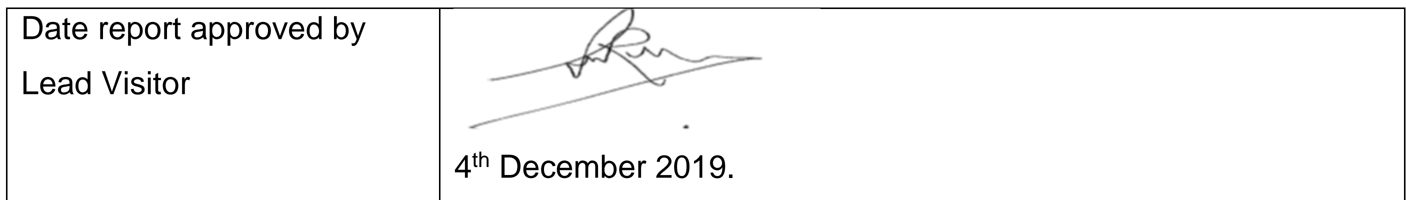
Scotland Deanery
Quality Management Visit Report

Date of visit	6th November 2019	Level(s)	FY/CMT/IMT/GPST/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
Robin Benstead	GMC Visits & Monitoring Manager
Archie Glen	Lay Representative
Dr Nick Dunn	Associate Postgraduate Dean – Quality
Dr Jim Hall	GMC Representative
Alex McCulloch	Quality Improvement Manager
Dr Vinodh Devahkumar	College Representative
Dr Yatin Patel	Foundation Representative
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 Reem Al-Soufi Dr Alan McKenzie
Quality Improvement Manager(s)	Alex McCulloch Heather Stronach
Unit/Site Information	

Non-medical staff in attendance	7									
Trainers in attendance	9									
Trainees in attendance	7 FY1	1 FY2	2 GPST	2 CMT & 1IMT		2 ST				
Feedback session: Managers in attendance	Chief Executive	X	DME	✓	ADME		Medical Director	✓	Other	Foundation Programme Director and General Manager for Medicine

Date report approved by Lead Visitor	 4th December 2019.

1. Principal issues arising from pre-visit review:

University Hospital Ayr (UHA) has been under the General Medical Council's (GMC's) enhanced monitoring process since November 2016. Conditions set by the GMC were also added in August 2018 following further deterioration in the training environment. It was last visited by the deanery in November 2018 for an enhanced monitoring re-visit.

At the last visit, the visit panel found a significantly improved training experience was being offered to trainees and only 1 requirement was generated as a result of the visit:

- There must be a policy in place that trainees are aware of, regarding the selection of patients who are potentially suitable for boarding.

The GMC conditions imposed in association with the ongoing enhanced monitoring are as follows:

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

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

The aim of the visit team was to investigate the issues previously highlighted and be informed of progress made towards their resolution. The visit team also used the opportunity to regain a broader picture of how training is carried out within the department visited and to identify any points of good practice for sharing more widely.

2.1 Induction (R1.13):

Trainers: Trainers felt the induction provided to trainees was comprehensive and effective in preparing the trainees to work at UHA. Induction was a full day which was split between site and departmental induction. A number of catch up induction sessions were run for trainees who started on nights or were on leave at changeover. Logins to electronic systems were provided to trainees by the postgraduate administrator on their first day in post. Trainers felt induction had improved this year and ward cover was provided for them to attend and deliver it, by advanced nurse practitioners (ANPs). An induction app was in the later stage of development at the time of the visit and it was due to go to pilot shortly.

Foundation Trainees: All trainees present had received induction both to site and department and felt induction to be of a good standard. Shadowing had worked well.

General Practice Trainees: Trainees present had received induction. They confirmed that induction was split ½ day site and ½ day department and although it was comprehensive, more information could be provided regarding the running of the medicine wards at weekends, i.e. a "who does what" guide. Trainees reported they were unsure of what the responsibilities were for those designated 1st or 2nd on-call. Not all received their IT usernames and passwords upon starting and didn't have access to an electronic white board system.

Core Medicine and Internal Medicine Trainees: Trainees present had all attended induction and felt it to be of a good standard, they had received usernames and passwords for IT systems and lots of mandatory e-learning but had difficulties accessing some of the clinical systems which took a while to resolve. Trainees described site and departmental as being split with them being provided with a half day of each, although not all trainees had received departmental induction. They reported that a catch-up induction was available for those who missed the main event.

Specialty Trainees: Trainees present had received both hospital and departmental induction. They described induction as 'a lot to remember' but useful. Trainees were provided with their IT usernames and passwords in an envelope during induction and were given an introduction to the electronic prescribing system that was in use in the hospital in the computer lab. Departmental induction was variable depending on which ward the trainees worked in. They were less structured; cardiology induction was thought to be useful and included ward orientation and an introduction to the on-call

arrangements within medicine. The medicine induction included a helpful contribution from an emergency medicine consultant on ‘grey areas’ at the interface between medicine and the emergency medicine department.

Nursing and Non-Medical Staff: Staff felt induction was effective in preparing trainees to work both during the day and out of hours, they felt it gave them a basic grounding in the job which then allowed them to support the trainees when they came on to the wards.

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

Trainers: Trainers felt a comprehensive teaching programme was provided for trainees. Local teaching was delivered weekly on a Tuesday (x-ray/radiology meeting) and Friday (divisional medicine meeting). FY1 regional teaching took place weekly on Wednesdays and trainees were able to attend without interruption as they were able to leave their pagers with the postgraduate administrator. Journal clubs also took place on a monthly basis. Attendance lists and trainee feedback on teaching was collated by the postgraduate office. Video conference links were provided for Core Medicine and Internal Medicine trainees to allow them to attend their regional or Core Medical Education Programme (COMEP) teaching at the deanery in Glasgow, if they couldn’t attend in person. In addition to the local and regional teaching opportunities provided, additional learning opportunities were offered including lumbar puncture and central line insertion courses which were both ran twice annually.

Foundation Trainees: Trainees confirmed lots of teaching opportunities were provided for them. Trainees estimated they got to around 3 hours teaching per week, although this was slightly less for FY2 at 2 hours per week. Local teaching consisted of a Tuesday x-ray meeting, general medicine/surgery teaching on a Friday afternoon and regular weekly foundation teaching (on Wednesday) which was bleep free for FY1. Regional teaching was also repeated 3 times per block giving multiple opportunities to attend sessions.

General Practice Trainees: Trainees were able to attend local teaching sessions that took place on Tuesdays (radiology/x ray meetings) and Friday general medicine sessions. Although trainees could attend the local sessions, they did not feel the Tuesday sessions provided valuable learning and there was generally no radiologist present at them. Trainees were able to attend the general practice

regional teaching sessions that took place at the Golden Jubilee Hospital and had their teaching days planned into the rota for them.

Core and Internal Medicine Trainees: Trainees were able to attend local teaching sessions on a Tuesday and Friday and generally were able to attend unless they were on-call. They made the observation that the radiology meeting would be enhanced by having a radiologist present. Trainees also were able to attend locally provided central line insertion training and chest drain training and described both courses to be very good. They also were able to attend monthly journal club meetings and described teaching as very informative. As well as local teaching, trainees had no difficulties with attending regional teaching or COMEP either in person in Glasgow or through a video conferencing link. The trainees present had also been granted study leave to attend the Internal Medicine Training (IMT) residential bootcamp.

Specialty Trainees: Trainees confirmed local teaching comprised of Tuesday radiology meetings and Friday medicine department teaching. Trainees confirmed that both were consultant led and the general medicine sessions also included trainee led teaching sessions. Trainees estimated they got to around 2 hours teaching per week and were also able to attend monthly regional teaching sessions.

Nursing and Non-medical staff: Trainees encouraged trainees to attend teaching and would remind of when sessions were taking place, ward cover was also provided by the ANPs to allow them to attend.

2.3 Study Leave (R3.12)

Trainers: Trainers did not feel there were any challenges in supporting study leave for trainees. Learning opportunities were planned into the rota for trainees by the local rota coordinator (Janet Stevenson). If given the adequate notice period of 6 weeks, there generally would be no barriers to receiving approved study leave.

All Trainee Cohorts: Study leave is not applicable to FY1 trainees. All other trainees had no concerns and reported no issues in obtaining study leave. They noted the rota coordinator as being excellent at scheduling in study leave to their rotas.

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

Trainers: Trainers confirmed that trainees are allocated educational supervisors, before starting in their post and they would remain with the same for the full training year, this was the same for clinical supervisors although they could change more often depending on the length of placement or ward the trainee was working in within the hospital. To keep continuity and familiarity with the various curricula, supervisors-maintained responsibility for the same cohort of trainee each year, where possible. All consultants within medicine were educational supervisors and had received the appropriated training and had the appropriate time allocated for education in their job plans, due to each supervisor having responsibility for 5 or 6 trainees, this could often mean they were stretched to capacity.

All Trainee Cohorts: Trainees present had all been allocated educational supervisors, had met them at the beginning of their current block and had learning plans in place. Discussion has taken place around their personal development plans and plans put in place to achieve them. The GPSTs' educational supervisors were based in practices and they had been given tours of those practices and met the practice partners.

Nursing and Non-medical Staff: Staff felt that trainees were well supported and could access senior support through the on-call consultants or through senior nursing staff.

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

Trainers: Trainers confirmed that some supervisors, maintained responsibility for cohorts of trainees, this provided them with familiarity of the specific curriculums and was also supported by the use of e-portfolio. Trainers confirmed that during initial meetings with trainees they would ask them what their learning needs were and would create an educational plan around them. Time to undertake learning opportunities could be planned into the trainee's rotas by the rota coordinator (providing required notice period was given). FY1 trainees were provided with "learning days" which were 3 days per block, these were planned into the rota in advance and could be used for any learning opportunities they wished to undertake.

Foundation Trainees: Foundation trainees thought the balance of duties of educational relevance versus service provision was good but they highlighted that a lot of their time was spent writing immediate discharge letters for patients they had neither met nor been involved in their care. Trainees highlighted good access to core procedures and trainees were given "learning days" which were 3 full days planned into the rota which they could use to undertake learning opportunities. Some trainees had used them to gain clinic experience but could also use them for other learning opportunities. They reported they are supported by a good phlebotomy service that managed 'most bloods'.

General Practice Trainees: Trainees felt that lots of learning opportunities were available to them and were able to get to lots of out-patient clinics that were planned into the rota for them. Trainees felt the clinic experience was very good and they were able to see patients independently and could receive feedback from consultants after. GPSTs had never previously accessed the number of clinics that they had in this post.

Core Medicine and Internal Medicine Trainees: Trainees felt a good learning experience was provided to them at UHA. They described lots of opportunity to attend clinics and review patients at the clinics, which was then followed up with a discussion with a consultant to get feedback on those reviews. Trainees described being moved quite frequently from their base wards to cover other wards but still felt the balance of time spent carrying out duties that were of educational value vs service provision was good.

Specialty Trainees: The trainees had different learning experiences depending on which department they were based in. Some difficulties were experienced in accessing opportunities for achieving acute care assessment tool (ACAT) assessments, that were at times because some consultants favoured reviewing patients in a particular order (that precluded the possibility of doing ACATs). The trainee experience in cardiology was highlighted as good but less so in respiratory medicine. Trainees felt that clinic access was difficult for them due to the increased clinic curriculum requirements for IMT trainees taking precedence over their own.

Nursing and Non-Medical Staff: Staff would support trainees by making sure they got experience of wards rounds, by training them on processes and being there to answer any questions they may have.

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

Trainers: Trainers had an awareness of what workplace-based assessments trainees had to complete through familiarity of the curriculum(s) and the use of the of e-portfolio. They felt trainees could complete workplace-based assessments fairly easily (although ACATs were noted to be more difficult than others to get.

All Trainee Cohorts: Trainees found it easy to complete workplace based-assessments most of the time and felt they were assessed fairly and consistently, although whilst working on-call it was felt to be more difficult, with ACATs being particularly difficult to achieve. The consultants supported the trainees to complete them, by doing ward rounds with them but this could be difficult to arrange.

Nursing and Non-Medical Staff: Staff supported trainees by completing tickets sent to them through e-portfolio for workplace-based assessments and by supporting them on-site when they were working in the out of hours period.

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

All Trainee Cohorts: Trainees described regular opportunities to learn with other health care professionals, mostly on an informal basis but also more formally through Morbidity and Mortality (M&M) meetings.

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

Trainers: Not asked.

Foundation Trainees: Trainees described variable opportunities for engagement in audit or quality improvement projects and noted some ward to offer more time and opportunity than others.

General Practice Trainees: Trainees had no concerns around opportunities to engage in audit and or quality improvement projects.

Core and Internal Medicine Trainees: Not asked.

Specialty Trainees: Trainees had no concerns around opportunities to engage in audit and or quality improvement projects.

2.9 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 confirmed the existence of a colour coded badge system, lanyards were colour coded and there were blocks of colour on each badge, this was further supported by posters describing each grade of trainee's level of ability. This made it easier for all staff to differentiate between them. An audit had been conducted by trainees recently to investigate the impact of the system. Trainees were made aware of who to contact for support at induction, this was generally the ward consultant, back up consultant or duty physician. During the out of hours period and weekend, this was confirmed as consultant of the day.

Foundation Trainees: Trainees were aware of who to contact for supervision both during the day and in the out of hours period. For most trainees, their clinical supervisor was the same as their educational supervisor and an escalation policy was in place that trainees found easy to follow. On occasions where they had to contact the out of hours consultant, they felt the support they received was good and they did not report any instances where they had to cope with problems beyond their competence.

General Practice Trainees: Trainees were aware of who to contact for supervision during the day and out of hours. At nights GPSTs are on with a 2nd on call and a FY1 covering medicine for the hospital; trainees felt the 2nd on-call contact was a very junior grade of trainee or middle grade trainee (CT2 or ST3) but acknowledged that further support was available to them by an on-call consultant if they required it. Trainees found senior colleagues to be accessible and approachable if they required support.

Core Medicine and Internal Medicine Trainees: Trainees present were aware of who to contact for support both during the day and out of hours, although occasional delays to senior colleagues responding could happen in the out of hours period. CMT2s felt that the step up to 'acting-up' as medical registrar had felt very challenging with the increased responsibility but felt adequately supported by their senior colleagues in making the adjustment. Trainees felt their colleagues were

open and supportive and a coloured badge system was in place that made staff aware of the trainee's level of responsibility and capability.

Specialty Trainees: Trainees were aware of who to contact for support both during the day and in the out of hours period. Trainees did not feel they had to cope with problems beyond their competence and experience including out of hours (OOH) and felt their senior colleagues to be supportive and approachable. They reported that high dependency unit (HDU) beds were looked after by the Intensive Care Unit (ICU): medicine trainees would look after the patients in the out of hours period, but trainees still felt they could get support if required in this situation, from the anaesthetists.

Nursing and Non-Medical Staff: Staff were able to differentiate between different grades of trainees through a coloured badge system, which was supported by posters around the hospital explaining what each grade of trainee's level of capability and responsibility was. They were unaware of any situations where trainees have had to cope with problems that were beyond their competence or experience.

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: Trainers confirmed that feedback was provided to trainees on a regular basis, either during ward rounds or at morning handover. Afternoon support was provided for trainees by a clinical teaching fellow, who would take the trainees pager from them to allow them to attend handover. A trainer present used "tuck in calls" where they would a call the trainee on night shift, if they were the on-call consultant to "check in" with them at 11pm and follow up with a morning call to discuss the previous night's activity.

Foundation Trainees: Trainees confirmed they received feedback mostly on an informal basis on their clinical decision making during the day but less so in the out of hours period.

General Practice Trainees: GPSTs did not get on consultant ward rounds after overnight receiving and therefore did not get feedback on their management of acute medical cases to inform their learning. Also, on the clinical assessment unit (CAU) consultants were variable in their engagement with GPSTs – some just doing ward rounds as if unaware the GPST were there. The overnight workload was around 12-14 cases of which at best there might be feedback on ~3, if that.

Core and Internal Medicine Trainees: Trainees felt feedback on their clinical decision could be variable during the day depending on the ward they were in and even more difficult following the out of hours period, again with lack of opportunities to get post-receiving feedback to inform their learning. Ward rounds could be very quick also limiting time for feedback. It was the understanding of some trainees that a clinical fellow should take their pager to allow them to attend the 5pm handover but until recently there was limited awareness of this opportunity.

Specialty Trainees: Trainees also reported that feedback opportunities were limited and most feedback they received was informal and not provided on a routine basis. Although it was not as much as they would like, there was some feedback. They did say that feedback was available when they asked for it.

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

Trainers: Trainers confirmed a trainee forum took place every 8 weeks, to which trainees could bring any concerns they may have around their training. An "orange form" or anonymous feedback form was also available for trainees to complete and submit in the medicine handover room, this was a more informal method for trainees to report incidents.

Foundation Trainees: Trainees confirmed different opportunities to provide feedback on their training to the senior team, including chief residents (x2) who would relay any concerns trainees had to the senior team. Trainees could raise concerns that were not in relation to patient safety through 'orange forms', which were available in the handover room; the 'orange form' system was highlighted at induction. Trainees were aware of the junior doctors' forum.

General Practice Trainees: Trainees were able to feedback on the training they received as a group through the trainee forum and using 'orange forms', or individually through their clinical or educational supervisor.

Core Medicine and Internal Medicine Trainees: Trainees described opportunities to provide feedback as ad hoc. They confirmed a junior doctors' forum with Dr Sword had taken place but were unaware when the next meeting was scheduled. They also referred to the 'orange form' system that

they said had been set up by the emergency department (ED) to identify issues at the ED-medicine interface.

Specialty Trainees: Trainees were unaware of the trainee's forum and noted opportunities to feedback on their training to be variable.

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

Trainers: Not asked.

Foundation Trainees: Trainees were very positive about their rota. They were not aware of any current gaps in their rota. They felt they had an excellent rota coordinator who would manage any gaps with appropriate cover arrangements, as well as scheduling in learning opportunities. Some trainees were concerned about the grouping together of their on-call weekends over a 4-week period but this was preferred by other trainees. Overall, trainees agreed this was manageable.

General Practice Trainees: Trainees were unaware of any gaps or vacancies on their rota. Trainees described support provided to the CAU at weekends as variable, they explained that middle grade trainees (CT2 – ST3) who were working in the wards 9 – 5 were supposed to come to CAU at 5pm to help with clerking patients but due to the back of the hospital/wards being so busy they often didn't have time to come down to the CAU, which adds to the pressure of the trainees working in the unit. Trainees were unaware if this was a rota issue or it was scheduled patient reviews during the weekend that were causing it.

Core Medicine and Internal Medicine Trainees: Trainees were not aware of any gaps or vacancies in their rota and were on two different rotas depending on whether they were a CT/IMT 1 or 2. The 'junior rota' was perceived to be good. Trainees described working on-call at nights as very stressful and busy, especially for CT2s. Trainees who were at FY2 – CT1 level worked as first on-call and those second on-call were CT2 – ST3. Trainees highlighted the rota coordinator as very friendly and approachable and she enabled access to formal learning opportunities including getting to clinics by building these needs into the scheduling. The trainees had varying opinions around the grouping of their on-call weekends together.

Specialty Trainees: Trainees were unaware of any current vacancies on their rota. Trainees described an issue regarding the medicine patients who remain in ED overnight without assessment and being unaware of which consultant is responsible for the patients. A trainee had raised their concern with a consultant who has engaged with the issue – but resolution of the lack of clarity is awaited.

Nursing and Non-Medical Staff: Staff had no concerns about the impact of the rotas on trainee wellbeing.

2.13. Handover (R1.14)

Trainers: Not asked.

All Trainee Cohorts: Trainees confirmed that handover takes place daily at 9am, 5pm and 9pm. Consultants were present more often at morning handover and sometimes in the afternoon but on most occasions, it would be a registrar who would lead. An electronic handover system was in operation at weekends but not during the week. Trainees felt handover was not used as a learning opportunity as it was often too busy.

Nursing and Non-Medical Staff: Staff felt handover was safe and effective and could be used as a learning opportunity for trainees.

2.14. Educational Resources (R1.19)

Trainers: Not asked.

Foundation Trainees: Trainees noted facilities to be adequate with a local assessable on-site library available for them to use.

General Practice Trainees: Trainees felt facilities to support their learning were adequate and described the local library to be well stocked.

Core Medicine and Internal Medicine Trainees: Not asked.

Specialty Trainees: Trainees described desk space as limited and IT could often be slow and frustrating to use. Wi-Fi was described as ‘patchy’.

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

All Trainee Cohorts: Trainees felt that support would be available to them if they required it, although non present had to do so. Trainees noted the local postgraduate administrator, as a very supportive colleague.

Nursing and Non-Medical Staff: Staff confirmed they would speak to consultants about any concerns they would have about a trainees’ performance and could do this informally or formally.

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

Foundation Trainees: Trainees were unaware of who their Director of Medical Education was.

General Practice Trainees: Trainees were unaware of who their Director of Medical Education was, they thought they may have been told in induction but couldn’t remember who they were. Trainees confirmed the existence of a trainee forum.

Core Medicine and Internal Medicine Trainees & Specialty Trainees: Not asked.

2.17 Raising concerns (R1.1, 2.7)

Trainers: Trainees were encouraged to raise concerns through Datix, they were supported by trainers to complete Datix reports and would receive hot and cold debriefs on the ones they had submitted. Learning from Datix incidents were discussed at monthly Morbidity and Mortality meetings. As well as Datix reports, trainees could also complete “orange forms” which could be used for incidents which did not affect patient safety.

Foundation Trainees: Trainees confirmed they would raise concerns through the Datix system.

General Practice Trainees: Trainees had some concerns around the management of boarded

patients and in general patient safety concerns with the environment in the busy winter period. They advised that wards in medicine were in a situation where they had more patients than beds and a trainee described an incident where a patient was accommodated in a day room but required oxygen, which was unable to be administered there. They described the hospital as overcapacity.

Core Medicine and Internal Medicine Trainees: Trainees reported their impression that the senior team wanted trainees to raise concerns. Trainees confirmed they would raise any concerns through Dr Shetty as their educational lead if it was about process, if it was a concern about a patient, they would raise with the consultant in charge of the patients care. They noted the 'orange form' system for raising concerns at the ED interface. There were also reported to be ad hoc opportunities to raise concerns at the Friday meeting.

Specialty Trainees: Trainees would raise any concerns through the Datix system.

Nursing and Non-Medical Staff: Staff felt it was an open and honest culture within medicine, with patient safety concerns being discussed on a regular basis, through huddles, Datix reporting and orange forms.

2.18 Patient safety (R1.2)

Trainers: Trainers felt the environment was safe for patients but advised there was not much slack at senior level to support the trainees and they could often be stretched to capacity when the hospital was busy. On occasions there could be an overspill of patients from the assessment unit and in the emergency department and this often meant a large number of boarded patients were accommodated around the hospital, who were managed by a boarders' team.

Foundation Trainees: Trainees felt patient safety within the hospital was generally good, although there could be delays to patient care caused by a lack of doctors in the Combined Assessment Unit to clerk or assess them. Patients could wait on occasion up to 10 hours before being assessed, although the usual waiting time was thought to be 4 – 6 hours. It was possible during the week to get additional support for assessment of these patients from clinical fellows. Patients who are boarded to other areas of the hospital could be accommodated in areas of the hospital where there was no suitable equipment available to support their care, for example, the endoscopy suite, again this was

thought to delay patients care. The list of boarded patients was shared at handover. There was general awareness of who was boarding and where these patients were and they were generally included in ward rounds.

General Practice Trainees: Trainees felt they may have some concerns if their friend or relative was admitted to medicine at the UHA. An issue that was a concern for them was a lack of on-site facilities to get blood results processed and the bloods had to be sent to University Hospital Crosshouse (UHC) by taxi to be analysed. They reported instances when blood samples going to UHC were lost in transit and had to be done again, which caused a delay in the patient's care. They reported a concern around boarding whereby a patient admitted to the hospital on a Friday to the CAU could be boarded out to a ward out with medicine without prior senior / consultant review, and not be assessed by a consultant until the following Monday. Trainees were aware of the boarders list and the arrangements for boarded patients, and it wasn't clear why such patients could be missed.

Core Medicine and Internal Medicine Trainees: Trainees present would have no concerns if a friend or relative was to be admitted to the hospital. They did have some concerns around the management of boarded patients, and they described the current period as very busy, with lots of boarded patients in the hospital. They also advised that patients could sometimes be boarded out with medicine directly from the CAU, without prior assessment, and subsequent delays in senior medical input.

3. Summary:

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

The visit panel found that although some progress had been achieved towards provision of a positive training experience to trainees at University Hospital Ayr, there was not enough sustained improvement to recommend de-escalation from enhanced monitoring. Discussion and a final decision around any changes to the GMC conditions, will take place between the deanery and the GMC, following final approval of this report.

Trainees scored their overall satisfaction with the training environment highly and it was as follows:

Foundation Trainees: Scored between 7 - 9 out of 10, average score of 8.
General Practice Trainees: Scored 8 out of 10.
Core Medicine/Internal Medicine Trainees: Scored between 8 and 9 out 10, average score of 8.
Specialty Trainees: Scored between 5 and 7 out of 10, average score of 6.

Positive aspects of the visit:

- Good provision of formal learning opportunities and access to these. Provision also included valuable locally delivered clinical skills sessions (including chest drain and central line insertion). GPSTs and higher trainees felt local teaching was of less relevance to their needs.
- Very helpful, accessible and supportive consultants – ensuring good and effective clinical supervision for doctors in training. Drs Shetty and Sword were particularly commended).
- The open culture within medicine.
- The rota itself was commended as was Janet Stephenson in her role as 'rota coordinator' as an enabler of access to learning opportunities and study leave.
- Opportunities for doctors in training to feedback on their experiences through the 'trainee forum' and chief residents, although not all cohorts were aware of the forum.
- Overall, induction to hospital, to department and to ward works well.
- Exemplary management of scheduling access to clinics and monitoring of clinic numbers for almost all cohorts of trainees (although access for ST3+ trainees seems to be less positive). The clinics provide excellent learning opportunities.
- FY1 learning days; 3 days per block available to each trainee, to use as they wish to experience other specialties.

Less positive aspects of the visit:

- Workload was high and was challenging especially out of hours for those who were more junior but, on the rota that leads acute medical receiving; there is good access to senior advice over the phone, but not to additional manpower. Other challenges were the backup of medical patients in the ED, commonly with 4-6hr backlog, but could be as long as 10hrs.

- We heard allegations of undermining behaviours towards foundation trainees from out with medicine.
- Boarding directly from CAU of patients who have not had senior assessment, and subsequent delays in senior medical input.
- Lack of feedback regarding contributions to their input to the management plans of acute medical patients admitted overnight for most cohorts of doctors in training.

4. Areas of Good Practice

Ref	Item	Action
4.1	FY1 learning days (3 days per block)	
4.2	Exemplary management of scheduling access to clinics and monitoring of clinic numbers for almost all cohorts of trainees (although access for ST3+ trainees seems to be less positive). The clinics also provide excellent learning opportunities.	

5. Areas for Improvement

Ref	Item	Action
5.1		
5.2		
5.3		

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	Concerning behaviours at the Radiology – Medicine interface must be addressed.	immediate	FY
6.2	The potential risks associated with a) patients being boarded out directly from CAU, and b) the additional risks from consequent delays in consultant assessment, must both be addressed.	immediate	FY/CMT/IMT/GPST/ST
6.3	OOH medical staffing must be reviewed to ensure doctors in training have a reasonable and manageable workload.	5th August 2020	FY/CMT/GPST/ST
6.4	Measures must be implemented to address the potential patient safety concerns associated with the lengthy delays between arrival and definitive assessment of patients within the ED and CAU departments, (more usually 4-6hours but reported to be up to 10 hours at times).	5th August 2020	FY/CMT/IMT/GPST/ST
6.5	A process for providing feedback to FY, CMT and GPSTs on their input to the management of acute cases must be established.	5th August 2020	FY/CMT/IMT/GPST/ST