**Scotland Deanery Quality Management Visit Report**

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<th>Date of visit</th>
<th>30th January 2019</th>
<th>Level(s)</th>
<th>FY, GPST, CMT and ST</th>
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<td>Hospital</td>
<td>University Hospital Crosshouse</td>
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<td>Specialty(s)</td>
<td>General Internal Medicine</td>
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### Visit panel

- **Professor Alastair McLellan**
  - Visit Chair - Postgraduate Dean
- **Dr Stephen Glen**
  - Associate Postgraduate Dean – Quality
- **Dr Nick Dunn**
  - General Practice Representative
- **Carol Dobson**
  - Lay Representative
- **Alex McCulloch**
  - Quality Improvement Manager

### In attendance

- Patriche McGuire
  - Quality Improvement Administrator

### Specialty Group Information

- **Specialty Group**: Medicine
- **Lead Dean/Director**: Professor Alastair McLellan
- **Quality Lead(s)**
  - Dr Stephen Glen
  - Dr Alan McKenzie
  - Dr Reem Al-Soufi
- **Quality Improvement Manager(s)**
  - Alex McCulloch and Heather Stronach

### Unit/Site Information

- **Non-medical staff in attendance**: 11 – including Senior Charge Nurses, Advanced Nurse Practitioners and Pharmacists.
- **Trainers in attendance**: 14
- **Trainees in attendance**
  - 9 x FY1
  - 1 x FY2
  - 5 x CT
  - 2 x GPST
  - 9 x ST
- ** Feedback session:**
  - Managers in attendance: 9 including, Director of Medical Education, Assistant Directors of Medical Education, Clinical Directors, General Manager for Medicine, Assistant General Manager (Medical Specialties), Associate Medical Director and Joint Medical Director.
1. **Principal issues arising from pre-visit review:**

University Hospital Crosshouse was last visited by the deanery in March 2018, this visit was the last of 3 visits to the site that have taken place since 2015. Attendance at the last visit was impacted by adverse weather conditions and no FY2 trainees were able to attend. 9 requirements were identified at the visit:

- The lack of explicit cross-cover arrangements for patient review and for support for doctors in training during times of Consultants’ sickness absence or annual leave must be addressed urgently. This has potential implications for safety of care and of the training environment.
- The roles and responsibilities of ST3+ doctors in training must be redesigned to deliver training and education.
- A robust and consistent handover system must be implemented for 5.00 pm and weekend handover.
- Access to out-patient clinics for FY/GPST/ST trainee cohorts must be provided.
- The burden of non-medical tasks trainees are expected to undertake that have no educational value should be reduced. The need for many doctors in training to write “blood forms” must be removed.
- FY1 trainees in medical specialties must have opportunities to clerk and assess acutely unwell patients during ward rounds and to receive feedback on their contributions to add learning to their experience.
- Access to tailored learning opportunities for General Practice trainees must be provided to ensure that posts in UHC are relevant to the needs of future general practitioners.
- ST3+ trainees in dual training should have separate named Educational Supervisors for GIM and for specialty, as the current arrangement is failing to serve the needs of GIM training.
- IT hardware must be sufficient – in terms of availability and speed and efficiency to facilitate the work and training of the doctors in training. All perceive IT to be a barrier to efficient working.

This visit is a re-visit to investigate the site’s progress against the above requirements. The visit panel interviewed the supervisors and then groups of trainees as follows: Foundation, CMT, GPST and ST3+. 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.

2. Introduction:

University Hospital Crosshouse is situated two miles from Kilmarnock town centre. It is a large district general hospital providing a wide range of services, including paediatric inpatient services. It is also home to the national Cochlear Implant Service and has the Emergency Department (ED) for East and North Ayrshire.

3.1 Induction (R1.13)

**Trainers:** Trainers felt an effective induction is provided to trainees. They advised that 3 set hospital inductions were provided for trainees and repeat inductions were organised for trainees who were unable to attend the initial dates. The on-call rota was covered during induction and an induction handbook was sent to trainees before they started their post. The Acute Medicine trainers provided a departmental induction that included a tour of the Combined Assessment Unit and training on how to use the Trak Care and Athena systems. The Acute Medicine team confirmed they were also planning to develop video tours to post on the local intranet site, for trainees to view should they miss the original tours.

**Foundation Trainees:** All trainees present had received hospital/site induction. A pre-induction session was organised for trainees as an introductory day to the site before the official induction. The trainees noted their experience of the shadowing period provided as good. Clinical support for trainees in their first week was felt to be variable and they advised that a list of pager numbers for their consultant colleagues would have been helpful.

Trainees experience of departmental induction was more variable than site induction. The Endocrinology and Diabetes department and Renal departments were noted as providing good induction whilst other departmental inductions were less comprehensive. The trainees in Infectious Diseases highlighted they were not introduced to the nurses and other non-medical colleagues in their department. Trainees felt access to clinical guidelines or protocols would be an improvement to induction.
Core Medicine Trainees: All trainees present had received hospital/site induction, which included all relevant IT passwords, ID badges and covered the hospital out of hours and escalation policies. Trainees thought induction could be improved by providing more information on logistical and practical workings of the Medicine department such as how to order bloods. Once the hospital induction was finished it wasn’t clear to trainees whether they should report to their base wards, some trainees went to their base ward but found no consultants present. The trainees felt communication around this could have been better. Trainees confirmed departmental induction to the various Medicine departments as good, Endocrinology and Diabetes, Gastroenterology, Renal Medicine and Acute Medicine were highlighted by trainees as providing a good standard of departmental induction. These departmental inductions included the provision of handbooks, clinical guidelines and introductions to ward colleagues both medical and non-medical. One consultant was reported to have cancelled clinics to support induction.

General Practice Trainees: All trainees present had received hospital/site induction, which included all relevant IT passwords, ID badges and covered the hospital out of hours and escalation policies. Although they described hospital induction as good, not everyone received ward induction and those who did felt ward inductions could be more thorough as some were not introduced to their ward colleagues (medical/nursing) and felt unclear about their roles and responsibilities.

Specialty Trainees: All trainees present had received hospital/site induction although a trainee present had difficulty obtaining appropriate IT logins/passwords. Departmental induction was again variable for trainees. Trainees in Respiratory Medicine advised they didn’t get any departmental induction. The induction to Acute Internal Medicine (AIM) comprehensive and was valued highly by trainees: it included a tour including the layout of CAU (Clinical Assessment Unit), handover arrangements, the white board system and the roles and responsibilities of how to arrange investigations. The AIM handover was run twice to include those who missed out on the first run.

Nursing and Non-Medical Staff: Nursing staff felt the induction provided for the trainees was effective in preparing them for their roles. The CAU induction was highlighted as was the Renal department in providing good departmental induction.
3.2 Formal Teaching (R1.12, 1.16, 1.20)

Trainers: The trainers confirmed local teaching was provided to trainees on Monday mornings, which covered in/out patient case studies. General Internal Medicine teaching was provided on Wednesdays at 1.00 pm, at these sessions the consultants would organise, and trainees would generally present cases for discussion, these sessions were not bleep free. Acute Internal Medicine teaching was delivered on Thursdays and FY1 teaching was provided on Tuesday’s at lunchtime and was interruption free. Medical Education meetings took place every alternate Friday, but trainers acknowledged it was not always practical for trainees to attend due to weekend pressure and changeovers for nights, but no other day was felt to be suitable for it. A video link to the Royal College of Physicians of Edinburgh teaching session was provided in the evenings. General Practice specific sessions were organised every few months which was a half-day session that was delivered by speakers from various specialties. The trainers were monitoring how often trainees were interrupted by their pagers during teaching sessions and felt they tried to protect trainee attendance at teaching as much as possible.

Foundation Trainees: Trainees attended local FY1 teaching at Tuesday lunchtime and were also able to attend the General Medicine teaching sessions provided on Wednesdays and were delivered by consultants and some by Pharmacists. Trainees estimated they could get to 1 hour of teaching per week. Trainees felt the timing of teaching on some topics could be better. The trainees perception was that around 50% of the sessions were Pharmacy based and they would benefit from more clinical scenario-based teaching. Trainees did not report any issues with access to regional teaching.

Core Medicine Trainees: Trainees confirmed local teaching was provided on Wednesdays at lunchtime and each speciality would take turns at delivering sessions each week. Trainees found it difficult to attend the teaching due to ward pressures and they would often find that communication around sessions could be poor and as a result, sessions could often be poorly attended. Acute Medicine teaching was provided on Thursdays which was open to trainees from all specialties but was mostly attended by trainees based in Acute Medicine. There is also a Grand Round on alternate Friday afternoons.

Regional teaching (Core Medical Education Programme COMEP) was also difficult for trainees to attend due to the rolling rota and trainees would use rest days to attend regional teaching.
Attendance at the regional COMEP teaching was through a video link as trainees found it difficult to attend in Glasgow in person and there were also issues with the video link which worked sporadically.

**General Practice Trainees:** Trainees could attend local departmental teaching on Tuesday and Friday afternoons and were able to attend the General Internal Medicine sessions that took place on Wednesdays. Although trainees could attend teaching, they were required to carry their pages with them and were sometimes called back towards from sessions. They estimated they were able to attend around 2 hours of teaching sessions per week. One had participated in simulation training. They had no concerns about getting to their General Practice regional teaching.

**Specialty Trainees:** General Internal Medicine teaching took place on Wednesdays at lunchtime. Responsibility for delivery rotated around the various Medicine departments. Trainees felt it was difficult for them to get to teaching due to workload pressures and estimated they were only able to attend around 20/30% of sessions provided. Some trainees were rarely able to attend these sessions. Attendance was not ‘bleep free’. Trainees averaged they got to around 45 minutes' worth of teaching per week. Trainees in Acute Internal Medicine attended more sessions due to departmental teaching provided for them (Thursday weekly and jointly with Emergency Medicine), they estimated attending around 90 minutes of teaching per week. The AIM weekly sessions included regular Morbidity and Mortality (M&M) meetings.

**Nursing and Non-Medical Staff:** Not covered.

### 3.3 Study Leave (R3.12)

**Trainees:** Trainers were unaware of any issues with trainees being able to obtain study leave, if appropriate notice period was given by them.

**All trainee cohorts:** No concerns were reported by trainees in getting study leave approved.

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

**Trainees:** As soon as the names of the new trainee cohorts were provided by the deanery, Educational and Clinical Supervisors were allocated to them and the trainees were e-mailed confirmation of who would be supervising them before they started their post. Trainers tried to ensure
they kept continuity for supervision by ensuring where possible the same supervisor kept responsibility for a cohort of trainees each year. Trainers confirmed it was unusual to receive any information of trainees with known concerns before they started their post, bar the occasional phone call.

**Foundation Trainees:** The trainees present had all been allocated Educational Supervisors and had initial meetings with them. Foundation trainees are also noted their Educational and Clinical Supervisor to be the same person. Trainees confirmed they had learning plans in place and felt their initial meetings to be useful.

**Core Medicine Trainees:** All trainees present had been allocated Educational Supervisors and had initial meetings with them and had learning plans in place. Trainees had also been allocated Educational Supervisors.

**General Practice Trainees:** Trainees had been allocated Educational Supervisors (who were based in GP practices) and were able to meet with them on a regular basis through use of study leave. They were also in regular contact with them through e-mail.

**Specialty Trainees:** Trainees had been allocated Educational Supervisors and had met with them, although some felt their supervisor’s knowledge of the curriculum was lacking.

**Nursing and Non-medical Staff:** Nursing staff advised trainees could access senior support whenever they required it. The CAU was noted as having lot of senior staff around on a regular basis that were accessible to trainees.

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

**Trainers:** Trainers maintained responsibility for the same cohorts of trainee each year, this ensured they maintained familiarity with the curriculum and they advised they tried to map the training experience to their specific curriculum outcomes. Trainers felt it could often be difficult for the trainees to maintain balance between their time spent developing as a doctor and non-educational activities, they noted vacancies in the Phlebotomy service meant they often had to support the service by taking bloods or completing blood forms. A working group was currently looking into addressing this issue.
**Foundation Trainees:** Trainees felt they received a good standard of training and all felt they will be able to achieve their curriculum competences. Some practical procedures were noted as being more difficult than others to get but trainees thought they would get them over the course of the training year. Outpatient clinics were planned into the rota for FY2 trainees, but one hadn’t been to any yet. Trainees noted an imbalance in the time spent doing non-educational tasks such as writing referral letters or completing blood forms as opposed to time spent developing as a doctor. Trainees confirmed the Phlebotomy service was down to around 80% of its usual staffing which meant the FY1 trainees were supporting the service and the situation at weekends was described as worse than during the week.

**Core Medicine Trainees:** Trainees at CT2 level found it difficult to get procedures completed and signed off and felt they were not going to meet their curriculum requirements. This was felt to be due to workload pressures was something they had raised locally with hospital management. Experience of procedures for CT1 trainees was easier to get as there appeared to be less workload pressures for these trainees. A pager has been introduced to notify trainees of opportunities to undertake procedures. Clinics were planned into the rota for CTs and access to them was good. Time spent doing activities of non-educational value varied across the Medicine specialties, trainees in Renal Medicine noted the hospital winter admissions meant they spent most of their time looking after medical boarded patients which they felt affected their ability to learn any new skills.

**General Practice Trainees:** Trainees felt the posts they were in provided a good learning experience. Sign off for some workplace-based assessments required an ST4 or more senior to sign them off and this could be difficult for trainees to get as most of the higher trainees at the hospital were ST3 level. Trainee felt an improvement to their training would be to get clinic experience from other specialties. Trainees we able to get to clinics but the numbers accessed ranged between 2 – 15+ over 5+ months and it could sometimes be difficult due to staffing on the wards. They felt the balance of service provision verses training to be good and to be around 80% training/20% service. Trainees highlighted the input of the ‘GP champion’ (who organised training opportunities for GP trainees and tailored opportunities to needs) as very positive. One trainee was very positive about the opportunity to perform endoscopy.

**Specialty Trainees:** Trainees reported good exposure to general medicine. Doctors in acute medicine training reported very positive experiences including of ‘acting up’. Other than Acute
Medicine trainees, out of hours, higher trainees cover the ‘back of hospital’. Their role attracts little to no feedback to inform their learning. There is also lack of HDU opportunities. Most struggle to get out-patient clinic experience and when they do they tend to sit in with the consultant rather than seeing and assessing patients. Clinic access in gastroenterology and nephrology is better. Respiratory is reported to carry a particularly heavy workload of boarders with need for ‘safari ward rounds’. Overall they assessed their ration of service:training generally as 70:30 with the ratio in Cardiology slightly better at 50:50

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

Trainers: Trainers were aware of what assessments trainees were required to complete as per their curriculum requirements. They noted Acute Care Assessment Tools (ACATs) as the most difficult assessment for trainees to complete. They had implemented changes to the ward round structure to try to focus on the cases trainees could use for these assessments. They noted some trainees to be more pro-active than others in seeking out support for assessments.

Foundation Trainees: Trainees were able to complete their workplace-based assessments and did not note any concerns in obtaining them. They felt the assessments they completed were fair and consistent.

Core Medicine Trainees: Trainees thought they would be able to meet the minimum required workplace-based assessments required by their curriculum. They noted Acute Care Assessment Tools (ACATs) as difficult to get. This had been escalated to the Junior Doctors Forum. They confirmed the assessments they did complete were fair and consistent.

General Practice Trainees: Trainees were able to complete their workplace-based assessments (noting the challenges of their need to have sign off by ST4+ trainees or trained staff) and did not note any concerns in obtaining them. The assessments were felt to be fair but were reported to lack detail.

Specialty Trainees: Trainees felt workplace-based assessments were difficult to get completed (especially ACATs) and signed off. The workplace-based assessments they did complete were felt to
be fair and consistent.

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

**Trainers:** Multi-professional learning took place through simulation sessions which the trainees attend along with their nursing colleagues. Nursing staff were also encouraged to attend the monthly combined divisional meeting. Various departments within Medicine also conducted departmental meetings, which all team members attended.

**All trainee cohorts:** Trainees noted most teaching sessions delivered by Pharmacy and Acute Medicine as multi-disciplinary (MDT) but were not aware of any other opportunities.

**Nursing and Non-Medical Staff:** The pharmacists present ran a programme of Pharmacy based education and provided weekly teaching sessions which all members of the multi-disciplinary team could attend. Other forums for multi-disciplinary learning included the monthly M&M meetings.

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

**Trainers:** Trainers felt they actively supported trainees to undertake quality improvement projects and the trainees had also formed a Quality Improvement group amongst themselves.

**Foundation Trainees:** Trainees felt there were opportunities to engage in quality improvement or audit projects but of the trainees present, none had started any yet.

**Core Medicine Trainees:** Trainee experience of opportunities to engage in audit or quality improvement projects was variable, some trainees were able to. It was reported that there is, however, a rolling list of QI projects. A trainee noted difficulty to get approval for a project around the appropriateness of medication provided to discharged heart failure patients because they were asked to write to formally obtain approval from the R&D committee and the project never came to fruition. Another was engaged in a QI project to address concerns about access to procedures.

**General Practice Trainees:** Trainees not currently engaged in quality improvement or audit projects.
**Specialty Trainees:** Trainees felt the environment provided good opportunities for audit or quality improvement projects, but the time needed to conduct them was very difficult to get.

**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 maintained responsibility for cohorts of trainees each year which ensured familiarity with the curriculum. Staff were able to differentiate between different grades of trainees through colour coded badges which were supported by posters confirming the grade of trainee and level of responsibility. These were visibly posted around the hospital. Trainees were informed of how to contact senior colleagues for support at induction, this information was also provided in the induction handbook that was distributed to them. Trainers confirmed that contact details of consultants were displayed on the white boards in each ward.

**Foundation Trainees:** Trainees felt they had access to senior support both during the day and in the out of hours period. They did not note any instances of having to cope with problems beyond their competence or experience. Trainees noted their consultant colleagues to be accessible and approachable. Trainees confirmed they would only seek consent from patients for blood transfusions.

**Core Medicine Trainees:** Trainees felt they had access to senior support both during the day and in the out of hours period. An incident at September weekend was highlighted when they were not told about known gaps in the rota due to sick leave and a trainee was expected to provide cover for 40+ medical patients and had to cover the High Dependency Unit. They reported the perception that if someone doesn’t turn up you are just expected to get on with it. In general they felt isolated at night and described the senior support on night shifts as variable.

**General Practice Trainees:** Trainees could access clinical supervision when they required it both during the day and in the out of hours period. They did not report any instances of having to work beyond their competence and felt their consultant colleagues to be supportive and approachable.

**Specialty Trainees:** Trainees could access clinical supervision when they required it both during the day but support in the out of hours period was described as variable and dependent on which consultant was on-call. Trainees again felt isolated when working nights and described the workload as very intense.
Nursing and Non-medical Staff: The nursing and non-medical staff present seemed unaware of the coloured badge system that was in operation within Crosshouse and had not seen any of the posters the were posted around the hospital. The nursing staff differentiated between the different grades of trainee by asking them directly.

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

Trainees: Trainers confirmed feedback was provided to trainees on a regular, informal basis and after ward rounds.

Foundation Trainees: Trainees felt feedback was more freely available to them during the day (from more senior trainees) than feedback in the out of hours period. In the out of hours period the trainees advised they saw more acute medicine cases but received no feedback on their input to these patients' management plans. Any feedback they did receive was felt to be constructive and meaningful.

Core Medicine Trainees: Trainees felt they did not receive feedback on a regular basis; they estimated they receive feedback on 13-20% of their overnight acute medical caseload but can direct which patients are chosen for feedback. They often got feedback by reading the patient notes after a post take ward round.

General Practice Trainees: Trainees advised they did receive feedback. Although informal, it was often conducted during or after ward rounds and was felt to be useful and often initiated teaching. More formalised feedback in Workplace Based Assessments (WBAs) was scant.

Specialty Trainees: Trainees felt feedback was more freely available to them during the day than in the out of hours period. Out of hours there was little interaction with consultant. They expressed the view that ‘terrible things could happen and you would never know’. Consultant feedback was generally felt to be variable in how constructive it was for the trainees. Some trainees were unaware of how they were progressing as a result of receiving little feedback. Trainees in Acute Internal Medicine described more regular real time feedback.
3.11. Feedback from trainees (R1.5, 2.3)

Trainers: Trainees were able to provide feedback on their learning experience through the trainee forum. In the various Medicine departments, trainees had opportunities to provide feedback at departmental meetings. The trainers in Infectious Diseases noted a written a feedback form which the trainees could complete and submit and changes to practice could be implemented as a result of them.

Foundation Trainees: Trainees were aware of the trainee forum, but none present had attended any of the meetings so far. They were unaware of any other opportunities to provide feedback aside from the forum.

Core Medicine Trainees: Trainees could provide feedback to trainers and management through the monthly junior doctors’ forum. Trainees would contact each other through WhatsApp if they were unable to attend and wanted something raised on their behalf. A recent example of a concern being raised and addressed was around trainee attendance at clinics, now clinics were planned into the rota for CMTs and attendance monitored.

General Practice Trainees: Trainees were aware of the trainee forum and who their Chief Resident colleagues were. Any feedback they wanted to provide on their training they would be happy to do so through the forum. Minutes of the Junior Doctors forum meetings were reported to be shared with trainees.

Specialty Training: Trainees described tensions between clinicians and bed managers that had potential to impact on patient care overnight. They highlighted their concerns at the junior doctor forum but did not feel their concerns were addressed. They described the junior doctors’ forum as only having clinical staff present and thought it should also include hospital management staff present to discuss and resolve issues. Chief Residents had been appointed in November 2018.

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

Trainers: The trainers advised the rota was structured in tiers and effort was made by the various departments within Medicine to tailor the rotas to the learning outcomes the trainees require to meet
their curriculum requirements. The trainers did not feel there were rota issues that would affect patient safety or training.

**Foundation Trainees:** Trainees advised workload was high and how manageable their rota could be would vary from week to week. Trainees in Respiratory noted they often did not finish on time and the system for boarding respiratory patients often meant that patients were boarded across 4 or 5 different wards. This meant the trainees were stretched to cover these wards as well as the patients in their own ward. They weren’t clear why Respiratory appeared to have a disproportionate share of boarded patients. Trainees felt their rota was more manageable in the out of hours period. The trainees noted that they covered the Clinical Assessment Unit (CAU) for a week which was a very high intensity period of work for them. The pattern of the shifts in the CAU which involved 2 days of night shift followed by a day shifts and then into nights again was not thought to be conducive to their well-being. The trainees felt an improvement to the rota would be to align their start/finish times with handover; this has been raised at the junior doctors’ forum, but the trainees were unaware of what progress had been made.

**Core Medicine Trainees:** Trainees reported their rota during the day Mon-Fri was manageable. The out of hours rota was much less manageable. The trainees felt night shifts were probably unsafe (but did not report examples of harm) and they often came onto shift into a backlog of up to 25 patients and estimated up to 50 patients could present overnight. The trainees felt most of their training experience was gained during night shifts.

**General Practice Trainees:** Trainees felt their rota to be manageable both during the day and out of hours. Trainees did not feel there were any patient safety issues with their rotas, but they did advise the rota was very tight and it could become difficult if there was any sick leave and or if you wanted to take annual leave. This could often be managed amongst the trainees themselves but an improvement to the rota would be to increase the number of middle grade level staff in the hospital.

**Specialty Trainees:** Trainees described their rota as exhausting and workload as very high. Overnight the trainees cover the ‘back of hospital’, HDU and CCU, looking after unwell patients rather than managing the acute medical receiving cases.
**Nursing and Non-medical Staff:** The nursing and non-medical staff described awareness of gaps/vacancies in the rotas and these often being identified only at the last minute and expressed concern that cover for these vacancies had not been arranged by administrative staff who did not appreciate the clinical risk in the gap not being filled. Staff described known gaps in the rota that cover arrangements were not made for.

3.13. **Handover (R1.14)**

**Trainers:** Trainers confirmed handover took place at 9.00 am, 5.00 pm and there was a formal evening handover to the night team. At the weekend electronic handovers were conducted through TrakCare and plans were in place to extend the use of TrakCare to handover during the week.

**Foundation Trainees and Core Medical Trainees:** Trainees advised handover took place in the morning at 9.00 am, in the early evening at 5.00 pm and the handover to the night team at 9.30 pm. During the week the 9.00 am handover was formalised and a representative from each Medicine team attended (usually the FY1) and would then feedback to their own team. The other handovers (5.00pm and 9.30 pm) were less formalised and conducted verbally.

**General Practice Trainees:** Trainees reported handover to take place in the morning, late afternoon and the evening each day and was generally recorded electronically on the patient management system. The day shift – night shift however was paper based. Trainees advised morning handover was led by a consultant colleague, representatives from each medicine department attended as well as nursing colleagues, attendance is monitored and audited. The weekend handover was recorded electronically on the patient management system.

**Specialty Trainees:** Trainees felt handover to be safe and effective. The described morning 9.00 am handover and 9.30 pm handover to be more formalised than the early evening 5.00 pm handover. Although they felt it to be safe, they did not view handover as a learning opportunity.

**Nursing and Non-Medical Staff:** Handover was felt to be effective and particularly the morning handovers could be educational. The CAU handover was described to be very thorough and took place 3 times per day, in the morning, lunchtime and in the evening.
3.14. Educational Resources (R1.19)

Trainers: Trainers confirmed trainees have access to a library and access to it was available in the out of hours period. Trainees will also able to participate in ward simulation training.

All Trainee Cohorts: Trainees advised IT was very poor in the hospital, (other than in CAU) laptops were either very slow or the battery life was so poor they were unusable unless they were plugged in. They also noted a shortage of ward phones and described WIFI as slow, most clinical websites also appeared to be blocked by the board’s firewalls. The need for multiple logins was noted to be another frustration. Doctors rooms were available only in some wards but not in all the medicine wards. An electronic prescribing system was in use which the trainees highlighted as very good.

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 could raise concerns through Datix if they had concerns related to patient safety. In Acute Internal Medicine they also operated a written feedback form system, in which trainees can submit written feedback forms to a box, which is then reviewed by a consultant and the cases were discussed at Morbidity and Mortality meetings.

Foundation Trainees: Trainees named Sandra Hodgson (Post Graduate Administrator) as a colleague who was very supportive of their training and education needs. They were unaware of who to contact if they were to go off on sick leave and trainees felt this was even more unclear in the out of hours period. Of the trainees present, none were working less than full time hours or had been out of programme and returned from a career break.

Core Medicine /General Practice/Specialty Trainees: Trainees had no concerns with receiving support if they required it. None of the trainees present were less than full time or had returned from career breaks.

Nursing and Non-Medical Staff: Not covered.
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 junior forum as the main forum for trainees to raise any concerns around the quality of education and training they are receiving. An email would then be sent to all trainees with a summary of the discussion and a list of actions from the forum. The actions (depending on what they are) can escalated to a service manager, clinical director or DME depending on the nature of them. Not all consultants will attend the forum, but it was chaired by the chief resident. Consultant representation was provided by the various departments within Medicine. The trainers also noted the National Training Survey and the Scottish Training Survey as other feedback sources.

Foundation Trainees: Trainees were unaware of how the quality of their education was managed but noted Dr McKenzie as their contact for the trainee forum. Trainees reported unawareness of who their Chief Resident was.

Core Medicine Trainees: Trainees highlighted the Director of Medical Education as being responsible for their education and training. Trainees felt involved in the process by way of the trainee forum.

General Practice Trainees: Trainees were unsure of how quality was managed and who was responsible for it.

Specialty Trainees: Not covered.

3.17 Raising concerns (R1.1, 2.7)

Trainers: Not covered.

Foundation Trainees: Trainees would raise any concerns about patient safety either through Datix or with their Senior Nurse colleagues.

Core Medicine Trainees: Trainees reported two ‘near misses’ that they had reported to the CD who suggested submitting these to Datix; feedback had been received by the trainees involved in reporting them. Trainees felt there was a robust process in place for managing adverse incidents. For
any concerns about their own education and training, trainees felt comfortable discussing them with either their consultant colleagues or chief residents for escalation through the trainee forum.

**General Practice Trainees:** Trainees would raise any concerns about patient safety through Datix and if they had any concerns about their own education and training they would raise them with their Educational Supervisor.

**Specialty Trainees:** Trainees would report patient safety concerns through Datix and felt they would be addressed and that they would receive feedback. Learning from Datix incidents was discussed at Acute Medicine’s M&M meetings, which the trainees were able to attend. If they had any concerns about their own education and or training, they would raise them with a consultant colleague or supervisor.

**Nursing and Non-medical Staff:** Staff felt a culture existed where concerns were regularly raised and discussed openly, mainly at the nursing huddles. Concerns could be raised either with Consultant colleagues or could be logged more formally through Datix.

### 3.18 Patient safety (R1.2)

**Foundation Trainees:** Trainees would be concerned about patient safety in some of the wards within medicine. They described the 5th floor of the hospital as a boarders’ ward which had Renal, Geriatric and Respiratory patients accommodated on it. The ward was described as having “too many” patients in it, “no consistency of patient care” and with no consultant or team responsibility for the ward itself. The trainees felt this was not a seasonal issue that was caused by the winter pressures and had been the case since they started their posts in August 2018. The trainees did not describe any concerns around patients being boarded out to other wards from the Clinical Assessment Unit without a consultant review.

**Core Medicine Trainees:** Trainees in general would not have any concerns about the quality or safety of patient care if a friend or relative was admitted to the hospital. They expressed some concerns around the consistency of consultants’ engagement. Trainees described concerns with the care boarded patients received. A boarded patients list had been created and was e-mailed around
everyone. It was generally accurate for tracking where boarded patients are (~90% of the time). Trainees estimated a boarded patient receive consultant review every 1 or 2 days

**General Practice Trainees:** Trainees in general would not have any concerns about the quality or safety of patient care if a friend or relative was admitted to the hospital although they had some concerns over waiting times for initial assessment. Trainees were unaware of any instances of medical patients being boarded to other wards from CAU without a consultant review. They advised the boarding process was now more specific and organised.

**Specialty Trainees:** Trainees reported concerns about the safety and care of patients in medicine if they were admitted after 5.00 pm: they described the staffing of the hospital after this time as ‘unsafe’. Concerns were expressed about the autonomy of bed managers in moving patients. Some wards were described as boarding wards that were said to have no clear leadership by either medical or nursing staff. The interface between the Emergency Medicine department and Medicine was described in very challenging terms.

**Nursing and Non-medical Staff:** The nursing staff had concerns around the number of outlying boarded Medicine patients, they described the trainees’ caseloads as very high. Staffing during the day in the hospital was thought to be adequate but after 5.00 pm the number of staff clerking patients in was reduced to 3. This was felt to have an impact on both the assessment of these patients and potentially their safety. Inappropriate boarding was also a concern for Nursing staff and sometimes it is not always clear why a patient was boarded to a specific ward. Although there were some concerns around boarding in Medicine, it was now virtually never the case that a patient would be boarded from CAU without the review of a consultant. Concerns again were raised around the challenging interface between the Emergency Medicine and Medicine departments in the hospital.

3.19 **Adverse incidents (R1.3)**

**Foundation Trainees:** Trainees would report any adverse incidents through the Datix system, a trainee present had submitted a Datix report but had not received any feedback on it.
Core Medicine Trainees: Of the trainees present, 3 had submitted Datix reports. Trainees received feedback on them but were not aware of any group learning from Datix feedback (such as Morbidity and Mortality meetings).

General Practice Trainees: Trainees would report any adverse incidents through the Datix system, they had not submitted any reports in their current posts. Trainees were unaware of any group learning around Datix incidents and had not attended any M&M meetings.

3.20 Duty of candour (R1.4)

Foundation Trainees: Trainees felt they would be supported by their consultant colleagues if they were involved in an incident where something went wrong. There were no reported incidents by trainees in the group.

Core Medicine Trainees: Trainees felt they would be supported if they were involved in an incident where something had gone wrong. A trainee had submitted a Datix report around concerns they had over a consultant’s care plan for a patient, the trainee received feedback on this and felt they received adequate support in how it was addressed.

General Practice Trainees: Trainees felt they would be supported by their consultant colleagues if they were involved in an incident where something went wrong. There were no reported incidents by trainees in the group.

3.21 Culture & undermining (R3.3)

Foundation Trainees: Trainees felt they had a good relationship with their consultant colleagues and described a very supportive environment within Medicine. An instance of an interaction a trainee had with a consultant Radiologist was mentioned, the trainee reported this to their base ward consultant who became involved in resolving the issue. The Foundation trainees described this as incident as a regular occurrence in their interactions with Radiology consultants.

Core Medicine Trainees: Trainees advised that 60% of consultants were very approachable and ‘really helpful’ and that the ‘good consultants are really good’.
General Practice Trainees: Trainees felt they had a good relationship with their consultant colleagues and described a very supportive environment within Medicine. No incidents of undermining or bullying behaviours were reported.

Specialty Trainees: Trainees reported their relationships with their clinical teams and consultant colleagues within medicine were good. A specific undermining incident at the Emergency Medicine – Medicine interference has been reported and addressed. The trainees felt the interface between Emergency Medicine and Medicine was challenging.
4. Summary

<table>
<thead>
<tr>
<th>Is a revisit required?</th>
<th>Yes</th>
<th>No</th>
<th>Highly Likely</th>
<th>Highly unlikely</th>
</tr>
</thead>
</table>

The visit panel found several positive initiatives are taking place in University Hospital Crosshouse, most notably the weekend handover which is now recorded on TrakCare and the appointment of a GP training champion. A previous serious concern regarding the boarding of Medicine patients from CAU without consultant review appears to have been addressed. Although the visit panel acknowledges the above-mentioned improvements to the training environment, several of the previous visit requirements appear to have not been addressed, one of which was highlighted by the General Medical Council during their national visit to Scotland in 2017.

This was a major concern of the visit panel and merits further discussion between Professor Alastair McLellan and GMC colleagues which may produce further requirements or recommendations. The requirements identified at the last visit (inclusive of GMC requirement 2) that appear to have not been addressed are as follows:

**GMC National review of Scotland – NHS Ayrshire and Arran requirement 2:**
- NHS Ayrshire & Arran must design rotas that provide learning opportunities which allow learners to meet the requirements of their curriculum.

**Requirements from March 2018 not addressed:**
- Access to out-patient clinics for FY/GPST/ST trainee cohorts must be provided.
- The burden of non-medical tasks trainees are expected to undertake that have no educational value should be reduced. In particular the need for many doctors in training to write “blood forms” must be removed.
- IT hardware must be sufficient – in terms of availability and speed and efficiency to facilitate the work and training of the doctors in training. All perceive IT to be a barrier to efficient working.
The trainees rated their overall satisfaction with their training out of 10 and the results were as follows:

Foundation Trainees score between 6 – 8 out of 10 with an average of 6.
Core Medicine Trainees scored between 4 – 7 out of 10 with an average of 6.
General Practice Trainees scored between 6 – 9 out of 10 with an average of 7.5.
Specialty Trainees scored between 4 – 7 out of 10 with an average of 6.

The positive aspects of the visit were:

- Junior doctor forum – doctors in training value it and reported changes that had come about following raising of issues at the JDF.
- Weekend handover – managed through TrakCare.
- Good range of provision of formal educational meetings but access to these is difficult for many trainees.
- GP training champion
- Acute Medicine – excellent training environment – good induction, good supervision, overall provides an excellent package of training.
- Sandra Hodgson (Post Graduate Administrator) – named by every cohort of trainee as very supportive of their education and training needs.
- Electronic prescribing system
- CMTs’ rostered access to clinics

Note: the serious concern identified by GMC during their visit to UHC – Medicine as part of their national review of Scotland in 2017 relating to the boarding of patients from CAU to non-medical beds without consultant review has been fully addressed, and the solution appears sustainable.

The less positive aspects of the visit were:

- Workload – intensity and staffing, in particular OOH with concerns around the safety of the system. Also implications for training and concern that Requirement 2 (NHS Ayrshire & Arran must design rotas that provide learning opportunities which allow learners to meet the requirements of their curriculum) set by the GMC following their visit in 2017 has not been addressed.
• Lack of feedback to inform the learning of FY, Core and GP doctors in training in relation to their management of acute medical admissions. Lack of feedback also to inform learning of higher doctors in training in relation to their management of their patients OOH.
• Boarding – impact on workload and selection of patients for boarding.
• IT provision – number of computers including laptops, poor battery life of laptops, multiple logins, speed and Wifi access.
• Dominance of non-educational tasks impacting on FY and Core trainees especially phlebotomy and blood form administration (although we heard there is a working group looking at the latter).
• Lack of rostered access to clinics other than CMTs (who have this currently).
• Relationships at the Emergency Medicine – Medicine interface.
• Departmental induction is variable – some very good, others not so good or absent.
• Radiology – process for requesting investigations is inefficient and time-consuming.
• Access to workplace-based assessments for trainees can be difficult (ACATs in particular)
• MDT learning from Datix incidents – (FY/CMT/GPSTs) were unaware of any group learning around Datix incidents/reports at M&M meetings. They didn’t appear to have had the opportunity to attend M&M meetings.

5. Areas of Good Practice
### Areas for Improvement

<table>
<thead>
<tr>
<th>Ref</th>
<th>Item</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>Acute Medicine as a training environment, good induction, good supervision, overall an excellent package of training.</td>
<td></td>
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<tr>
<td>5.2</td>
<td>GP training champion</td>
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<table>
<thead>
<tr>
<th>Ref</th>
<th>Item</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1</td>
<td>The process for requesting Radiology investigations should be improved to remove the inefficient and unnecessary need for doctors in training to negotiate (not necessarily successfully) for Xrays and scans to be done.</td>
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<td>6.2</td>
<td>Access to group learning from Datix incidents should be improved. The scope of attendance at Morbidity and Mortality meetings should be opened to Foundation, Core and GP trainees, only the Specialty trainees appear to be aware of and attend the meetings regularly.</td>
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</tbody>
</table>

7 Requirements - Issues to be Addressed:
<table>
<thead>
<tr>
<th>Ref</th>
<th>Issue</th>
<th>By when</th>
<th>Trainee cohorts in scope</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1</td>
<td>The Board must design rotas to provide learning opportunities that allow doctors in training to meet the requirements of their curriculum and training programme.</td>
<td>20th November 2019</td>
<td>FY, CT, GPST, ST</td>
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<td>7.2</td>
<td>A process for providing feedback to FY, CMT and GPSTs on their input to the management of acute cases must be established. Higher trainees must similarly receive feedback on their out of hours work (whether 'back of hospital' or acute medical receiving).</td>
<td>20th November 2019</td>
<td>FY, CT, GPST, ST</td>
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<td>7.3</td>
<td>The Board must make sure there are enough staff members who are suitably qualified to manage the workload generally. There is also a need to address the additional workload associated with the selection and assessment of medical boarders.</td>
<td>20th November 2019</td>
<td>FY, CT, GPST, ST</td>
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<td>7.4</td>
<td>The Board must provide sufficient IT resources to enable doctors in training to fulfil their duties at work efficiently and to support their learning needs.</td>
<td>20th November 2019</td>
<td>FY, CT, GPST, ST</td>
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<td>7.5</td>
<td>The burden of tasks for all cohorts of doctors in training that do not support educational or professional development and that compromise access to formal learning opportunities must be significantly reduced.</td>
<td>20th November 2019</td>
<td>FY, CT, GPST, ST</td>
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<td>7.6</td>
<td>Appropriate outpatient clinic training opportunities must be provided for FY2s, GPSTs &amp; ST3+ trainees (in addition to current provision for CMTs).</td>
<td>20th November 2019</td>
<td>FY, CT, GPST, ST</td>
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<td>7.7</td>
<td>Relationships at the Emergency Medicine – Medicine interface must be improved.</td>
<td>20th November 2019</td>
<td>FY, CT, GPST, ST</td>
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<td>7.8</td>
<td>Departmental induction must be provided which ensures all trainees are aware of all of their roles and responsibilities and feel able to provide safe patient care</td>
<td>20th November 2019</td>
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