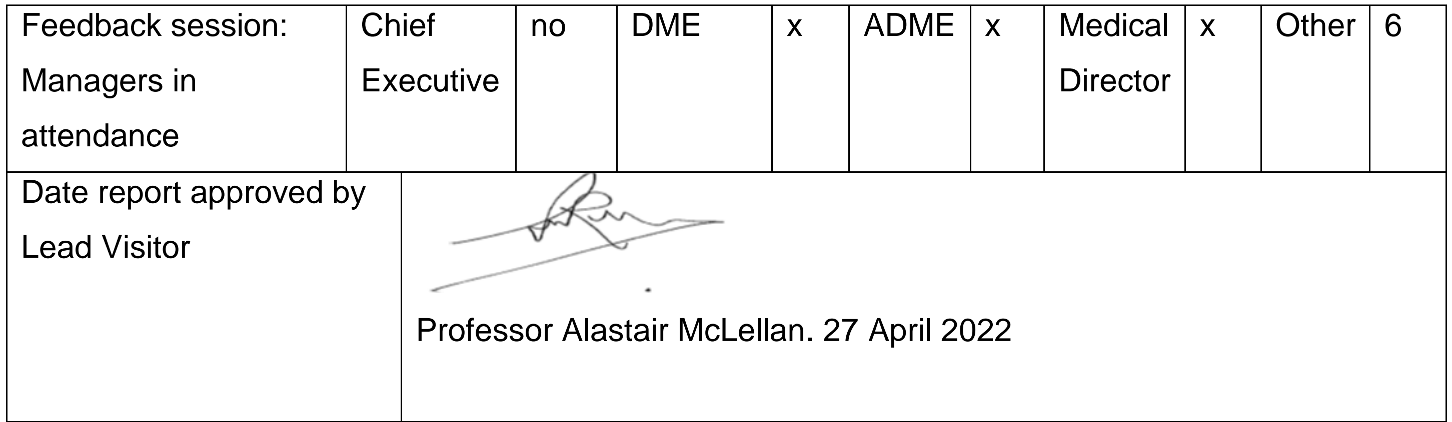
Scotland Deanery
Quality Management Visit Report

Date of visit	13th April 2022	Level(s)	FY, GPST & IMT
Type of visit	Enhanced Monitoring Revisit	Hospital	University Hospital Ayr
Specialty(s)	General Internal Medicine	Board	NHS Ayrshire & Arran

Visit panel	
Professor Alastair McLellan	Visit Chair – Postgraduate Dean
Dr Jennifer Craig	Training Programme Director – General Practice – North Region
Mrs Cathy Fallon	Lay Representative
Dr Alan McKenzie	Associate Postgraduate Dean for Quality
Ms Kate Bowden	General Medical Council Representative
Miss Kelly More	Quality Improvement Manager
Dr Catherine Ward	Trainee Associate
In attendance	
Mrs Alison Ruddock	Quality Improvement Administrator

Specialty Group Information		
Specialty Group	Medicine	
Lead Dean/Director	Professor Alastair McLellan	
Quality Lead(s)	Dr Alan McKenzie, Dr Greg Jones & Dr Reem AL-Soufi	
Quality Improvement Manager(s)	Miss Kelly More & Mr Alex McCulloch	
Unit/Site Information		
Non-medical staff in attendance	n/a	
Trainers in attendance	5 consultants	
Trainees in attendance	10 FY1s, 2 GPSTs & 8 IMTs	



Feedback session: Managers in attendance	Chief Executive	no	DME	x	ADME	x	Medical Director	x	Other	6
Date report approved by Lead Visitor	Professor Alastair McLellan. 27 April 2022									

1. Principal issues arising from pre-visit review:

The deanery last visited Medicine at University Hospital Ayr in April 2021. The requirements that were set following that visit were:

- A process for providing feedback to FY, IMT and GPSTs on their input to the management of acute cases must be established.
- There must be sufficient substantive consultant staff in 'medicine' to provide appropriate supervision and feedback to trainees and to support the safe care for patients.
- Departmental induction must be provided to all trainees which ensures they are aware of all of their roles and responsibilities and feel able to provide safe patient care. Handbooks or online equivalent may be useful in aiding this process but are not sufficient in isolation
- The potential risks associated with a) patients being boarded out directly from the Clinical Assessment Unit (CAU), and b) the additional risks from consequent delays in consultant assessment, must both be addressed
- An update on the progress of the agreed plan to follow through on the specific concern raised with the medical director (MD) and colleagues must be provided.

There is 1 condition that remains attached the UHA – Medicine Enhanced Monitoring case and the visit panel will consider what progress has been made to address the following condition:

- NHS Ayrshire & Arran must ensure that internal medicine trainees are provided with appropriate learning opportunities and feedback.

The visit team will also use the opportunity to regain a broader picture of how training is carried out within the department and to identify any points of good practice for sharing more widely.

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 includes numeric reference to specific requirements listed within the standards.

The Deanery would like to thank Dr Hugh Neill (Director of Medical Education) for the informative presentation which gave a detailed overview of work being done to address the 2021 visit requirements, which was delivered to the visit panel during the management session. The Deanery

QM visit panel acknowledged the great work done by staff in UHA-Medicine during the COVID pandemic both in terms of patient care and in sustaining the delivery of training, even in these more challenging circumstances.

2.1 Induction (R1.13):

Trainers: They recognised that there is always room for improvement. The rota coordinator ensures that trainees are not on-call when they are due to attend induction. Induction is delivered in batches so that everyone is not away at the same time. Consultants' clinical commitments are reduced during the first week so that they are available to support new staff and deliver induction.

FY Trainees: All trainees got induction when they started in medicine last August. The induction covered roles and responsibilities, on-call work including how acute receiving works, who to contact for support and the trainees' clinical and educational supervisors. Trainees noted that consultants were around every day in the first week. They did not suggest there was need to improve on the content.

GP & IMT Trainees: They all got induction when they started - which covered on-call, who to contact for support and who the trainee's clinical supervisor is. A supporting handbook is available. Suggested improvements were to include guidance on 'how to make things happen' – such as on how to arrange a CT scan or how to arrange for a central line to be inserted if they didn't have the requisite competence to do so and how to manage conditions such as stroke and thrombolysis.

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

Trainers: Sessions usually take place in afternoons, teaching days are highlighted to the rota co-ordinator who notes sessions on the rota so that the trainees can get time off to attend. Sessions are recorded if the trainees cannot attend the actual sessions. There are 3 departmental teaching sessions – the Friday medical division meeting where there is a speaker, usually a consultant. This is delivered face to face and on teams and attendees get a lunch voucher. There is a 1-hour trainee led teaching session on a Tuesday where trainees present cases, this session is also delivered using a hybrid teaching model. FY's have a fixed bleep-free weekly 1 hour session. Most of the teaching sessions continued through COVID. There is also a journal club held on the first Friday of each month. Attendance records are kept for all sessions.

FY Trainees: The teaching sessions they have available to them are 1 hour core FY1 teaching and 1 hour Friday wider hospital teaching. There is also a monthly journal club and morbidity & mortality (M&M) meeting. They always get to core teaching but attendance at others is variable due to ward pressures. They said that they can actually attend on average 1-2 hours formal teaching per week. The majority of trainees had no suggestions for improvement & they felt that sessions were pitched at the correct level. Although one trainee suggested more practical teaching sessions that were relevant to the curriculum as current sessions don't always reflect what they do day to day on a ward.

GP & IMT Trainees: GP trainees have specific pan- NHS Ayrshire & Arran GP teaching sessions which take place every 4 weeks and last around 2-3 hours. They also attend the Tuesday and Friday local teaching sessions (as per IMTs) as well as a monthly M&M meeting. Their ability to actually attend averages out at around at least 2 hours a week of formal local teaching. Dr Shetty tries to make sure that local teaching sessions happen and that all the information regarding dates and topics is communicated to trainees. IMTs attend an average of 2 hours of teaching a week ~ 1 hour on a Tuesday and 1 hour on a Friday. IMT trainees would like to be able to suggest some teaching topics that were even more relevant to their curriculum although they recognise that this is harder in a smaller hospital to have consultant led topics relevant to everyone all the time. IMTs also attend monthly national IMT teaching over teams. These monthly sessions are built into the rota. If trainees are on-call or are based in a ward that is busy, when the teaching was due to take place - it can be tricky to attend.

2.3 Study Leave (R3.12)

Trainers & Trainees: n/a

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

Trainers: n/a

FY Trainees: They have met with their educational supervisor twice per block. They see them more regularly informally if they are based in the ward, they are working in.

GP & IMT Trainees: IMT trainees have met their educational supervisor formally around 4 times since they started in post and also informally during the working day. GPSTs, whose educational supervisors (ES) are based in General Practice had not at the time of the visit yet met their educational supervisor in person but are still in regular contact with them. They have been able to organise their GP practice days, and this will enable meetings with their ESs.

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: Trainees are told as part of their ward induction told who to contact both in and out of hours. Trainees know the consultant timetable so know who is around, who is doing ward rounds and who has external commitments on another site. Out of hours there is an on-call consultant. There are acute physicians also in attendance. If on-call the consultant will check in with trainees before heading to bed. They were not aware of any instance where trainees have had to deal with things out with their experience. They feel that they are all approachable and visible on the wards.

FY Trainees: They are told who to contact for support at induction. During the day they would contact a senior colleague first then the consultant. Out of hours it would be the person who is carrying the page that would be contact. They do have to deal with things out with their competence and experience but can always access support when required whether in person or over the phone. Senior colleagues are very supportive and approachable.

GP & IMT Trainees: They know who to contact during the day and out of hours although some trainees said that some consultants are not always easy to contact or to track down. Generally, they felt supported by senior colleagues. GPSTs also find the second on 'registrar' to be very approachable and supportive for advice.

Support for trainees around decisions relating to the 'ceiling of care' and similarly challenging ethical issues is readily available for patients in the medical high care ward during the week from an acute physician works who is based there; at weekends medical high care is covered by the on-call general medical consultant and support for trainees then tends only to be by phone call, rather than by the consultant being in attendance

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

Trainers: Clinics are allocated via the rota coordinator, many clinics have still been running during the COVID era, although they resumed at different times. IMT trainees get first preference but other grades also get a chance to attend. Clinic attendance is reviewed every 3 months to ensure that all trainees get adequate experience. Chest drain, joint injections and central line procedures' training sessions still happen, and trainees take part in these. Trainees are allocated to specific wards to ensure that experience requirements are met. They think that the balance is good between service and teaching.

FY Trainees: They are managing to achieve their competencies with no issues. They get experience of managing acutely unwell patients as they are assigned for 1 or 2 blocks per 4months to the acute receiving unit. They get good feedback on their clerk-ins and clinical decisions from middle grade trainees, less so from consultants. Most of work they undertake is of limited educational benefit, mostly service however they perceive that this is the nature of the FY1 role. Senior colleagues do try to get them involved where possible and they do see patients. If they would like to have more access to training in procedures as there are lots of opportunities in the hospital and more access to educational opportunities such as audits and quality improvement projects. OOH they cover the back of the hospital rather than acute medical receiving. They estimate overall that their role is around 75% service and 25% education and training.

GP & IMT Trainees: These cohorts feel that they have adequate curriculum coverage and clinic attendance to meet their respective needs. Clinics are built into the rota – and while they have not managed to access all those the trainees have been allocated to – they are getting to sufficient numbers of clinics. For IMTs rheumatology clinics predominate among these. Trainees are able to see patients on their own and run things past the consultants.

Both cohorts have sufficient opportunity to manage the breadth of acutely unwell patients.

They believe that their posts are a lot more about service provision than education (around 60-80% (service) versus 20-40%(education)) but see the value of these posts.

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

Trainers: It can be difficult in the morning to provide feedback and complete assessments post ward round, but they all do their best to provide feedback in all forms and to make themselves available.

FY Trainees: They have no issues getting assessments signed off by more senior trainees.

GP & IMT Trainees: WPBAs are fairly easy to complete although ACATs can be tricky to get signed off as they would want to do them at the end of a night shift, but the patients are scattered, and they are split across 3 simultaneous ward rounds.

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

Trainers & Trainees: n/a

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

Trainers & Trainees: n/a

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: Trainers suggested that if they had a trainee with them, it was straightforward to provide feedback. However, if a patient has been clerked the night before and the trainee is no longer there, it is too busy to track them down and it is preferrable to provide feedback face to face. Consultants do see trainees regularly so they will address any issues with them either formally or informally. CAU is a challenging environment to provide feedback in, within specialty it is more feasible to provide feedback, but it can also be tricky with the shift patterns of trainees.

FY Trainees: They get feedback on their clerk-ins of acute medical receiving cases from more senior trainees. However, if they ask for it from a consultant, they will get it. The provision of feedback is variable but usually happens at least weekly. If a trainee does something wrong, they will find out. If they clerk a patient, this needs to be discussed and feedback will be provided. When given this feedback is helpful.

GP & IMT Trainees: There is little provision of feedback on these trainees' clinical management decisions of their acute medical cases from consultants. In the CAU there is little opportunity for feedback either during or after an out of hours shift. When ward based GPSTs can get some feedback from other trainees. Feedback in the ward-setting is consultant-dependent but will be given if sought out. Trainees endeavour to go back to refer to case notes to find out what has happened to cases.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: There is a junior doctor forum conducted by chief residents which meets every 2-3 months. Time is allocated at this meeting to each grade of doctor and the forum sends surveys to juniors. Minutes are sent round and discussed with consultants and the management team. Previously there was also a box (for 'orange forms' – through which concerns could be raised out with the Datix system) in the doctors mess for trainee feedback however because of COVID and space restrictions this is no longer in use.

Trainees: n/a

2.12 Culture & undermining (R3.3)

Trainers: They are not aware of any issues and get regular feedback from trainees. The department is small and very friendly. They feel that they are approachable as they see the trainees every day. If there any issues they have been raised in the past and trainees are told that they can speak to anyone in the team, it doesn't have to be their allocated supervisor. Any previous issues have been with locums. The consultants enjoy having trainees in the team and they do their best for them.

FY Trainees: There is good peer support from other trainee doctors. The consultant support is variable, but most are supportive. One trainee experienced some negative behaviour from a consultant and was able to raise that – but was unaware of any outcome. They were aware of previous issues with the same consultant. They know who to raise issues with if they experience any negative behaviours.

GP & IMT Trainees: They feel that generally the environment is generally very supportive. Dr Shetty is particularly supportive; he is very approachable, concerned about trainees' welfare and seeks out any problems. One trainee had witnessed an incident where the consultant was rude to a trainee on a ward round, but the consultant apologised afterwards. If they had any concerns trainees felt able to raise these with a consultant. Ms Janet Stephenson, the rota coordinator, was again commended by many for her support for enabling access to learning opportunities through incorporation of these into the rota.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: The rota co-ordinator notes clinics and teaching sessions on the rota. A rota compliance officer helps with making sure that trainees get their protected time for study afternoons. They are fully staffed, apart from 1 less than full time trainee which means that the department has to carry the 0.4 gap.

FY Trainees: Some slots on the rota have substantially more on-call than others and some raised perception of 'unfairness'; slots seem to be allocated randomly. They do not feel that there are any actual patient safety issues, but they perceive the shift patterns can be heavy and demanding.

GP & IMT Trainees: The rota co-ordinator is perceived to be excellent and an asset to the hospital (and, by some, even to the NHS as a whole). The rota is generally ok except certain stretches where 3 long days are worked then a weekend, with 1 day off then working for 4 nights - working out at 84 hours over 7 days. This pattern is worked once every 9 weeks. It was not thought that this constituted a risk to patient safety. At weekends it can feel short staffed at this time and it can be tricky to manage everything especially boarders.

2.14 Handover (R1.14)

Trainers: They think that handovers provide safe continuity of care. There is a handover at 0900 handover attended by the on-call team and overnight team. There is another handover in 1700 where the day team hands back to the on-call/night team. The on-call consultant attends both these handovers.

Trainees: All trainees felt that handovers are safe and support safe handover of care.

2.15 Educational Resources (R1.19)

Trainers & Trainees: n/a

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

Trainers & Trainees: n/a

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: n/a

FY Trainees: They would speak to their clinical supervisor if they had an issue with quality of training. There is also a junior doctor forum which meets around once per block. They hadn’t seen any minutes from these meetings.

GP & IMT Trainees: If they had any issues with training they would speak to their clinical supervisor, but maybe someone else depending on the nature of their concern for example the rota co-ordinator.

Some trainees had met with the clinical director who then spoke to consultants about ensuring that assessments were completed. There is a junior doctor forum run by the chief residents that is quite well attended. Issues raised at this meeting are well received by some of the consultant body.

2.18 Raising concerns (R1.1, 2.7)

Trainers: Trainees approach consultant staff to raise any concerns they have with them. There had been an incident recently with some late bloods and this was raised with a consultant. They want trainees to know that consultants are on their side. Another forum to raise issues is the morbidity and mortality (M&M) meetings.

FY Trainees: Any issues would be raised with a more senior trainee. The chief residents (CR) are very approachable (there is CR with a particular focus on FY training) so they would likely raise anything with them in first instance.

GP & IMT Trainees: It would depend on the situation, but they would talk to a consultant directly, charge nurse on ward or maybe the clinical director. There are also the M&M meetings.

2.19 Patient safety (R1.2)

Trainers: The hospital has been overwhelmed by new admissions at the moment due to COVID and they all do their best with resources available. There are several long-term locums who are perceived to be of better quality than previous locums. The consultants would always step in to help a trainee. Consultants slept in the hospital overnight during the worst COVID spell and helped trainees with calls to patients' families.

Every morning they get a boarders' list at handover where unwell patients highlighted. A category system (with 5 tiers) for boarders has recently been introduced so that they see ill patients quicker. If boarders are on a non-medical ward can be delays in these patients being seen by a consultant.

FY Trainees: Some trainees would have concerns about a friend or family being admitted to the hospital because of the volume of workload and other COVID-related pressures and is ward-dependent. They do not have concerns around any safety of care in relation to any individual member of medical or nursing staff. However, they noted they haven't worked in any other hospitals yet.

They do have some concerns about the boarding of patients, some of whom appear to be quite unwell but will still be boarded. They have never seen medical staff being involved in the decisions as to who is suitable for boarding. The hospital is trialling a new boarding category system which is based around 5 tiers that provides guidance around the level of ongoing input required; level 5 signifies 'medically stable, ready for and awaiting social care'.

GP & IMT Trainees: Potential concerns around safety of patient care were raised in relation to the CAU (discussed separately), in relation to boarding directly from CAU to non-medical beds and in relation to inconsistency of approach to review by consultants for patients assessed by the medical receiving team but who were backed-up awaiting admission to CAU (these patients were not reviewed by some consultants because they were not in the CAU). COVID-related service pressures were compounding the issues but were not the explanation. Some trainees also flagged the absence of services such as a stroke service at this site.

The concerns in relation to boarded patients related to how unwell these patients could be, the care that was available in what were perceived to be inappropriate wards, the delay in consultant review and the fact that boarders were occasionally missed off the boarders' list. To help prioritise the management of boarders we heard that a new tiered approach to categorising the patients (identifying those who were in greater need of review) was being introduced.

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

Trainers: Trainees get more formal feedback at M&M meetings and any issues are addressed straight away informally.

FY Trainees: They haven't really been involved in submitting any DATIX. Issues are raised at the M&M meetings, but they have not managed to attend these meetings.

GP & IMT Trainees: Only 1 trainee had recently completed a DATIX so there is no feedback as yet. They can attend M&M meetings. There is a good culture amongst junior doctors about what is going on in terms of shared learning. Trainees commended the provision of debriefs after cardiac arrest.

2.21 Other

FY Trainees: In an ideal world they would have fairer rotas, dedicated clerking shifts, more staff, dedicated feedback time and more learning opportunities. Their overall satisfaction scores ranged between 5 and 8, with the average being 7.

GP & IMT Trainees: Suggested improvements were to get feedback on clerking and dedicated feedback time. Their overall satisfaction scores ranged between 6 and 8, with the average being 7.

3. Summary

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

The visit panel noted significant progress in some areas and that trainees were being provided with a more positive training experience. There remains ongoing challenges and discussion will take place between the Deanery and the GMC around Enhanced Monitoring status & Conditions, following final approval of this report. A SMART objectives meeting will be arranged 4-6 weeks after receipt of this report. A further action plan update meeting will be co-ordinated to take place in October 2022.

Progress had been made against some of the previous visit requirements, although more work is required to address others. The visit panel has categorised previous visit requirements into Addressed, Progress noted, or little progress noted:

Req	Theme	Commentary
7.1	A process for providing feedback to FY, IMT and GPSTs on their input to the management of acute cases must be established.	Little progress noted
7.2	There must be sufficient substantive consultant staff in 'medicine' to provide appropriate supervision and feedback to trainees and to support the safe care for patients.	There remain several locums in post, but supervision is satisfactory
7.3	Departmental induction must be provided to all trainees which ensures they are aware of all of their roles and responsibilities and feel able to provide safe patient care. Handbooks or online equivalent may be useful in aiding this process but are not sufficient in isolation.	Addressed
7.4	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	Little progress noted
7.5	An update on the progress of the agreed plan to follow through on the specific concern raised with the MD and colleagues must be provided.	Agreed plan progressed

Positive aspects of the visit were:

- Scheduling of teaching opportunities including formal teaching sessions & clinics into the rota.
- Access to outpatient clinic opportunities for IMT & GPST is excellent, and this is despite COVID.
- The contribution of the Rota Co-ordinator, Janet Stephenson, to the training culture was commended.
- Dr Shetty was commended for his pastoral support & for his leadership of teaching.
- The handover system is safe and effective.
- Attendance at formal local and regional teaching is excellent for all levels of trainees.
- Approachable, accessible, and supportive cohort of substantive consultants.
- Induction is well supported and effective. The effectiveness of the induction was enhanced by greater availability of consultants during the first week as their scheduled commitments had been cancelled.
- Effectiveness of the system for engagement with and for feedback from doctors in training including the Junior Doctor Forum and the Chief Residents (who ensure engagement with all levels of trainees).

Less positive aspects of the visit were:

- Lack of feedback from consultants to GPSTs & IMTs on their management of acute medical admissions.
- Ongoing concerns around the management of boarders, acknowledging that COVID has exacerbated an existing issue.
- Clinical supervision around challenging decisions relating to HDU patients in relation to consultant cover arrangements at weekends & OOH.
- Variation in practice around the locus of consultant physician review of patients remaining in the ED following assessment by the medical team.

4. Areas of Good Practice

Ref	Item	Action
4.1	Scheduling of teaching opportunities including formal teaching sessions & clinics into the rota.	n/a

5. Areas for Improvement

Areas for Improvement are not explicitly linked to GMC standards but are shared to encourage ongoing improvement and excellence within the training environment. The Deanery do not require any further information in regard to these items.

Ref	Item	Action
5.1	Support for trainees around challenging decisions relating to patients in the medical high care at weekends should be similar to that available at other times, and in-person when necessary.	
5.2	A consistent approach should be introduced to ensure review by consultants of patients assessed by the medical receiving team but who are backed-up awaiting admission to CAU.	

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	A process for providing feedback to FY, IMT and GPSTs on their input to the management of acute cases must be established (including, in addition, completion of ACAT assessments for IMTs)	6 months from date of report	All
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.	6 months from date of report	All