Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	27th November 2019	**Level(s)**	FY/GPST/CMT/IMT/ST
Type of visit	Re-visit	**Hospital**	University Hospital Crosshouse
Specialty(s)	General Internal Medicine	**Board**	NHS Ayrshire and Arran

Visit panel	
Professor Alastair McLellan	Visit Chair - Postgraduate Dean
Dr Reem Al-Soufi	Associate Postgraduate Dean – Quality
Dr Nick Dunn	General Practice Representative
Dr Izhar Khan	Foundation Representative
Dr Jessie Sohal-Burnside	Trainee Associate
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 Alan McKenzie Dr Reem Al-Soufi Dr Stephen Glen
Quality Improvement Manager(s)	Alex McCulloch and Heather Stronach
Unit/Site Information	
Non-medical staff in attendance	6

Trainers in attendance	9			
Trainees in attendance	11 - FY	2 – GPST	7 – CMT/IMT	7 – ST

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

Date report approved by Lead Visitor	11th December 2019  Professor Alastair McLellan

1. Principal issues arising from pre-visit review:

University Hospital Crosshouse Medicine has been on a re-visit cycle with the deanery since 2015 and was also visited by the GMC as part of their national review of Scotland in 2017. The last visit to the site took place in January 2019. At this visit some requirements that were identified at the March 2018 visit were raised again, which were:

- 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.

In addition to this, one of the requirements generated in the GMC 2017 visit, had not been resolved:

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.

The January 2019 visit generated 8 requirements, 3 of which had not been resolved since the March 2018 visit.

- The Board must design rotas to provide learning opportunities that allow doctors in training to meet the requirements of their curriculum and training programme.
- 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).
- 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.

- 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.
- 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.
- Appropriate outpatient clinic training opportunities must be provided for FY2s, GPSTs & ST3+ trainees (in addition to current provision for CMTs).
- Relationships at the Emergency Medicine – Medicine interface must be improved.
- 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.

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

Discussion with Director of Medical Education and Medical Director:

Dr McGuffie and Dr Neil and provided the visit panel with an update regarding progress at University Hospital Crosshouse since the last deanery visit in January 2019. They acknowledged that workload was very high in the hospital, in particular at the time of this visit, and perceptions of progress against requirements could be affected by this.

- Feedback should have improved for trainee cohort and was now imbedded in the rota for senior trainees.
- The rota was now a 4-tier rota (FY1/FY2&GPST/CMT&IMT/ST), which they felt provided more tailored learning experiences for trainees.
- A clinic week for FY2 and GPSTs was now planned into the rota.
- The diversity of learning experience – with a lot of speciality opportunities on site in UHC.
- Attempts to improve the experience trainees have in Geriatric Medicine were underway but had been made more difficult by recruitment issues at consultant level. In the Geriatric Medicine wards, there were two consultants, work was being done with the hospital quality improvement team working with them on escalation and feedback processes.

- Challenges around 15.5 WTE consultant vacancies in NHS Ayrshire & Arran, including in UHC.
- Trainees routinely involved in Morbidity and Mortality (M&M) meetings and other meetings.
- The implementation of Chief Residents, as an approachable trainee representative to raise concerns and the management team feel they are responsive to those concerns. Several clinical development fellows had been employed and would support trainees on the wards. The current issues for trainees were the rota gaps and the site felt they were trying to proactively manage that.
- IT issues – electronic ordering was expected in January 2020; hardware upgrade was delayed but coming; the electronic prescribing system (HEPMA) was not Windows-based.

2.1 Induction (R1.13):

Trainers: Trainers advised they had made improvements to induction and now felt it worked well. There was a consultant lead for induction. The induction was split between a ½ day of site/hospital induction and ½ day of departmental induction. Attempts to improve departmental induction had been made and a standardised checklist and timetable was now in operation, that included what should be covered by departmental induction. The improvements to induction were now being further supported by an app, which was currently being developed. Induction was repeated 3 times for trainees who were unable to attend on the 1st day and efforts were made to get trainees along to it. Attendance records were kept by the post graduate administrator and induction was evaluated through Survey Monkey, although the response rate was acknowledged to be low. Trainers from the various departments described the various inductions their departments offered, most were supported by departmental handbooks and evaluation. Trainers from the Infectious Diseases (ID) department described difficulties obtaining protective clothing for ID trainees to use in their training.

Foundation Trainees: All trainees present had received site and departmental induction, which was felt to be through and had provided them with the appropriate information required to allow them to start their posts. The FY1 trainees had received shadowing experience, which they described as good.

General Practice Trainees: Trainees present had all received formal site induction. Trainees described departmental induction as less formal and their experience of it was very variable. One induction did not include a tour of the department (Geriatric Medicine), the Gastroenterology induction consisted of a short meeting where an induction booklet was handed out. Potential improvements were shared including – need for consistency around provision of ward orientations, roles and responsibilities on the ward (when there was no consultant ward round scheduled) and at clinic. The provision of a medicine and Combined Assessment Unit (CAU) application was, however, useful.

Core Medicine and Internal Medicine Trainees: All trainees present had received site induction but issues were reported in the variability of who had received their usernames and passwords, some trainees who had been working nights, hadn't received them, others had received but they hadn't worked and they spent the majority of their first night shift trying to get the issue resolved by local IT. An improvement to induction that was suggested by trainees was to include a practical session on the various IT systems in the hospital such as Portal, KMS and Trakcare. Trainees had all received departmental inductions and felt they worked well.

Specialty Trainees: Most trainees received induction to the hospital, one trainee hadn't received induction, this was due to working in the hospital previously (a couple of years previously) and it had been assumed they didn't require it. The trainee explained that lots of changes had been made to the way the hospital worked and they felt they had to repeatedly ask to get an induction. Departmental induction was felt to be variable and some trainees present had not received a departmental induction.

Nursing and Non-Medical Staff: Staff felt that induction was effective in preparing trainees to work during the day and out of hours. Nursing staff provided support for trainees on also delivered the hospital at night induction.

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

Trainers: Trainers confirmed that there was a consultant lead for the local teaching sessions. General Internal Medicine (GIM) teaching took place weekly on Wednesdays at lunchtime, consultants were allocated slots to deliver on a rotational basis. All consultants were involved in the delivery of teaching and the trainers advised that trainee attendance had improved this year. Although this arrangement had broken down on occasion, the trainers felt it worked well. FY1 teaching was kept interruption/bleep free) for trainees. Trainees were now sent e-mail reminders of what teaching was taking place. As well as the GIM teaching, various departmental teaching took place (e.g. Acute Medicine ran weekly sessions on Thursdays, Care of the Elderly had meetings on Tuesdays & Fridays) some departments ran journal clubs and multi-professional learning sessions and M&M meetings.

Foundation Trainees: Trainees estimated they get to around 2 hours of teaching per week, which included FY1 specific teaching on a Tuesday and GIM teaching on a Wednesday. Trainees could regularly attend and FY1 teaching was bleep free. Trainees felt the standard of regional FY teaching they received was good. Trainees reported a variable experience of being able to attend Morbidity & Mortality meetings, although some departments had them, they could be difficult to attend due to workload pressures.

General Practice Trainees: Trainees advised that GIM teaching took place on a Wednesday; departmental teaching in Geriatric Medicine on Tuesdays & Fridays. Until recently there had been no Gastroenterology teaching. Geriatric Medicine teaching was protected, and the trainees could attend, the trainee in Gastroenterology felt their ward was too busy to attend teaching. Trainees were able to attend Ayrshire GP teaching, which comprised of 2 half day sessions per month and Regional teaching in the Beardmore Hotel in Clydebank.

Core Medicine and Internal Medicine Trainees: Trainees experience of teaching was variable but generally inadequate with between 15 minutes – 1 hour of teaching per week on average. There was no protected local teaching. Lack of advanced scheduling of sessions may now have been addressed,following their complaint about that. Barriers included consultant not turning up to deliver the teaching, but although trainees received reminders that teaching was taking place, they advised they could rarely get to it due to a heavy workload. Regional teaching starts in January. IM1 trainees had accessed the national IM bootcamp.

Specialty Trainees: Trainees advised they could get to around 2 hours of teaching per week, although getting to it could be difficult for some trainees. Trainees in Acute Medicine highlighted they could rarely get to teaching because of ward staffing and workload.

Nursing and Non-Medical Staff: Nursing staff advised they tried as much as possible to provide ward cover for trainees to allow trainees to attend teaching, this was felt to be easier to do for FY/GPST trainees than the higher specialty trainees.

2.3 Study Leave (R3.12)

Trainers: Trainers were unaware of any challenges in supporting study leave, if trainees gave the required notice period of 6 weeks.

Foundation Trainees: Not applicable to FY1 trainees. The FY2 trainees reported no difficulties with obtaining study leave.

General Practice Trainees: Trainees raised no concerns in being able to request or to take study leave.

Core Medicine and Internal Medicine Trainees: Trainees described study leave as difficult to obtain and estimated they managed to get around 60% of the study leave they were entitled to.

Specialty Trainees: Trainees highlighted that study leave access could be difficult because of workload. Trainees understand they can’t apply for study leave at certain times because of the rota and know when they should not apply.

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

Trainers: Trainees were allocated Educational Supervisors before they started in their posts, all Educational Supervisors had been trained to undertake their educational roles and had allocated time in their job plans of around 1 hour per trainee per week to provide that education. The educational supervisors maintained responsibility for the same cohort of trainees, which helped maintain continuity and familiarity with the various curricula. Trainers confirmed that educational supervision was discussed separately at their appraisals.

All trainee cohorts: The trainees present had all been allocated educational supervisors and had met with them for initial formal meetings. Some trainees had also met their supervisors for mid-point reviews and informal adhoc meetings.

Nursing and Non-medical staff: Staff felt that senior support was available to trainees, the trainees were also further supported by advanced nurse practitioners, clinical support officers and on-call pharmacists.

2.5 Clinical supervision (day to day) (R1.7, 1.8, 1.9, 1.10, 1.11, 1.12, 2.14, 4.1, 4.6)

Trainers: Trainers advised a coloured badge system was in operation, which was further supported by posters around the hospital, advising what each grade of trainees' level of capability and level of responsibility was. Trainees were made aware of who to contact for advice or support, through contact lists provided to them as part of their induction. Trainees should now no longer have to seek consent for procedures that they were not competent to carry out, endoscopy consent was now carried out by the appropriate team, rather than trainees.

Foundation Trainees: Trainees were aware of who to contact in hours, but it was thought to be more difficult in some departments and within acute receiving, during the out of hours period. A situation was described by trainees, where they had 2 unwell patients for which they required senior input for but had found it difficult to get as the registrar and other senior colleagues were busy. A few of the trainees had to use the 'peri-arrest' page to get help, even though the situations were not 'peri-arrest'. A trainee reported being asked to consent for a procedure (CT-guided biopsy) for which they perceived they were not competent to obtain consent, very early on in a shift within Haematology; they had declined to do so, but had felt pressurised by the department, who kept calling them back and repeating their request. The trainee in question had raised the issue with their educational supervisor.

General Practice Trainees: Trainees were aware of who to contact for support both during the day and out of hours. They did not feel they had to cope with problems beyond their competence or experience and felt their senior colleagues to be accessible and approachable.

Core Medicine and Internal Medicine Trainees: Trainees described concerns regarding a lack of clarity around the escalation pathways for senior advice on the management of patients who are referred to the doctor in training holding page 3850 (an example was given of a medical problem arising in someone who was pregnant). Trainees also described a lack of higher trainees on some wards which meant they could sometimes be the most senior trainee on their ward when more senior colleagues were busy elsewhere in the hospital (Gastroenterology and Endocrinology and Diabetes wards highlighted), trainees advised this could sometimes make it difficult to get senior advice when they required it. IMT1 trainees found being the lead for the cardiac arrest team stressful and they suggested that role was more suited to CMT" or above trainees.

Specialty Trainees: Trainees were aware of who to contact during the day but felt it was more difficult at the weekend to identify who to contact for support. The felt there was a lack of team working of consultants and 'registrars' at the weekend (acting independently of each other with little engagement) despite being on shift at the same time; this meant trainees were unsure of who they should approach. They never found themselves working beyond their level of competence.

Nursing and non-medical staff: Staff were able to differentiate between different grades of trainee, through the coloured badge system and supporting posters, which were visible around the hospital. They were not aware of instances where trainees had to work beyond their competence.

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

Trainers: Trainers were aware of the various teaching and curriculum requirements for the trainees within medicine, as they maintained responsibility for the same cohort of trainees each year. Some curriculum requirements were more difficult than others for trainees to get and trainers had created a procedures list which detailed who trainees should contact to get experience of procedures. Trainers felt that there was still work to be done to reduce the burden of non-educational tasks such as blood forms or Immediate Discharge Letters (ILDs) on trainees.

Foundation Trainees: Trainees (FY2s) described the designated, scheduled 'clinic weeks' system as good and effective at providing access to clinic learning opportunities. It had been unclear to some trainees as to what their role should be in a clinic (whether they should be seeing patients or just observing); some of the consultants leading the clinics also seemed to be unaware of what their role should be. Trainees felt clarity should have been provided.

FY1 trainees described a large percentage of their workload was service-orientated and was felt to be of little benefit to their education; they estimated their workload to be 80% non-educational and only 20% educational. FY2s felt their workload to be more educational. Trainees at FY1 level felt they had limited exposure in dealing with very ill and deteriorating patients, as they were generally managed by an FY2 and an ANP. FY1 trainees felt this prepared them poorly for FY2, as they had a lack of experience in managing acutely unwell patients.

General Practice Trainees: There were opportunities to carry the 1st on bleep and to assess acutely unwell medical patients. Access to feedback on their management of these patient was limited – as not all consultants were willing to prioritise their post-receiving wards rounds around the patients they had managed, and there was reluctance to stay behind after shifts to be on the post-receiving ward rounds. There were some opportunities to seek out consultant feedback on cases during the day.

Trainees advised they received an allocated clinic week, which was planned into their rota. The trainees felt the clinic experience they received was variable, with different departmental experiences in Geriatric Medicine and Gastroenterology. In Gastroenterology is was more of a shadowing experience (sitting in as a medical student would do) rather than leading in a clinic and in Geriatric Medicine, the clinics were in General Internal Medicine as opposed to specific Geriatric Medicine.

Although trainees felt the balance of their work being educational vs service provision was an equal split of around 50/50, there was thought to be a lack of FY1 staff in some areas, which meant the trainees felt they were overburdened by non-medical tasks such as taking bloods and writing discharge letters for patients.

Core Medicine and Internal Medicine Trainees: Trainees advised the panel they found it very difficult to get to clinics, with workload being the main barrier to them being able to get them. There was no scheduling of access to clinics, although Respiratory did offer ‘clinic weeks. It was possible to get to some clinics in Endocrinology/Diabetes and Gastroenterology. Overall the numbers will fall well short of curricular targets. Workload was so busy that some trainees estimated the percentage of time carrying out duties which were supporting service provision could be up to 100% of the time in some wards, especially where there was no FY1. Some of the trainees’ present stated they did not feel they would be able to meet their ARCP clinic requirements for this year. Feedback to inform their learning around their overnight management of acute medical cases was limited -and was available on between 0-5 patients, typically just 1-2. Not all consultants provided this opportunity and opportunities to undertake procedures were limited (especially for chest and ascitic drains, although there were opportunities to do LPs). Concerns were raised in relation to the perceived compromise to learning opportunities and care in the Infectious Diseases department. More details will be shared out with this report.

Specialty Trainees: The role is busy. Daytime roles are seen as being no different from FY2s – dealing with busy wards and ward work in the face of being 'short staffed'. Trainees felt that much of their time was spent on non-educational activities. Trainees found access to clinics was difficult with numbers of clinics accessed typically ranging from 3-6 over 4 months (with one exception having attended over 20 clinics during this period). Ward work was the key barrier to accessing clinics. The ST3+trainees do not benefit from formal scheduling of clinics. Much of their out of hours work was again, 'very busy', and spent covering the 'back of hospital', typically with 2ANPs – and much of this was non-educational and task-orientated. This role was not conducive to getting Acute Care Assessment Tools (ACATs) done. There was lack of opportunity to progress their learning around feedback based on their management of acutely unwell patients. Acute Medicine trainees had much greater commitment to acute medical receiving. Feedback was available in relation to their management of patients in HDU overnight.

Nursing and Non-Medical staff: Staff advised that lots of teaching was delivered by nursing staff and they were invited to present at trainee teaching sessions by the local post praduate administrator.

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

Trainers: Trainers were familiar with the various workplace-based assessments that trainees were required to undertake as they maintained responsibility each year for the same cohort of trainees. They described changes in the rota (away from 'back of hospital') to have involvement in acute medical receiving for ST3+ trainees, for some of their time in UHC, to enable some opportunities for Acute Care Assessment Tools (ACATs). Trainers advised that most trainees should be able to achieve their curriculum requirements, although it was acknowledged that ACATs, could be more difficult than others for them to get. Trainers had not received training or had the opportunity to benchmark their assessments against those of other trainers.

All trainee cohorts: Trainees found it relatively easy to get most workplace based assessments completed and signed off but ACATs were highlighted to be particularly difficult to get signed off. Trainees advised they had raised this issue through the trainee forum.

Nursing and Non-medical staff: Nursing staff contributed to the assessment of trainees by completing tickets from e-portfolio sent to them by trainees to support the completed of workplace-based assessments, such as MSF (multi-source feedback).

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

Trainers: Trainers confirmed that multi-professional learning happened informally on the wards and more formally at M&M meetings.

All trainee cohorts: Trainees described opportunities to learn with other health professionals as informal, these happened through departmental multi-disciplinary meetings and more informally through day to day working on the wards.

Nursing and non-medical staff: Multi-professional learning took place through peer learning on the wards and in some of the departmental teaching sessions.

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

Trainers: Trainers confirmed that they had an active quality improvement department that promoted projects to trainees and would support them to undertake them.

Foundation Trainees: Trainees reported variable experience of quality improvement and audit opportunities being available to them and it was thought to be easier for FY2 trainees to access opportunities than FY1 trainees.

General Practice Trainees: Trainees confirmed there were opportunities to engage in quality improvement and audit projects, the trainees either had a project underway, or were planning to start one shortly.

Core Medicine and Internal Medicine Trainees: Trainees advised that opportunities for them to engage in quality improvement and audit projects were available but that there wasn't any time for them to engage in them because of workload.

Specialty Trainees: Not covered.

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: Trainers had made changes to the night shift rota in order to try and improve the feedback given to trainees on their out of hours work. An extra 30 mins had been added to their shift, to encourage feedback following their ward round. Trainers were currently monitoring the trainees' attendance at this. The senior trainees' night shift duration had been extended by 30min to enable handover, and potentially get feedback, on their input to high care / High Dependency Unit (HDU) patients in the mornings.

Foundation Trainees: Trainees described the feedback they received as adhoc and exposure to acutely unwell patients to receive feedback on their case management was described as variable by FY1 trainees, particularly during nights. FY2 received more feedback in the mornings following night shifts and could go on ward rounds and receive feedback following handover in the last hour of their shift.

General Practice Trainees: Trainees considered the feedback they received as variable as the workload was so busy it made it difficult to find the time to receive feedback and discuss cases.

Core Medicine and Internal Medicine Trainees: Trainees described feedback as supportive when provided but was generally lacking to inform their learning around their overnight management of acute medical cases was limited -and was available on between 0-5 patients, typically just 1-2. Not all consultants provided this opportunity.

Specialty Trainees: Trainees felt that feedback could be variable depending on the department they worked in. Trainees who worked in the stroke wards described feedback as difficult to get, they had raised this as an issued but felt that not action had been taken to resolve the issue. Whilst working in CAU, trainees felt that although consultants were open to discussions, limited staffing meant that there was often no time to receive feedback.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: Trainers confirmed feedback was collected from trainees through evaluation of their induction programme through Survey Monkey, through meetings with their educational supervisors, the 6 weekly trainee forums and chief residents.

Foundation Trainees: Trainees were aware of the existence of the junior doctor forum but felt it was aimed more at trainees of a higher grade. They were aware of when it took place but attendance amongst the group was variable, mostly due to workload pressures on the wards.

General Practice Trainees: Trainees described the junior doctor forum as an opportunity to provide feedback to their senior colleagues on the quality of training they were receiving. The trainees could also raise concerns with their chief resident colleague.

Core Medicine and Internal Medicine Trainees: Trainees described the junior doctor forum as an opportunity to provide feedback to their senior colleagues on the quality of training they were receiving. The also described the local ADME as supportive and trustworthy.

Specialty Trainees: Trainees described the junior doctor forum as an opportunity to provide feedback to their senior colleagues on the quality of training they were receiving, however they often felt that as a group they could often be silent and that issues may not always be raised. The trainees could also raise concerns with their chief resident colleague.

2.12 Culture & undermining (R3.3)

Trainers: Trainers felt a team culture was enabled by the small teams at the hospital. They felt they tried to include trainees in decision making and tried to be as approachable as possible**.** Trainees also had the use of a junior doctors' room or mess. Trainers were unaware of any current issues in relation to undermining incidents and felt that in the past, issues had been due to interactions the trainees had with other departments outside of medicine. Since the last deanery visit, improvements had been made to improve the interface between the Emergency Medicine department and Acute Internal Medicine, the consultants now regularly engaged and tried to resolve issues as they came up and they felt this improved the relationships between the departments at all levels.

Foundation Trainees: Trainees felt their senior colleagues were supportive and approachable. Some incidents of alleged undermining behaviours involving registrars and non-medical staff, that trainees observed were described, trainees did not go into detail about the incidents but had reported them to their senior colleagues.

General Practice Trainees: Trainees noted their senior colleagues were supportive and approachable and had not witnessed any undermining or bullying behaviours. If they had any concerns or witnessed any such behaviours, then they would raise them with their educational supervisor.

Core Medicine and Internal Medicine Trainees: Some concerns were raised by trainees in relation to their interactions with some Nursing staff members, displaying what they considered to be undermining behaviours. A similar concern was raised in relation to their observations of a senior trainee' s interactions with FY1s. Both concerns had been escalated locally already.

Specialty Trainees: Trainees did not have any concerns in relation to undermining and bullying and had not experienced or witnessed any such behaviours.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Trainers felt that gaps or vacancies in their rota were managed appropriately. Trainers had implemented changes to the senior tier rota to allow more time for feedback to be provided to trainees. Attendance at clinics was monitored by the business intelligence team, that could provide reports on which trainees had attended, consultants would then follow up on non-attendance.

Foundation Trainees: Trainees had some concerns around vacancies and how they were managed on their rotas. Some of the variability in staffing in wards was perceived to be due to poor scheduling and rota management. The balance of FY1 staffing across the wards was felt to be inconsistent.

General Practice Trainees: Trainees advised there were vacancies in Geriatric Medicine that effectively left them managing the ward on their own, and more senior trainees were pulled in from other departments to help cover the ward. Due to the lack of ward cover across Geriatric Medicine and Stroke, GPSTs could often be moved around different wards daily to provide cover.

Core and Internal Medicine Trainees: Trainees felt their rota was demanding, the pattern of the rota included the grouping together of challenging runs of long days, between blocks of days of 9 -5 days, although on those 9 -5 days, trainees described not being able to leave the hospital until 8.00 pm on some occasions. Workload was thought to be high generally and more so because the hospital had a lot of boarders dispersed across the hospital. The Respiratory unit had a lot of boarders.

Specialty Trainees: Trainees described workload as very heavy and potentially impacting on their well-being. Backshifts were thought to be overwhelming and it could be difficult to prioritise tasks because of the workload. The support that was provided to trainees could be variable, particularly in the out of hours period. Trainees felt that some of the bed management decisions were not always consistent and they were often not informed when a patient was moved elsewhere in the hospital. Trainees advised the hospital was full and there could be long waits for patients from the Emergency Department who required admission to a medical ward.

Nursing and non-medical staff: Nursing staff acknowledged that workload in the out of hours period at the weekend could be very busy but felt trainees were well supported by the nursing and AHP team.

2.14 Handover (R1.14)

Trainers: Trainers advised handover took place daily at 9.00am and 9.00 pm, with an informal handover at 5.00pm. They felt handover, particularly at night to morning worked well. The senior rota night shifts had been extended to include handover in the morning, this provided more opportunity for trainees to be given feedback. Trainers advised weekend handover had improved and was recorded through the Trakcare system, during the week handover was conducted verbally. Trainers felt the current gap in handover which they were looking to address, would be the 5.00 pm handover and an IMT had been tasked with looking into improving and formalising this handover.

Foundation Trainees: Trainees advised handover took place at 9.00 am and 9.30 pm formally, both during the week and at weekends. There was an informal 5.00 pm handover and a bleep was used to handover tasks. Handover was led generally by higher trainees or consultants, with each team sending a member to attend. Handover could be busy and as a result could be difficult to use as a learning opportunity. For those patients requiring weekend reviews or tasks performed – a weekend task-list was compiled before the weekend.

General Practice Trainees: Trainees advised that handover in General Medicine took place daily at 9.00 am and at 9.00 pm, both daily and at the weekend. Handover in the Geriatric Medicine ward was reported to be fragile and comprising doctor to doctor emails and was reported to be lacking in Gastroenterology.

Core and Internal Medicine Trainees: Trainees advised that handover took place daily at 9.00 am and 9.30pm, with an informal meeting taking place at 5.00 pm. At weekends handover was the same but trainees highlighted that the shift pattern at night did not align with when handover took place, with the shift in the evening finishing at 8.30/9.00 pm and the handover taking place at 9.30 pm. Handover was recorded on a paper list during the week and electronically through Trakcare at the weekend.

Specialty Trainees: Not covered.

Nursing and non-medical staff: Nursing staff felt that handover was safe and effective, it took place at 9.00am in the morning and at 9.00 pm in the evening, this was the same during the week and at weekends.

2.15 Educational Resources (R1.19)

Trainers: Not covered.

All trainee cohorts: Trainees felt the facilities available to them, to be adequate. They described access to a library, Wi-Fi access and teaching and simulation rooms. They had also received unannounced mock cardiac arrest training (provided ~monthly) that was valued greatly.
Some concerns were raised in relation to doctor's rooms on the wards, which were limited in some.

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

Trainers: Not covered.

Foundation Trainees: Trainees felt support would be available to them as well as access to reasonable adjustments, should they require them.

General Practice Trainees: Trainees felt support would be available to them as well as access to reasonable adjustments, should they require them. One of the trainees' present was working less than full time but felt supported to do so and adequate adjustments had been made to their training to support this.

Core Medicine and Internal Medicine Trainees: Not covered.

Nursing and non-medical staff: Staff would raise any concerns they had in relation to a trainee's performance with consultants or the DME.

Specialty Trainees: Trainees felt they could receive support, should they require it. None of the trainees' present were working less than full time or had requested reasonable adjustments to their programme.

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

Trainers: Not covered.

Foundation Trainees: Trainees were unsure of who their Director of Medical Education was. They noted the trainee forum, the foundation training committee and the chief residents as avenues to raise any concerns related to the quality of the training they were receiving. They were aware the ED ran a wellness awareness group.

General Practice Trainees: Not covered.

Core Medicine and Internal Medicine Trainees: Not covered.

2.18 Raising concerns (R1.1, 2.7)

Trainers: Trainers noted Datix as the most formal method for trainees to report incidents, Datix reporting was covered in the trainee's induction programme. An informal method of reporting incidents which were not related to patient safety was in operation in Acute Internal Medicine. All trainees who submitted a Datix report, should have received feedback on it. Trainees were encouraged and supported to raise concerns about their training through their educational supervisor or director of medical education.

Following a previous serious adverse event (SAE), if a doctor in training is involved in a SAE a senior (DME /ADME) is assigned as a trainee liaison person to support the trainee through the process.

Foundation Trainees: Datix was highlighted by trainees to be the formal method of reporting any concerns about patient safety. There was awareness of e-learning around the Datix system. Trainees had raised a Datix report around unsafe staffing concerns, which had been addressed immediately.

General Practice Trainees: Trainees confirmed they would raise any concerns about patient safety through the Datix system and felt any concerns they did raise would be addressed.

Core Medicine and Internal Medicine Trainees: Trainees confirmed they would raise any concerns about patient safety through the Datix system and felt any concerns they did raise would be addressed, the feedback they received could sometimes be inconsistent.

Specialty Trainees: Trainees advised they would raise any concerns about patient safety to consultants and formally report them through the Datix system, learning from patient safety concerns were discussed at M&M and trainees confirmed they would receive feedback on the Datix incidents they were involved in.

Nursing and non-medical staff: Nursing staff confirmed concerns were raised through the Datix system and learning from incidents were discussed at M&M meetings.

2.19 Patient safety (R1.2)

Trainers: Trainers felt the environment was safe for both patients and trainees. Trainers acknowledged that although boarding could affect patient safety, the boarded patients were managed and monitored closely, through a boarded patients' list with allocated consultants responsible for their care. The boarders list was updated and circulated to everyone regularly.

Foundation Trainees: Trainees would be concerned if a friend or relative was admitted to the hospital about the quality and safety of the care they would receive, particularly in the CAU and in some ward areas where medical patients are boarded. They described the hospital as very busy currently, which meant a lot of patients were being boarded all over the hospital. Patients were now being reviewed in CAU before being boarded out to a ward. It was the trainees' perception that Respiratory Medicine had particularly large numbers of boarded patients to manage. Patients who were boarded to day surgery could sometimes wait 3 or 4 days for a consultant review, following initial assessment. In general, the boarders list was accurate (showing who was where) but at times consultant responsibility for those boarded was not always clear. The trainees suggested that it would have been helpful if roles and responsibilities for patients who are boarded was covered at induction and also that contingency arrangements should be in place with regard to who is responsible for tasks that require to be done on these patients. No patients had been lost, to their knowledge.

General Practice Trainees: Trainees would not have concerns if a friend or relative was admitted to the hospital in the CAU but would be concerned if they were admitted to Geriatric Medicine. The concerns were related to lack of nurses and FY1 trainees (currently only 1) to support patient care in the wards. Trainees felt a good system was in place to manage boarded patients and that a list was e-mailed round all staff each morning; the boarders lists was accurate in identifying patients and their locations. Their perception was that boarded patients' care was on a par with that of patients who were not boarded.

Core Medicine and Internal Medicine Trainees: The greatest concerns were around workload – and the change from 5 doctors managing acute referrals at 0900 to just 2 overnight. At the start of night shifts there could be 14-32 patients waiting to be seen. Trainees would be concerned about the care of patients in some areas of the hospital and highlighted patients who were GP referrals to the hospital could wait up to 14hours to be seen, and up to 20 hours to receive a consultant review. Further concern was raised in relation to the lack of access to patients for their usual medications whilst they were waiting long periods of time to be seen in the Emergency Department as the department did not use the electronic prescribing system.

Specialty Trainees: Trainees were concerned about patient safety and in particular the movement of elderly patients both during the day and at night on a regular basis in CAU and in the Emergency Department. They felt there were often patients moved to the discharge lounge without the appropriate package of care in place to support them on discharge from the hospital. The trainees advised that patients who came into the Emergency Department could wait up to 12 -14 hours, without access to their usual medications before being admitted to a Medicine ward.

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

Trainers: Not covered.

Foundation Trainees: Trainees felt they would be supported if they were involved in an adverse incident.

General Practice Trainees: Trainees felt they would be supported if they were involved in an adverse incident. The trainees present had not submitted Datix reports as they advised the nursing staff would do it for them, for the incidents they were involved in, they couldn’t remember if they had received feedback on them.

Core Medicine and Internal Medicine Trainees: Not covered.

Specialty Trainees: Not covered.

3. Summary

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

The visit panel were concerned about some of the issues raised in this visit, most notably the sites lack progress against the GMC National review of Scotland requirement 2 for – NHS Ayrshire and Arran: *NHS Ayrshire & Arran must design rotas that provide learning opportunities which allow learners to meet the requirements of their curriculum.*

A very heavy workload and rota management issues appear to be affecting the trainee's ability to achieve their curriculum requirements (most notably for Core/IMT trainees) who are unable to attend enough clinics to meet their ARCP requirement.

Concerns were evident in the relation to patient safety issues which were highlighted by trainees regarding the management and delay of care being provided to GP referrals to the hospital. Further concerns were expressed around difficulties in the provision of patients' usual medications while they have prolonged waits in the Emergency Department.

Positive aspects of the visit

- Introduction of rota'd clinic week for FY2s & GPSTs.
- Positive experience of training in the Endocrinology and Diabetes unit.
- AIM – very positive feedback regarding the trainers, described by trainees as some of the most engaged they have worked with.
- Mock cardiac arrests as a learning opportunity.
- Combined Emergency Department and Acute Internal Medicine teaching.

Less positive aspects of the visit

- Workload is compromising training of all cohorts.
- FY1 trainees had concerns around receiving very little training, with most of their time spent undertaking tasks that they felt were of no benefit to education; concerns were expressed regarding the lack of experience and training to prepare them for working as FY2s.
- Lack of clarity around the escalation pathways for senior advice on the management of patients who are referred to the doctor in training holding page 3850 (an example was given of a medical problem arising in someone who was pregnant).
- Perception of safety issues with potentially long waits for assessment of GP referrals.
- Concerns were expressed around difficulties in provision of patients' usual medications while they have prolonged waits in the ED.
- Limited opportunities for feedback to GPST, CMT-IMT, ST3+ trainees to inform their learning around their management of acute medical cases.
- Lack of access to clinics for IMT-CMTs & ST3+ trainees.
- Concerns around engagement of seniors in ID, that has potential to compromise patient care and training.
- Lack of team working of consultants and 'registrars' at the weekend (acting independently of each other with little engagement).

From the previous requirements that were put in place at the last visit in January 2019, there has been limited progress against most:

January 2019 visit requirements:

- The Board must design rotas to provide learning opportunities that allow doctors in training to meet the requirements of their curriculum and training programme. – **Not met.**
- 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) – **Not met.**
- 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 - **Not met.**

- 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. – **Progress being made**.
- 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 - **Not met.**
- Appropriate outpatient clinic training opportunities must be provided for FY2s, GPSTs & ST3+ trainees (in addition to current provision for CMTs) – **Partially met (**met for FY2/GPST but now issue for CMT/IMT trainees and ST3+ trainees).
- Relationships at the Emergency Medicine – Medicine interface must be improved – **Met.**
- 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. – **Partially met – still inconsistent across departments in Medicine.**

Trainees overall satisfaction with their programmes: (scores out of 10):

Foundation Trainees: 6 – 8 out of 10 (with an average score of 6).
General Practice Trainees: 6 – 7 out of 10.
Core Medicine and Internal Medicine Trainees: 3 - 8 out of 10 (with an average score of 6)
Specialty Trainees: 6 – 7 out of 10 (with an average score of 6).

Following the release of the final version of this report, discussions will take place between the deanery and the GMC, regarding the possible escalation of the site to the GMC Enhanced Monitoring process.

4. Areas of Good Practice

Ref	Item	Action
4.1	If a doctor in training is involved in a SAE a senior (DME /ADME) is assigned as a trainee liaison person to support the trainee through the subsequent process.	

5. Areas for Improvement

Ref	Item	Action
5.1	Concerns were expressed around difficulties in provision of patients' usual medications while they have prolonged waits in the ED.	

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	The scope of the ward cover and the associated workload all cohorts of trainees at weekends and overnight must be reduced as currently they are not manageable and safe.	26th August 2020.	FY/CMT/IMT/GPST/ST
6.2	The Board must design rotas to provide learning opportunities that allow doctors in training to meet the requirements of their curriculum and training programme	26th August 2020.	FY/CMT/IMT/GPST/ST
6.3	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	26th August 2020.	FY/CMT/IMT/GPST/ST
6.4	There must be a clear escalation policy which is understood and followed by all involved for trainees managing pager no 3850.	26th August 2020.	CMT/IMT
6.5	A process for providing feedback to doctors in training on their input to the management of acute cases must be established. This should also support provision of WPBAs.	26th August 2020.	FY/GPST/CMT/IMT/ST

6.6	Appropriate outpatient clinic training opportunities must be provided for CMT/IMT trainees and ST3+ trainees (in addition to current provision for FY2/GPST)	26th August 2020.	CMT/IMT/ST
6.7	Measures must be implemented to address the patient safety concerns associated with the lengthy delays between arrival and definitive assessment of GP referrals as soon as possible.	26th August 2020.	FY/GPST/CMT/IMT/ST
6.8	All trainees must have timely access to IT passwords and system training through their induction programme.	26th August 2020.	FY/GPST/CMT/IMT/ST
6.9	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.	26th August 2020.	FY/GPST/CMT/IMT/ST
6.10	All staff must be behave with respect towards each other and conduct themselves in a manner befitting Good Medical Practice guidelines. Specific example noted during the visit will be shared out with this report.	26th August 2020.	FY/GPST/CMT/IMT/ST