Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	6th November 2018	**Level(s)**	FY/GPST/CMT/ST
Type of visit	Enhanced Monitoring Re-visit	**Hospital**	University Hospital Ayr
Specialty(s)	General Internal Medicine	**Board**	NHS Ayrshire and Arran

Visit panel	
Professor Alastair McLellan	Visit Chair - Postgraduate Dean
Chris Lawler	GMC Visits & Monitoring Manager
Dr Jim Hall	GMC Representative
Dr Scott Morris	College Representative
Dr Alan McKenzie	Associate Postgraduate Dean – Quality
Alex McCulloch	Quality Improvement Manager
Dr Winnie Weir	General Practice Representative
Dr Euan Harris	Trainee Associate
Archie Glen	Lay Representative
In attendance	
Patriche McGuire	Quality Improvement Administrator

Specialty Group Information					
Specialty Group	Medicine				
Lead Dean/Director	Professor Alastair McLellan				
Quality Lead(s)	Dr Alan McKenzie Dr Stephen Glen Dr Reem Al-Soufi				
Quality Improvement Manager(s)	Alex McCulloch & Heather Stronach				
Unit/Site Information					
Non-medical staff in attendance	14				
Trainers in attendance	9				
Trainees in attendance	FY1 x 5	FY2 x 1	4 x CMT	1 x GPST	2 x ST

Feedback session: Managers in attendance	20 – inclusive of Director of Medical Education and Associate Director of Medical Education, General Managers, Trainers and Senior Nursing staff

Date report approved by Lead Visitor	 Prof Alastair R McLellan – Lead Dean 13th November 2018

1. Principal issues arising from pre-visit review

University Hospital Ayr has been on enhanced monitoring since a deanery visit conducted in November 2016. A subsequent notification of concern prompted an immediate triggered visit on 23rd June 2017. Following this it was agreed that a further enhanced monitoring revisit would take place on the 28th February 2018. Significant concerns persisted at that visit, particularly about the training environment for Foundation, Core and Specialty Trainees. Following this visit conditions were imposed (in addition to ongoing enhanced monitoring) by the GMC for the site to retain approval of these posts to remain on training programmes.

The conditions put in place were as follows:

- NHS Ayrshire and Arran must ensure that all trainees are aware of how to raise concerns and are able to so without fear of consequence.
- NHS Ayrshire and Arran must ensure there are enough staff in Medicine who are able to and are competent to provide appropriate supervision, including out of hours, and learning opportunities for trainees, as well as safe care for patients.
- NHS Ayrshire and Arran must ensure that Core Medical trainees are provided with appropriate learning opportunities and feedback.
- NHS Ayrshire and Arran must ensure that learners are not subject to behavior that undermines their professional confidence, performance or self-esteem.

NHS Ayrshire and Arran was required to provide monthly updates to the deanery and to the GMC against these conditions and against the February 2018 visit requirements.

This visit was an Enhanced Monitoring re-visit to explore the site's progress against the conditions mentioned above as well as the requirements put in place following the last deanery visit in February 2018.

2. Introduction

The panel welcomed the opportunity at the beginning of the visit to hear from the management team, who outlined several changes that had been introduced, in response to previous visit requirements and conditions. These included:

- refinements to the NHS A&A Board educational governance processes,
- improved inductions,
- pro-active rota management (including of rota gaps),
- educational induction of locum consultants to roles as supervising consultants,
- further developments of their system for engaging with doctors in training including with Foundation trainees and
- improvements at the interface between Emergency Medicine and General Medicine within the Acute Receiving Unit.

Overall the visit panel was encouraged by the positive engagement with the visit process and the efforts made at site and at board level to deliver improvements to the training environment.

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 includes numeric reference to specific requirements listed within the standards.

3.1 Induction (R1.13)

Trainers: Induction for trainees was split into hospital site induction in the morning and departmental/ward induction in the afternoon and was a half day of each. Elective commitments of consultants engaged in the inductions were cancelled to enable them to support and deliver the inductions. There were set 'catch-up inductions' for trainees who missed the main induction events.

Foundation Trainees: Trainees present had all received induction and shadowing. University of Glasgow Medical School graduates had received 6 weeks of preparation

for practice at the hospital. The other trainees starting FY1 from other medical schools received 1 week of shadowing. Trainees noted induction to be very comprehensive, although it was a lot of information to take in on one day. They noted an emphasis on mental health and wellbeing. Ward/departmental induction was also thought to be good.

Core Medicine and General Practice Trainees: Trainees present had all received induction, a trainee had started his post on night shift so had missed induction during the day but received a catch-up session. Trainees felt both their hospital and departmental inductions had been thorough. The only issue raised by trainees with regard to induction was that the IT passwords issued for online systems, for some trainees did not work during initial night shifts (because of the need for email verification) but they were able to get around this problem with the help of the charge nurse.

Specialty Trainees: Trainees all confirmed attendance at induction. They had received a full day, 9.00 am – 5.00 pm hospital and departmental induction and received lots of information before starting their posts. Trainees had received departmental handbooks.

Nursing and Non-Medical Staff: Nursing staff confirmed they were involved in the departmental inductions with trainees. If trainees hadn't worked in the hospital before and started on nights then a member of the nursing team worked with them, so they felt supported. The Advanced Nurse Practitioner role (ANP) role was new to the hospital but thought to be supportive to trainees.

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

Trainers: Formal local teaching was provided twice per week:

- Wednesday lunch time 1-hour sessions – Foundation trainees
- Friday lunch time 1-hour session Medicine division session open to all trainees.

There is a monthly hospital 'grand round', mainly organised by medicine. Trainers advised lunch was provided for trainees at these sessions.

Regional teaching such as the core medical education programme (COMEP) sessions were included in the trainees' rotas and for those that couldn't attend the sessions in Glasgow in person, a video link was provided. Re-runs of COMEP sessions were now

delivered locally in the hospital using recordings of the sessions. Trainers now monitored the trainee attendance at teaching to ensure the trainees were getting to it. Teaching was bleep free for FY1 trainees but not the other trainee cohorts.

Foundation trainees: Formal timetabled FY1 teaching was available to trainees on Wednesdays at lunchtime. Lunch was provided for the trainees and the sessions covered a variety of topics. Trainees also noted the Medicine wide teaching sessions that took place on Fridays were open to them. Radiology specific sessions on ECGs were also delivered on Tuesdays and were open to all trainees. The Wednesday FY1 specific sessions were protected and interruption free, the departmental Medicine teaching on Fridays were not bleep free. Trainees felt on average they received 2.5 hours per week of teaching. Trainees were also able to access FY1 regional teaching sessions.

Core Medicine and General Practice Trainees: Trainees noted Tuesday Radiology and ECG interpretation sessions as very good. They had all attended the Friday lunchtime Medicine department sessions and felt them to be of a good standard. Trainees could access the COMEP regional teaching sessions which were run at the deanery. For trainees who missed sessions, re runs were provided locally and trainees also had the option to attend via video link. The General Practice trainee was also able to access the General Practice regional teaching programme. Trainees estimated they got to 2 -3 hours of teaching per week. A recommendation for improvement regarding local teaching was to include a more formalised regular feedback structure on the content of formal teaching sessions. The contribution of the rota coordinator in incorporating access for formal learning sessions into the rota was commended.

Specialty Trainees: Trainees noted Tuesday Radiology ECG sessions and Friday lunchtime medicine wide local teaching. Trainees advised they got to 1 – 2 hours of teaching per week and generally were able to attend unless they were working on-call shifts. The teaching was thought to be well organised, but trainees advised it was only planned into the rota by the rota co-ordinator for junior trainees (FY/GPST/CMT).

Nursing and Non-Medical Staff: Nursing staff supported to trainees to attend their formal teaching sessions by helping them plan and prioritise their days to allow them to get to sessions.

3.3 Study Leave (R3.12)

Trainers: Trainers did not feel there were any challenges to trainees accessing study leave. Study leave requests were sent to the local rota-coordinator and were processed and planned into the trainee rotas.

All Trainee Cohorts: No issues were raised by trainees in obtaining study leave.

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

Trainers: Educational supervisors were allocated to trainees as soon as the trainee rotations were confirmed by the deanery. Educational supervisors were allocated to trainees for the whole training year and the trainees clinical supervisors would change every 4 months. Trainers did not maintain responsibility for specific cohorts of trainees each year. Information related to trainees with performance issues was generally discussed between supervisors informally and at Tuesday morning trainer meetings. All supervisors had received appropriate training and were involved in the delivery of local teaching. Trainers confirmed they had time in their job plans to undertake their educational roles and their roles were reviewed through the annual review process.

All Trainee Cohorts: All trainees present had been allocated Educational Supervisors and had initial meetings with them.

Nursing and Non-Medical Staff: Nursing staff noted senior support to be very visible and present to trainees on the wards within Medicine. Junior trainees (FY1/FY2) were paired up with more senior trainees in order for them to get experience of ward round based reviews of patients. If a consultant was present on the ward they could be contacted by the trainee for advice.

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

Trainers: Updates on changes to curriculum requirements were circulated to trainers by the local post graduate administrators. The local rota coordinator allocated clinic time each week to trainees in their rotas and prioritisation was given according to need. Clinic attendance was recorded, and trainers were sent the attendance lists, which they monitored to ensure trainees were able to achieve the curricular requirements for clinics. Trainers felt a good variety of General Internal Medicine experience was available to trainees in the hospital. Efforts had been made to reduce the amount of time trainees had to spend completing non-educational tasks and support was provided to help them with these tasks by Advanced Nurse Practitioners (ANPs).

Foundation Trainees: Trainees noted their consultant colleagues to be helpful and supportive. The practical skills courses and learning days available to them were thought to be excellent. For FY2s their experience of clinics was noted to be good and they had been to 4 clinics since August. Some practical procedures could be more difficult to get if they were not available either in Medicine or in the hospital, but trainees could plan ahead to access them in other departments or go to University Hospital Crosshouse to get them. Trainees felt the balance between non-educational tasks and time spent developing as a doctor was good. They commended the contribution of the rota manager in supporting their access to learning opportunities.

Core Medicine and General Practice Trainees: Trainees noted good experience of procedures and access to clinics was available to them. They were able to pick the clinics they wanted to go to each week from a clinic list and the rota coordinator would plan them into their rota. Trainees reported a good balance between time spent developing as a doctor and non-educational activity, which they felt to be minimal.

Specialty Trainees: Trainees noted their consultant colleagues to be open and approachable. They confirmed lots of learning opportunities were available to them both in General Internal Medicine and in their specialty experience such as Cardiology and could get to 2 or 3 clinics per week (around 12 -15 clinics since August). Trainees felt there was a good balance of time developing as a doctor and time of little educational benefit.

In general, we heard that for all groups of trainees there was improved continuity of base-ward attachments fostering more supportive relationships with trainers and continuity of patient care.

Nursing and Non- Medical Staff: The nursing staff would seek out trainees to give them experience of participating in procedures. Safety briefs in the morning and afternoon were also a good opportunity for trainees to raise any concerns the may have or to ask if they are looking to gain experience in any specific area.

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

Trainers: Updates on the changes to workplace-based assessments were provided by the local post graduate administrator who would post the requirements on the local trainers notice board and would keep them up to date with any changes. Trainees were actively encouraged to complete workplace-based assessments and they were advised at induction to spread the completion of them over the course of the training year. Trainers were able to benchmark their assessments at ARCP panels and had received feedback this year in some medical specialties on the educational supervisor reports they had provided for trainees.

All Trainee Cohorts: Trainees felt it was easy for them to complete workplace-based assessments and to have them signed off. They advised that consultants pro-actively sought the trainees out to give them experience of procedures that were happening and they felt their assessments to be fair and consistent.

Nursing and Non-Medical Staff: Nursing staff contributed to the learning of trainees by responding to ticket requests from e-portfolio to provide feedback on their workplace-based assessments. They also actively encouraged trainees to seek feedback on a regular basis.

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

Trainers: Multi-disciplinary learning was variable across departments. Trainers noted the pharmacists provided teaching sessions that were open to Foundation trainees and non-medical staff.

All Trainee Cohorts: Trainees did not describe opportunities for multi-disciplinary learning but noted the morning huddles with the nursing team and sometimes the Medicine-wide teaching sessions on Fridays were learning opportunities that could involve different disciplines.

Nursing and Non- Medical Staff: Shared learning experiences were described in Respiratory Medicine, the multi-disciplinary team (MDT) would discuss cases, what had gone well and not so well and possible improvements. Morbidity and mortality meetings were also noted as MDT learning experiences in some Medicine specialties.

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

Trainers: Trainers felt there were lots of opportunities for trainees to become involved in Quality Improvement projects.

All Trainee Cohorts: The trainees present felt they had lots of opportunities to engage in audit and quality improvement projects, but it could be more difficult when in their period of on-call shifts.

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: A colour coded badge system was in operation and each cohort of trainee was allocated a different colour according to their grade. Laminated posters were in circulation and posted on the wall of each ward. Trainees are made aware of who to contact for advice or support at their ward inductions and each ward had a minimum of 2 consultants on the ward each day up until 8.30 pm in the evening. In the out of hours period, support was provided by an on-call consultant. The trainers were not aware of any occasions were trainees had to work beyond their competence. Trainees were only

allowed to seek consent from patients for procedures that they were competent to carry out themselves.

All Trainee Cohorts: Trainees felt they always had access to clinical supervision and were aware of who to contact both during the day and in the out of hours period. They did not report any instances of having to work beyond their competence. They advised their consultant colleagues were accessible and approachable and they confirmed consultant presence on the wards until 8.30 pm each day. A Core trainee did note being 2nd on the on-call rota at CT2 level, which was challenging but they felt they had adequate senior support available to them, should they have required it.

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

Trainers: Feedback was provided to trainees during the morning and evening ward rounds. For trainees on night shifts, feedback was provided in the morning by the consultants who started their shifts earlier at 7.30 am**.**

Foundation Trainees: Trainees felt the feedback they received was on a day to day basis but mostly informal. They noted they received morning post receiving feedback.

Core Medicine and General Practice Trainees: Trainees received feedback on their clinical decisions both during the day and in the out of hours period. The post take ward rounds were noted to be very good for receiving feedback. Feedback in the out of hours period could be a bit more variable but trainees felt they could get it if they asked.

Specialty Trainees: Trainees was generally available to them and the consultants were forthcoming with feedback on the wards. Feedback during on-call shifts was variable and they estimated they got feedback during 40 – 50% of their on-call shifts. Trainees estimated the work they had to complete at the end of their night shift meant they couldn't always attend the morning ward rounds for feedback and they estimated this happened during 1/3 of their on-call shifts.

We heard also that many consultants were proactive in seeking opportunities to complete formal WPBAs.

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

Trainers: Trainees were able to provide feedback on their learning through the local trainee forums and through their Chief Resident colleagues, each grade of trainee had their own representative. The trainers monitored the output of the National Training Surveys and a recent site survey had been conducted around the organisation of the back wards of the hospital which because of the feedback from trainees had been changed. The Associate Director of Medical Education operated an open-door policy and offered 1-2-1 meetings with trainees. The trainers felt there was a culture of empowering trainees to make changes themselves to improve the training environment.

All Trainee Cohorts: Trainees noted their trainee forum to be a mechanism for providing feedback to trainers and management. They also noted their chief residents as being very involved in raising any concerns they had to hospital management. They described the environment as very open and noted the hospital management team to be very approachable and were confident feedback would be acted upon.

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

Trainers: Trainers felt a well organised and rota was in place, fixed night shifts and an on-call block were pre planned into the rota. Trainees had continuity with periods of 5 or 6 weeks at a time spent in their base wards**.** At the moment a full rota was in place in the hospital and the vacancies had been filled by locums. To maintain continuity for trainees, when rota gaps appeared, locums were rotated into them to cover.

Foundation Trainees: Trainees noted their rota to be very manageable and well organised. Rest days were said to be ‘well placed’. Their rota operated on a 10-week cycle and consisted of 5 weeks on the ward with four 9 – 5 shifts followed by a long day and an on-call block. Trainees did not feel their rota had any patient safety implications and noted the rota co-ordinator to be ‘brilliant’.

Core Medicine and General Practice Trainees: Trainees felt their rota to be manageable both during the day and in the out of hours period. The gaps in the rota

had been filled with locum doctors and the rota co-ordinator rotated the locum doctors to cover any gaps in the rota, this allowed the trainees to maintain continuity in their base ward. At the moment the trainees felt the rota had no patient safety implications, but the concern would be if the locum doctors were to leave their posts and are not replaced, this could reduce the educational experience for them.

Specialty Trainees: Trainees noted their rota to be manageable both during the day and in the out of hours period. They were not aware of any rota issues that have had an effect on patient safety. Trainees confirmed any gaps in the rota were generally filled. Before the trainees started, they were able to pick slots on the rota and of the order they wanted to do their shifts in.

All trainees commended the incorporation of educational goals within the rota (and specifically highlighted the contributions of 'Janet', the rota coordinator, and of 'Audrey', the education manager).

Nursing and Non-Medical Staff: There were no concerns regarding the impact of rotas on trainees' health and wellbeing. The rota had been designed to limit 7 day runs of on-call. CT2 and ST3 do 1 7 days run of on-call in their rota but they were kept to a minimum.

3.13. Handover (R1.14)

Trainers: Handover took place 3 times per day, 9.00 am in the morning, 5.00 pm in the afternoon and 9.00pm (handover to hospital at night team). Consultants were present at morning 9.00am handover but less so at 5.00 pm and 9.00 pm, although there were consultants on shift on each medicine ward until 8.30 pm each day. Handover in the morning was often used as a learning opportunity and trainers often came early to discuss patients with trainees finishing night shift.

Foundation trainees: Handover was noted to be verbal and took place 3 times per day. There was now an electronic system for recording handover but there was variable familiarity with it and the records were not felt to be as robust as they could be as a consequence. Trainees said consultants were present at morning handover but their

presence at the late afternoon and evening handover was more variable. Trainees felt handovers were effective and were a source of learning.

Core Medicine and General Practice Trainees: Handover was reported to take place 3 times per day by trainees and was recorded on an electronic system. Trainees felt it to be robust, effective and had no concerns regarding it.

Specialty Trainees: Trainees confirmed handover to take place regularly each day. It was generally consultant led in the morning but less so at the late afternoon and evening handovers. Handover was recorded electronically, handover was thought to be effective.

Nursing and Non-Medical Staff: An electronic handover system called PMS track was available for use, but trainees were requiring encouragement to use the system and seemed to favour verbal handovers. The handover to the HAN team was noted to be a useful learning opportunity for trainees. Nursing staff noted a Friday afternoon form highlights which patients are of a concern for over the weekend and this was then recorded on Trak.

3.14. Educational Resources (R1.19)

Trainers: Facilities to support learning included a simulation room and good video conferencing links to Royal College of Physicians study days in Edinburgh. A learning opportunity that was unique to the hospital was a chest drain ultrasound course which was provided for trainees.

Foundation trainees: Trainees noted IT facilities and the resources in the hospital to be good. They reported the Athena system was clunky and not particularly user friendly, and was the system where guidelines were archived.

Core Medical and General Practice Trainees: Facilities were noted to be acceptable by trainees although Athena was again mentioned as being difficult to use.

Specialty Trainees: Trainees noted the library to be very good but IT resources in general to be poor. Athena again was mentioned as not being user friendly. The doctors room was very small, and it was often too warm to spend any length of time doing anything educational in it.

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

Trainers: Trainees were able to provide feedback to trainers in a variety of different ways. An 'orange form' system was noted, this allowed trainees to submit feedback on clinical scenarios and the forms were left in the handover room with a drop box to submit completed forms. The trainees could put their name on the forms or they could choose to submit them anonymously. The 'orange form' differed from Datix as it was for scenarios that did not affect patient safety. For any patient safety concerns, trainees would be expected to complete a Datix report. The 'orange forms' were reviewed on a regular basis and learning from the incidents were posted in the handover room notice board. Trainers advised they would discuss any concerns they had about trainees first with their educational supervisors and could then escalate any concerns to the deanery.

Occupational Health support was also available to any trainee that required it.

Trainers noted lots of opportunity for trainees to become involved in research and some trainees had been involved in writing material for publications.

All Trainee Cohorts: Of the trainees present, none has worked less than full time or had gone out of programme on career breaks. They were not aware of any colleagues that had requested any adjustments to their programme.

Nursing and Non-Medical Staff: Nursing staff would raise any concerns they had of a trainee's performance causing concern in relation to patient care with their educational supervisor. They would also raise any concerns they had around a trainee's health or wellbeing with senior medical staff**.**

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

Trainers: Trainers noted the director and associate directors of medical education as being responsible for quality in training and the trainers received a good picture of the quality of the training environment through the national surveys.

All Trainee Cohorts: Trainees noted the associate director of medical education as being responsible for the quality of education as well as the chief residents and they felt there was a direct link to hospital management through the chief residents.

3.17 Raising concerns (R1.1, 2.7)

Trainers: Multiple tiers of engagement with doctors in training exist whereby concerns can be raised (including about patient safety or about the quality of training) including the trainee forum, chief residents (who represented different cohorts), as well as 1:1s with these ADME.

We heard about the new ‘orange form system’ for raising concerns. Trainees were encouraged to raise concerns about patient safety through Datix. Feedback was provided to trainees on their Datix submissions and they could not be signed off until feedback had been provided. Morbidity and Mortality meetings were forums where learning was gained from patient safety incidents. The trainers noted an open-door policy was in place and directors and associate Directors of Medicine were accessible to them.

Foundation Trainees: The trainees were confused about when they should use an ‘orange form’ as opposed to completing a Datix report. Only one of the trainees present had completed an ‘orange form’ (which they submitted in August) but had yet to receive feedback on it. The trainees in general felt more comfortable completing a Datix form rather than an ‘orange form’ and advised they had not been shown how to complete an ‘orange form’. If they had any concerns about their education and training they would be comfortable raising them with their educational supervisor or the local post graduate administrator. They advised their senior colleagues were always asking them if they had any concerns.

Core Medicine and General Practice Trainees: Trainees advised they would contact their supervisor or on-call consultant if they had any concerns about patient safety. The trainees were aware of the 'orange form' system. None of the trainees' present had submitted an 'orange form' or Datix (to date) but were aware of the process for doing so. The trainees noted their supervisors to be approachable.

Specialty Trainees: Trainees would raise any concerns regarding patient safety with their consultant colleagues, educational supervisors or lead nurses. The trainees present had not raised any. Trainees noted Professor Collier to be very supportive and approachable.

In general, we heard there is a culture that encourages the raising of concerns, is receptive to them and is willing to effect changes in response, with examples.

Nursing and Non-Medical Staff: Nursing staff felt the 'orange forms' were easier for trainees to use and feedback was displayed in handover room which trainees were able to view. There did seem to be some confusion amongst trainees around whether they should use an 'orange form' to record an incident or to record it in Datix. They felt trainees were more reluctant to raise a Datix report without support of a nursing colleague. Datix reports were sent to the Lead Nurses and it would be decided at that point whether the incident would be investigated by the nursing team or whether it should be sent to a department for investigation. Trainees were informed and included in the Datix feedback process.

3.18 Patient safety (R1.2)

Trainers: Trainers felt the environment was safe for patients. They reported that changes in their system had reduced the numbers of boarders. The weekends could be very busy which meant that some medicine patients required boarding in other wards. The trainers felt they had a safe, robust process in place to track boarded patients. A list of boarded patients was reviewed at morning handover each day and all boarded medicine patients were allocated consultants. The hospital operated a RAG (Red, Amber, Green) rating regarding admissions and the recent weekend before the visit had

been particularly busy. The weekend had been given a red rating and the overspill alerted to the Scottish Government as part of the hospitals monitoring process.

As noted above, a colour coded badge system was in operation and each cohort of trainee was allocated a different colour according to their grade. Laminated posters were in circulation and posted on the wall of each ward to raise awareness of the different grades of trainees.

Foundation Trainees: Trainees felt the environment was generally safe for patients. However, they did have some concern over non-communicative elderly patients being at risk of being slow to be assessed in the Clinical Assessment Unit (CAU), particularly at nights and at the weekend when it was busy. Trainees also noted there were no laboratories on site at the hospital which meant bloods taken from patients had to be sent to University Hospital Crosshouse to be processed; trainees felt this could delay treatment of patients until the next day if they were taken at night. Trainees felt a safe system was in place to look after patients boarded out to other wards. They noted that handover of care from the ED to medicine could be poor.

Core Medicine and General Practice Trainees: Trainees would have no concerns over the safety of their patient care if a friend or relative was admitted to the hospital. Although they had no concerns regarding patient care, they did note there were no laboratories on site at the hospital which meant bloods taken from patients had to be sent to University Hospital Crosshouse to be processed. They felt this could delay treatment of patients until the next day if they were taken at night. Trainees did not feel the hospital's policy for boarding patients was clear or consistent. Trainees were unsure as to how patients were chosen to be boarded out to other wards. Trainees advised the longest a boarded patient would wait for a consultant review would be 48 hours.

Specialty Trainees: Trainees felt the environment within Medicine was safe for patients and would have no concerns over the quality of care if a friend or relative was admitted to the hospital. Trainees were unsure of how patients were selected for boarding out to other wards and felt the protocol for this was not clear.

Nursing and Non-Medical Staff: Nursing staff felt the environment in the hospital was safe for patients. The wards within medicine had recently been re-organised and were now the same size which meant the space available was being more appropriately used to accommodate patients. On average the number of boarders within medicine was noted as being less than 6. The team made sure they are listed appropriately, and they are allocated appropriate consultants. Lists of the boarded patients are taken to the morning huddles to ensure trainees are made aware of who they are.

Nursing staff confirmed a coloured badge system was in operation and each trainee was allocated a different coloured badge. There were posters on the walls in the wards which confirmed each trainee's grade and level of competence.

3.19 Adverse incidents (R1.3)

Trainers: Not covered.

All Trainee Cohorts: Trainees were aware of procedures for when an adverse incident occurs. The trainees present hadn't been involved in any incidents but noted that feedback or learning points from adverse incidents were discussed at the Medicine wide M&M meetings.

3.20 Duty of candour (R1.4)

Trainers: Not covered.

All Trainee Cohorts: Trainees present felt they would be supported by their educational or clinical Supervisor if they were involved in an incident where things had gone wrong. They noted their nursing colleagues to be very supportive. A trainee present had been involved in a communication error, but he felt he had been supported appropriately through discussion of the incident and was satisfied with the outcome.

3.21 Culture & undermining (R3.3)

Trainers: Not covered.

Foundation trainees: Trainees felt their consultant colleagues were very supportive. Within medicine they had not witnessed or experienced any behaviours that could be considered undermining or bullying behaviours. Although the trainees had no concerns over their interactions with their senior medical colleagues, they did advise that some interactions with a consultant in the Radiology department had not been particularly pleasant. Trainees noted their chief resident to be very approachable and felt they could raise any concerns of undermining nature with them in order for them to be escalated. Trainees noted locum consultants to be slightly less engaged than their permanent colleagues but did not raise any concerns regarding them.

Core Medicine and General Practice Trainees: Trainees noted their senior colleagues to be very supportive. They had not witnessed or experienced any undermining or bullying behaviours. They noted the staffing and in particular the weekend staffing in the hospital to be very good. The trainees felt that in general most of their consultant colleagues were supportive and approachable, but they did note that some were not as engaged as others. Trainees advised they did not think FY2's were any longer covering the on-call rota at Biggart Hospital.

Specialty Trainees: Trainees advised their consultant colleagues were supportive and they had not experienced or witnessed any behaviours that could be considered undermining or bullying behaviours. Trainees felt the support provided by locum consultants was of a good standard although some were noted to be more interested in supporting education than others. The trainees were not aware of any concerns regarding trainees being rotated out to Biggart Hospital and thought the staffing levels both during the week and at the weekends were good.

3.22 Other

4. Summary

Is a revisit required? (please highlight the appropriate statement on the right)	Yes ✓ - to monitor sustainability	No	Highly Likely	Highly unlikely

The overall impression of the visit team was this site is now a supportive training environment that seeks and is responsive to feedback; trainees were very content with their training and significant improvements have been made since the last deanery visit in February 2018. Education and training are valued by the organisation and there has been commitment to improve the quality of training and of the training environment. The improvements to training in the hospital are evidenced by the high overall satisfaction scores given by the trainees in every cohort:

Overall Satisfaction scores out of 10:

Foundation trainees 7 - 8
General Practice trainees 8
Core Medicine Trainees 7 -10
Specialty Trainees 6 - 8

The site will remain on Enhanced Monitoring with conditions in order for the GMC and the deanery to monitor the sustainability of the significant improvements made to the training environment and a re-visit will be organised in about 12months'. The conditions placed on the site by the GMC will remain in place currently but there may an opportunity to revise the frequency of updates against the conditions and associated action plan; training leads will be advised if there is agreement to change the frequency of these updates.

Positive aspects of the visit:

- Educational goals are incorporated into rota management and trainees are very content with their rotas.
- Educational induction for locum consultants to be supervising consultants.
- Coloured badges and awareness among the wider clinical team of the different levels of competence of different training grades.
- Multiple tiers of engagement with doctors in training for monitoring quality of training, trainee forum, chief residents, 1:1s with ADME. etc.
- Induction process, includes cancellation of consultant elective activity to support induction.
- All trainees could access sufficient local and regional teaching.
- Culture that encourages the raising of concerns, is receptive to them and is willing to effect changes in response, with examples.
- Supportive, engaged and accessible trainers, who seek opportunities to perform WPBAs and also who provide post-receiving feedback.
- Scheduling, monitoring and managing trainees' clinic attendance.
- Improved continuity of base-ward attachment for all trainees fostering more supportive relationships with trainers and continuity of patient care.

Less positive aspects of the visit:

- Lack of awareness among doctors in training of how patients are selected for boarding.
- Variable familiarity among doctors in training with the 'Orange form' system – and of what happens to submissions, but it is recognised that this is work in progress.
- Lack of structured evaluation of the content of formal teaching, but trainees are currently happy with the content currently.
- Lack of multi-professional learning opportunities.

5. Areas of Good Practice

Ref	Item	Action
5.1	Educational goals are incorporated into rota management and trainees very content with their rotas. The contributions of the rota manager & the postgraduate administrator were commended by many trainees for their significant contributions to facilitating education and training.	
5.2	Educational induction for locum consultants to be supervising consultants	
5.3	Coloured badges and awareness among the wider clinical team of the different levels of competence of different training grades.	

6. Areas for Improvement

Ref	Item	Action
6.1	Multi-disciplinary, shared learning opportunities could be improved for trainees and non-medical staff	
6.2	The variability in trainees' awareness of the 'Orange form' system – and of what happens to submissions should be addressed, but it is recognised that this is a work in progress.	
6.3	Structured evaluation of local teaching should be incorporated into local teaching sessions to inform their content and development.	

7. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
7.1	There must be a policy in place, that trainees are aware of, regarding the selection of patients who are potentially suitable for boarding.	September 2019.	FY, GPST, CMT, ST