9, Average: 7.4 out of 10

4. Summary

Positive aspects of the visit

- Very approachable and supportive consultant team.
- Good multi-disciplinary team working.
- Rota changes have improved continuity resulting in better experience for trainees including improved team working.
- Access to formal teaching and tailoring of the educational opportunities facilitated by the green day system for FY2, GPST, ST1 and ST2 trainees have improved.
- Clear culture of safety for both patients and trainees.
- Positive impact of [redacted] on the training of first on-call tier trainees, in particular FY2 and GPST trainees.

- There is now a system for trainee engagement. The role of the chief residents and the trainee doctor forum appear to be working well, although in their infancy. Foundation trainees could be made more aware of these.
- There is a comprehensive and effective departmental induction programme in place which provides clarity around the trainees' roles and responsibilities in the different wards with trainees' awareness of their day to day duties. In addition, the use of laminate cards for common prescribing guidelines is good practice.
- Review of eportfolios by the college tutor to understand the learning needs of new ST trainees who are coming to the department and sharing awareness of their experience and learning needs with the consultant team.

Less positive aspects of the visit

- Lack of sufficient awareness among consultant trainers around the curriculum requirements for GP trainees in O&G posts.
- There continues to be a burden of non-educational tasks, in particular IDL's, impacting on FY2 and GP trainees' experience.
- At present, there is a lack of local formal teaching provision for ST trainees.
- Study Leave policy is perceived to be a barrier to accessing regional teaching.
- Perception of inequity in the number of green days, OOH shifts and of Gynaecology vs Obstetric exposure among the first on call tier of trainees.
- Poor office space for doctors in training in both Obstetrics & Gynaecology departments and slow IT.
- Concern about lack of surgical opportunities for senior ST trainees undertaking benign Gynaecology ATSM due to the number of doctors undertaking this concurrently. (This will be fed back to the Training Programme Director to review in the context of department's training capacity).

Progress against previous requirements: recorded as 'addressed', 'significant', 'some progress', 'little or no progress'.

Ref	Issue	Progress
7.1	All clinics must be supervised by a Consultant.	Significant progress
7.2	There must be protected bleep free local teaching for Foundation and General Practice doctors supported by the Consultant team.	Significant progress
7.3	A unit induction must be available to all trainees including those who start their post on nightshift.	Significant progress
7.4	GP trainees must know who is providing their supervision when working in the Maternity Admissions Units.	Addressed

7.5	There must be provision on the rota to ensure GPSTs can attend clinics relevant to their training needs.	Significant progress
7.6	The department must support ST3+ trainee attendance at regional teaching days.	Some progress – see new requirement 7.7
7.7	The department must ensure that there are clear systems in place to provide supervision, support and feedback to trainees working in clinics.	Significant progress
7.8	The department must develop and sustain a local teaching programme relevant to curriculum requirements of the ST3+ trainees including a system for protecting time for their attendance.	Little or no progress – see new requirement 7.3
7.9	Foundation and General Practice trainees must be assigned to a ward/unit for a minimum of a 4-week continuous period.	Some progress – see new requirement 7.8
7.10	Foundation and General Practice trainees must be included in Clinical Risk Meetings to have access to learning from clinical adverse events	Significant progress
7.11	The department must review and reduce the volume of non-educational tasks the Foundation trainees undertake in order to maximise the potential to attend educational opportunities including teaching and clinics. In particular, efforts should be made to allow them to avail of “Green Days”.	Some progress – see new requirement 7.2
7.12	Zero tolerance of undermining behaviours must be promoted.	Largely addressed
7.13	The department must review the rota structure and night shift allocation to ensure that daytime sub specialty training is not compromised.	See new requirement 7.6
7.14	The department must work with the Board in implementing changes to improve the educational environment for all grades of doctors in training.	Significant progress
7.15	All references to “SHO’s” and “SHO Rotas” must cease. The “Say No to SHO” programme must be adopted, with all staff involved.	Significant progress
7.16	GPSTs must have the opportunity to have assessments completed by another team member of appropriate grade to do this.	Significant progress

As the site is on enhanced monitoring there is a need for the department to demonstrate sustained improvements; a further enhanced monitoring visit will be scheduled in early 2020. The list of requirements provided in section 7 (that need to be addressed to meet the GMC's standards) includes new requirements and any previous requirements where there hasn't been significant progress or that haven't been addressed. For those aspects where significant progress has been achieved or that have been addressed it is essential to ensure that sustained resolution has been achieved.

Is a revisit required? **(please highlight the appropriate statement on the right)**	**Yes**	**No**	**Highly Likely**	**Highly unlikely**

5. Areas of Good Practice

Ref	Item	Action
5.1	Laminated prescribing cards for common prescriptions. This was highly thought of by FY2 and GP trainees as it supported patient safety and reduced the risk of prescribing errors.	
5.2	Designated consultant to champion the learning and training needs of FY2s and GPSTs.	

6. Areas for Improvement

Ref	Item	Action
6.1	The perception of inequity in the number of green days, OOH shifts and of Gynaecology vs Obstetric exposure among the first on call tier of trainees should be addressed to achieve parity.	

7. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
7.1	Educational and clinical supervisors must understand curriculum and portfolio requirements for the cohorts of trainees training in the unit.	24th November 2019	GP
7.2	Tasks that do not support educational and professional development and that compromise access to formal learning opportunities for GP and Foundation doctors must be reduced.	24th November 2019	FY2, GP
7.3	The department must develop and sustain a local teaching programme relevant to curriculum requirements of the ST3+ trainees including a system for protecting time for attendance.	24th November 2019	ST3+
7.4	Trainees must be given protected study leave to attend mandatory regional teaching.	24th November 2019	ST3+
7.5	Doctors in training must have access to appropriate resources to support their training - office space for doctors in training is an issue.	24th November 2019	ST3+
7.6	Assignment of STs undertaking ATSMs must be within the unit's capacity to provide training. ***This is a deanery requirement for the training programme director***	24th November 2019	ST3+
7.7	The department must support ST3+ trainee attendance at regional teaching days.	24th November 2019	ST3+
7.8	Foundation and General Practice trainees must be assigned to a ward/unit for a minimum of a 4-week continuous period.	24th November 2019	FY, GP

8. DME Action Plan: to be returned to QIM by 25th April 2019

Ref	Issue	By when	Owner	Action(s)	Date Completed
8.1	Educational and clinical supervisors must understand curriculum and portfolio requirements for the cohorts of trainees training in the unit.	24th November 2019			
8.2	Tasks that do not support educational and professional development and that compromise access to formal learning opportunities for GP and Foundation doctors must be reduced.	24th November 2019			
8.3	The department must develop and sustain a local teaching programme relevant to curriculum requirements of the ST3+ trainees including a system for protecting time for attendance.	24th November 2019			
8.4	Trainees must be given protected study leave to attend mandatory regional teaching.	24th November 2019			
8.5	Doctors in training must have access to appropriate resources to support their	24th November 2019			

	training - office space for doctors in training is an issue.				
8.6	Assignment of STs undertaking ATSMs must be within the unit's capacity to provide training.	24th November 2019	**TPD**		
8.7	The department must support ST3+ trainee attendance at regional teaching days.	24th November 2019			
8.8	Foundation and General Practice trainees must be given placements in ward areas of sufficient continuity to enable them to function as team members, and to allow others to make reliable judgements about their abilities, performance and progress.	24th November 2019			

Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	16th January 2017	**Level(s)**	FY2/GP/STs
Type of visit	Triggered	**Hospital**	Princess Royal Maternity Unit
Specialty(s)	Obstetrics & Gynaecology	**Board**	NHS Greater Glasgow & Clyde

Visit panel	
[redacted]	Associate Postgraduate Dean, Quality Lead for Obs & Gyn and Paediatric Specialties & visit chair
[redacted]	Royal College Representative
[redacted]	General Practice Training Programme Director
[redacted]	Lay Representative
[redacted]	Quality Improvement Manager
[redacted]	Quality Improvement Administrator
In attendance	
[redacted]	Shadow Lay Representative (attending for training purposes)

Specialty Group Information	
Specialty Group	Obstetrics & Gynaecology and Paediatrics
Lead Dean/Director	[redacted]
Quality Lead(s)	[redacted]; [redacted]
Quality Improvement Manager(s)	[redacted]

Unit/Site Information		
Non-medical staff in attendance	5 x senior charge midwives, 1 x chief midwife	
Trainers expected	The Deanery was given the names of trainers in the department in advance but was not supplied with a confirmed list of attendees.	
Trainers in attendance	7 Consultant trainers.	
Trainees expected	The Deanery was given the names of trainees in the department in advance and was supplied with a list of confirmed attendees	
Trainees in attendance	2 x FY2, 3 x GPSTs, 2 x ST1, 1 x ST2, 1 x ST3, 3 x ST7, 1 x post CCT	
Feedback session: Managers in attendance	There was good attendance at the feedback session including the Director of Medical Education, the service Medical Director, Consultant trainers and Clinical Director for the unit.	

Date report approved by Lead Visitor	28th February 2017

1. Principal issues arising from pre-visit review

A visit was confirmed for all levels of trainees within the Obstetrics & Gynaecology department at the Princess Royal Maternity Unit as an output of the annual Deanery Quality Review Panel (QRP) for Obs & Gyn and Paediatric specialties.

As part of the QRP process the following survey data was noted:

National Trainee Survey 2016

FY2 trainees (Obs & Gyn): pink flag for Overall Satisfaction.

GP trainees (Obs & Gyn): pink flags for Adequate Experience and Handover; red flags for Access to Educational Resources, Local Teaching, Overall Satisfaction, Supportive Environment and Reporting Systems.

ST trainees (Obs & Gyn): pink flags for Educational Supervision and Induction.

Scottish Trainee Survey 2016

FY2 trainees (Obs & Gyn): pink flag for Educational Environment & red flag for teaching.

GP trainees (Obs & Gyn): red flags for Educational Environment and Teaching.

ST trainees (Obs & Gyn): pink flag for Workload, red flags for Educational Environment and Teaching.

2. Introduction

The Princess Royal Maternity Unit is located within NHS Greater Glasgow & Clyde and sits adjacent to Glasgow Royal Infirmary. The unit has 140 beds and provides maternity and special care baby unit/ITU facilities for neonates.

A summary of the discussions has been compiled under the headings in section 3 below. This report has been compiled with direct reference to the GMC's *Promoting Excellence - Standards for Medical Education and Training.* Each section heading includes numeric reference to specific requirements listed within the standards.

3.1 Induction (1.6, 1.13, 5.9)

FY2/GP: Trainees felt that department Induction was adequate. However, as trainees are expected to work on a variety of different wards such as labour ward, Gynae ward and maternity assessment, they would have preferred more specific detail on their roles & responsibilities in each of these settings

Some trainees reported not having access to PACS on their first day in post. However, this was quickly rectified.

ST1-ST3: Trainees advised that an Induction to the department had taken place and included a tour of the relevant wards. It was felt to be a generally good Induction which covered a wide variety of topics. Trainees also received an Induction Handbook which provided them with contact information including Consultant names and pictures. However, it was felt Induction lacked information on specific roles & responsibilities within the various wards. It was also suggested that it would be very helpful for trainees new to the Specialty (Fy2, GP ST and O&G ST1) if there was a teaching session covering common clinical problems as part of the induction process.

ST3+: The unit induction was felt to be adequate.

All trainees: Some variability in attendance at induction was reported due to rota issues either in previous post or new post.

Trainers: Trainers advised that whilst Induction has improved it remains a work in progress. Trainers highlighted that the current group of trainees had provided them with feedback on ways in which Induction could be improved. Trainers were confident that IT access and passwords were provided in a timely manner and that trainees requiring immediate access to the system were identified and provided with all they required.

3.2 Educational Supervision (1.12, 1.21, 2.15, 3.13)

FY2/GP: Trainees all had an Educational Supervisor who they had met and discussed their learning plan with. Trainees were happy with their educational supervision.

ST1-ST2: Trainees all had an allocated supervisor who they had met with to agree a learning plan.

ST3+: Trainees all had an Educational Supervisor who they had met with and agreed a learning plan.

Trainers: Trainers advised that trainees are told who their supervisor is prior to or at induction. Trainers stated they felt that Consultant involvement in supervision was good and that trainees should be able to easily access meetings with their Educational Supervisor and obtain advice on their learning and development.

3.3 Formal Teaching (1.16)

FY2/GP: Trainees reported access to local teaching that takes place on a Monday and a Friday. The teaching sessions are viewed as being of good quality and are interactive. However, attendance at the teaching is limited due to Monday/Friday being a zero hours' day for approximately half the trainees on the rota.

Trainees suggested it may be beneficial have teaching on a mid-week day as this may increase access.

GP trainees reported that their regional programme teaching only takes place every 3 months and they felt this was too infrequent.

ST1-ST2: Trainees did not raise any concerns regarding local teaching. It was reported as being good quality and informative.

Trainees stated they are usually able to attend regional teaching once a month, though often have to swap shifts to enable attendance.

ST3+: Trainees reported that local teaching is very limited within the department. Trainees stated that no one appears to be responsible for organising it and when teaching does take place it is not protected time. Trainees reported that there have been recent attempts to start teaching sessions again.

Trainees highlighted to the panel that they receive informal teaching from Consultants whilst on the labour ward.

Trainees stated that attending regional teaching sessions is a problem due to rota and clinical commitments. Trainees also stated that they did not feel the regional teaching covers all their curriculum needs with the same 4 or 5 main components being repeated each year.

Trainees suggested that they may have better access to regional teaching sessions if the teaching rotated across the main teaching sites and changed to alternative days of the week.

Trainers: Trainers noted they felt local teaching opportunities targeted each trainee cohort with variable attendance at each.

3.4 Adequate Experience (1.12, 1.15-20, 5.1-11)

FY2/GP: Trainees reported that their rota included dedicated OPD time. However, they also reported that issues of sickness and rota gaps threaten their attendance at clinics. Most trainees are only able to attend approximately one clinic in a two-week period and if this

is substituted by providing other acute cover that represents a major training loss. The GP trainees indicated that Gynaecology clinics are particularly relevant to their training needs and were concerned that access to these clinics should be protected and enhanced.

Trainees highlighted that working within the maternity assessment is a useful learning experience due to the patients they see who have been referred from the community. Trainees stated they also do a lot of labour ward on-call but this is also a good learning opportunity.

Whilst workload is manageable, trainees reported that they spend a large amount of their working day completing IDLs, Venflons and blood tests. There is no phlebotomy service on the gynaecology wards.

ST1-ST2: Trainees reported limited opportunity to develop Gynaecological practical skills within the department. In particular the exposure to hysteroscopy is very limited compared to other local training sites. The very limited involvement of ST1-2 trainees in the day surgery service was felt to be a factor in this.

Trainees stated that the labour ward is a good learning opportunity and they are actively encouraged to get involved in patient care.

ST3+: Trainees did not raise any major concerns.

3.5 Study Leave (3.12)

FY2/GP: Trainees had no significant concerns about access to study leave. However, trainees highlighted that completing taster weeks was difficult due to pressures on rota.

ST1-ST2: Trainees were aware of the process to request study leave and had no concerns about it.

ST3+: Trainees had no significant concerns about access to study leave.

Trainers: Trainers advised that they tried to support study leave requests and were not aware of any significant concerns.

3.6. Educational Resources and IT Facilities (1.18-20)

FY2/GP: Trainees reported that they have access to both a library and IT facilities. However, trainees highlighted that whilst there are numerous PCs for use in the library there are only 2PCs in the doctor's room. Trainees stated this is not an ideal number due to the need to make confidential phone calls regarding patient care whilst updating computerised records.

ST1-ST2: Trainees reported that they were not aware of any further IT facilities available to them outwith the doctor's room**.**

ST3+: No issues were raised by the trainees.

Trainers: The panel were informed that there is access to library facilities at the site.

3.7. Working Hours (1.7, 1.12)

FY2/GP: Trainees did not raise any major concerns regarding their working hours, stating that they do not have to stay beyond their rostered hours very often and that workload is manageable. However, trainees reported that post night shifts they have less than one calendar day before they are expected to begin their day shifts.

Trainees reported having to cover planned absences at short notice and stated they felt this could be managed better.

Trainees stated that they are aware there will be rota gaps in the near future and are unsure how this will be managed. They are concerned this may impact on their training by compromising clinic opportunities.

ST1-ST2: The rota is managed by trainees with consultant oversight. Trainees stated that they try to distribute work equally but with some prioritisation of different elements of clinical work to meet the training needs of the specific trainee groups within the department.

ST3+: Trainees raised concerns regarding the rota. They reported they have no down time with insufficient break after completing night shifts. They reported that they currently average 55 night shifts per year and felt this was excessive and compromised their daytime training opportunities. These trainees also raised concerns about being overstretched in other in other areas. This is particularly the case for the Labour Ward on-call registrar but they also highlighted that they were regularly expected to cover clinics without a consultant present with no reduction in clinic capacity to reflect the reduced staffing. In addition they regularly find themselves covering theatre lists for absent consultants at short notice. The middle-grade trainee cohort in this department is skewed heavily towards the senior years of training and there was a clear sense that these senior trainees were being used to shore up inadequacies in consultant cover. The fact that every ST3+ trainee had to leave this visit session early to deal with clinical work supported this conclusion.

3.8. Handover (1.14)

FY2/GP: Trainees did not raise any major concerns regarding Handover and stated they felt it worked relatively well.

ST1-ST2: Trainees did not raise any major concerns. However, trainees highlighted that the medical handover takes place an hour after nursing/midwifery staff handover and whilst the midwifery handover is “sacrosanct” and protected from interruptions this is not the case for the medical handover.

ST3+: Trainees reported that Handover was fit for purpose and was very informative.

Trainers: Trainers advised that Handover takes place twice a day and that it was fit for purpose.

Non-medical staff: Midwives noted that doctors may have to ask for quiet whilst Handover takes place.

3.9. Clinical Supervision (1.7-1.12, 2.14, 3.13)

FY2/GP: Trainees stated that clinical supervision within the department was appropriate and that the majority of consultants were approachable and friendly. Trainees highlighted that they are actively encouraged to seek help from a senior colleague if it is needed. However, trainees stated that whilst on the Maternity Assessment Unit it can be difficult to get help due to being the only medic on the ward.

ST1-ST2: Trainees stated that they generally feel very well supported and are able to ask the department registrars for advice as required and in the event of a registrar not being available they are happy to seek help from Consultant staff. However, they did raise some concerns about access to support within the Maternity Assessment Unit. This is due to the pressures on the on-call Labour Ward Registrar whose remit covers all Obstetrics patients within Labour Ward, Maternity Assessment Unit, Day Care and antenatal wards. The ST1-2 trainees felt that this registrar was often overstretched which resulted in knock on effects on their own ability to access advice. They were clear that the consultants would provide support in a clear emergency but sometimes it can be hard to decide whether it is appropriate to wait for the registrar to become available or to call a consultant about something that the registrar would normally deal with.

When trainees ask for completion of workplace based assessments they stated their requests are always met with a good response.

ST3+: Trainees reported that there is always support available within Obstetrics. However, it is not always possible to access support easily from senior staff within Gynaecology due to the on-call Consultant working on another site. It was reported that the gynaecology consultant for the day carries the gynaecology page and does the routine ward round but quite regularly there is no gynaecology consultant available and the registrars pick up these roles.

3.10. Patient Safety and Raising Concerns (1.1-6, 3.1)

FY2/GP: Trainees did not have any patient safety concerns. They are aware of how to raise any concerns they might have.

ST1-ST2: Trainees did not have any patient safety concerns.

ST3+: Trainees did not raise any specific patient safety concerns.

3.11. Management of Adverse Incidents (1.1-5)

FY2/GP: Trainees reported that the reporting of Incidents through DATIX was covered as part of their Induction process. Trainees stated the culture within the department strongly encourages the use of the system and provides feedback on its use.

ST1-ST2: Trainees stated they are actively encouraged to use DATIX to raise concerns. Trainees are aware of the clinical incident meetings within the department.

ST3+: Trainees were aware of the DATIX system but few had used it.

Trainers: Trainers advised that there are departmental clinical incident meetings taking place regularly where findings from clinical incident reviews and DATIX were discussed.

3.12. Undermining/Bullying (3.3)

FY2/GP: Trainees stated they felt it was a generally supportive environment. However, some junior trainees shared concerns that at times they felt their opinion regarding medical decisions was not acknowledged by midwifery staff – this was not a view held by most trainees present.

ST1-ST2: Trainees commended the approachable & supportive nature of the consultants on the site

ST3+: Trainees did not raise any concerns regarding Undermining behaviour within the department.

3.13. Educational Roles & summary of discussion with trainers (2.16-17, 3.14-16, 4.1-6, 5.12)

The trainer group were all supportive of providing education and support to their trainees. All of the team reported having sufficient time in their job plan to carry out their roles as supervisors.

3.14. Discussion with non-medical staff.

The visit panel were able to have a general discussion with non-medical staff from across the Obstetrics & Gynaecology department.

The staff highlighted the supportive nature of the teams within the department. They also stated that they feel doctors in training are valuable members of the team.

4. Summary

The visit panel noted the engagement of the DME's office, Consultant staff, trainees and non-medical staff in this deanery visit. Trainees highlighted the supportiveness of the majority of Consultants at the site. GP trainees recognised the recent efforts within the department to improve their training experience

What is working well:

- High Overall Satisfaction score from junior trainees (Fy2, GP ST and O&G ST1-2), ranging from 7 to 8 out of 10.
- Approachable and supportive consultants, registrars and midwifery staff.
- In accordance with the GMC Recognition of Trainers initiative, trainers within the department have time for their educational roles explicitly identified within their current job plans.
- Induction received by trainees was perceived to be generally good (including department Induction Handbook)
- There is a wide breadth of high quality clinical experience that could be accessed.
- Work has been carried out to address concerns previously raised by GP trainees with positive results.
- Culture encourages use and reporting of DATIX

What is working less well:

- Induction lacks guidance on roles & responsibilities required for specific shifts
- ST1-ST2 trainees lack opportunities to develop some basic gynaecology practical skills
- Improvements in GP training (especially clinic opportunities) are deemed by trainees to be vulnerable to rota gaps

- Lack of consistent, protected, relevant local teaching days for ST3+
- Limited ability of ST3+ to attend regional teaching days due to clinical commitments. Regional teaching is also repetitive with insufficient new material for senior trainees who have been exposed to the same programme in earlier training years
- Labour ward on call person is over-stretched
- ST3+ trainees are over-stretched and stressed by covering consultant service gaps in clinics and theatre lists, excess nights (55/annum or 1:6.6) are reported to compromise sub specialty training opportunities. For guidance the joint RCOG and RCPCH publication "Children's and Maternity Services in 2009: Working Time Solutions" states that "it is highly unlikely that a rota with less than eight doctors will enable the trainee to have the appropriate training and educational opportunities."

Overall assessment of trainees' experiences:
When trainees were asked to score their overall satisfaction with their post, with 0 being very dissatisfied and 10 very satisfied the following average scores were recorded:

FY2/GPST: Range 7 – 8, average score 7
ST1-ST2: all trainees scored 8 out of 10, average score 8
ST3+: due to clinical service pressures all ST trainees at this level left during the course of the meeting leaving no-one (except an single non-ST trainee) to provide OS scores to the panel. However, it was clear from the earlier discussion that there was considerable dissatisfaction with the training placement.

5. Areas of Exemplary Practice

Ref	Item	Action
5.1	n/a	

6. Areas for Improvement

Ref	Item	Action
6.1	Consider further review of Induction provided to trainees – including information on specific	

	roles & responsibilities across the various wards.	
6.2	Consider providing a teaching session on common problems for junior trainees new to the specialty within the induction programme (or alternatively very early in the placement).	
6.3	Consider review of day of week for local teaching in the light of the rota structure to increase attendance opportunities for the junior (Fy2, GPST and O&G ST1-2) doctors.	
6.4	Explore ways to reduce interruptions and noise during the medical handover.	

7. Requirements - Issues to be addressed

Ref	Issue	By when	GMC Standard reference
7.1	Department should establish a more robust system to ensure that all trainees are either fully present at induction or subsequently receive comprehensive induction training as soon as possible.	Next induction	R1.13
7.2	There should be a phlebotomy service that covers the gynaecology wards.	30th August 2017	R5.9 h
7.3	The duties of ST1-ST2 trainees in O&G should provide opportunities to gain competencies in basic gynaecology practical skills (including hysteroscopy).	30th August 2017	R5.9 a&b
7.4	Department must work to ensure improvements made to GP training programme (especially gynaecology clinic opportunities) are maintained and protected from acute service pressures.	30th August 2017	R5.9 a,b&h
7.5	Department must develop and sustain a local teaching programme relevant to curriculum requirements of the ST3+ trainees including a system for protecting time for attendance.	30th August 2017	R1.6, R5.9 a&b
7.6	Department must develop support system for Labour Ward on-call registrar in particular with regard to their ability to support the junior trainee in Maternity Assessment Unit.	30th August 2017	R1.12 a&e
7.7	Department must support ST3+ trainee attendance at regional teaching days.	30th August 2017	R1.6

7.8	The department should review the rota structure and night shift allocation to ensure that daytime sub specialty training is not compromised. Trainees must be consulted with regard to the rota structure and an acceptable solution reached. The balance of daytime training and night shift working should deliver ATSM competencies and be consistent with any RCOG guidance	30th August 2017	R1.12, R5.9 h
7.9	The department should review the arrangements for providing consultant Gynaecology cover during the normal working day to ensure that there is a clearly identified consultant available to provide support and advice when required.	30th August 2017	R1.7, R1.8
7.10	Management should review the consultant cover for clinics and theatre lists to ensure that trainees are not being used to fill gaps in consultant cover other than in exceptional emergency situations.	30th August 2017	R1.8
7.11	The department should ensure that there are clear systems in place to provide supervision, support and feedback to trainees working in clinics and undertaking theatre lists.	30th August 2017	R1.7, R1.8

8. DME Action Plan: to be returned to QIM on 26th April 2017

Ref	Issue	By when	Owner	Action(s)	Date Completed
8.1	Department should establish a more robust system to ensure that all trainees are either fully present at induction or subsequently receive comprehensive induction training as soon as possible.	Next induction			
8.2	There should be a phlebotomy service that covers the gynaecology wards.	30th August 2017			
8.3	The duties of ST1-ST2 trainees in O&G should provide opportunities to gain competencies in basic gynaecology practical skills (including hysteroscopy).	30th August 2017			
8.4	Department must work to ensure improvements made to GP training programme (especially gynaecology clinic opportunities) are maintained and protected from acute service pressures.	30th August 2017			
8.5	Department must develop and sustain a local teaching programme relevant to curriculum requirements of the ST3+ trainees including a system for protecting time for attendance.	30th August 2017			
8.6	Department must develop support system for Labour Ward on-call registrar in particular with regard to their ability to support the junior trainee in Maternity Assessment Unit.	30th August 2017			

8.7	Department must support ST3+ trainee attendance at regional teaching days.	30th August 2017			
8.8	The department should review the rota structure and night shift allocation to ensure that daytime sub specialty training is not compromised. Trainees must be consulted with regard to the rota structure and an acceptable solution reached. The balance of daytime training and night shift working should deliver ATSM competencies and be consistent with any RCOG guidance	30th August 2017			
8.9	The department should review the arrangements for providing consultant Gynaecology cover during the normal working day to ensure that there is a clearly identified consultant available to provide support and advice when required.	30th August 2017			
8.10	Management should review the consultant cover for clinics and theatre lists to ensure that trainees are not being used to fill gaps in consultant cover other than in exceptional emergency situations.	30th August 2017			
8.11	The department should ensure that there are clear systems in place to provide supervision, support and feedback to trainees working in clinics and undertaking theatre lists.	30th August 2017			