Scotland Deanery
Quality Management Visit Report

Date of visit	2nd June 2023	**Level(s)**	FY, GPST, IMT, ST
Type of visit	Enhanced Monitoring re-visit	**Hospital**	University Hospital Crosshouse
Specialty(s)	General (Internal) Medicine	**Board**	NHS Ayrshire and Arran

Visit panel	
Professor Adam Hill	Visit Chair - Postgraduate Dean
Dr Alan McKenzie	Associate Postgraduate Dean – Quality
Dr Melvin Carew	Foundation Programme Director
Dr Kerri Baker	Associate Postgraduate Dean – IMT Stage 2/Training Programme Director
Dr Catherine Ward	Trainee Associate
Mr Richard Gibbons	Lay representative
Ms Kate Bowden	GMC representative
Ms Gillian Carter	Quality Improvement Manager
In attendance	
Ms Patriche McGuire	Quality Improvement Administrator

Specialty Group Information	
Specialty Group	Medicine
Lead Dean/Director	Professor Adam Hill
Quality Lead(s)	Dr Alan McKenzie, Dr Greg Jones, Dr Reem Al Soufi
Quality Improvement Manager(s)	Ms Gillian Carter
Unit/Site Information	
Non-medical staff in attendance	3
Trainers in attendance	11
Trainees in attendance	FY 13; GPST 5; IMT 6; ST 5

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

Date report approved by Lead Visitor	8th June 2023

1. Principal issues arising from pre-visit review:

University Hospital Crosshouse, Kilmarnock, has been on a re-visit cycle with the Deanery since 2015 and it was escalated to the GMC Enhanced Monitoring process in September 2021. The GMC had concerns in relation to the site not meeting training requirements for the following GMC standards:

S1.1 - The learning environment is safe for patients and supportive for learners and educators. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers, and families.

R1.8 - Organisations must make sure that learners have an appropriate level of clinical supervision at all times by an experienced and competent supervisor, who can advise or attend as needed. The level of supervision must fit the individual learner's competence, confidence, and experience.

R1.12 - Organisations must design rotas to provide learning opportunities that allow doctors in training to meet the requirements of their curriculum and training programme.

R1.15 Organisations must make sure that work undertaken by doctors in training provides learning opportunities and feedback on performance and gives an appropriate breadth of clinical experience.

The Deanery last visited Medicine at University Hospital Crosshouse in May 2022. The requirements arising from the visit were:

- Staffing levels must be reviewed to ensure that workload is appropriate to ensure access to learning opportunities including outpatient clinics and local formal teaching sessions in order for trainees to meet the requirements of their curriculum.
- Measures must continue to be implemented to address the patient safety concerns associated with the lengthy delays between arrival and definitive assessment of GP referrals.
- All trainees must have access to IT passwords and system training through their induction programme by the time they start clinical duties.
- 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 (including the significant amount of time spent competing blood test request forms).

- Feedback to all levels of trainees on their management of acute receiving cases must be provided to inform their learning and training (aiming for this in at least 40% of opportunities).
- The discontinuity of ward placements for Foundation, GPST and IMTs must be addressed as a matter of urgency as it is compromising quality of training, feedback, workload, and the safety of the care that doctors in training can provide. The duration of ward attachments of Foundation doctor must be increased to be for at least 4 weeks.
- The department must increase relevant training opportunities for GPSTs.
- The issue reported by trainees regarding the supervision arrangements within the Care of the Elderly Department must be fully addressed.

This visit aims to review progress against these 8 requirements and also take the opportunity to gain 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.

The panel wished to thank Dr Hugh Neill, Director of Medical Education, for the informative presentation given during the introductory session which described the progress made within the department since the previous Deanery visit.

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.

2.1 Induction (R1.13):

Trainers: Trainers felt induction was robust in terms of both generic and specialty-specific content. They felt the biggest challenge was providing induction for trainees who missed the first day of work. Whilst catch-up sessions are offered, trainers felt the quality of these sessions could be improved.

FY: Trainees reported that they received departmental inductions except in a speciality department. Induction prepared them well for starting work as it helped them become familiar with their teams and wards. They received all IT passwords and training prior to starting work.

GPST: Trainees reported that they received a short induction which included a visit to the Combined Assessment Unit (CAU) and having pictures taken for their ID badges. Trainees felt the medicine induction assumed prior experience of working at the hospital which some did not have and could have covered more generic topics such as how pagers worked. Some trainees did not have all IT passwords or security badges when they started work.

IMT: Trainees received a hospital induction, but felt this was overly complicated and confusing. Trainees also reported a lack of departmental induction in a speciality department and a limited catch-up induction for those who missed the first day in another speciality department. Some trainees had a delay of around 1 week to get access to all IT systems and required multiple conversations with IT to resolve these issues.

ST: Trainees felt they received adequate inductions covering all of their roles and responsibilities and generally received their IT passwords and training prior to starting work with the longest delay reported being 1 day.

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

Trainers: Trainers reported that general medicine teaching is available on a Tuesday lunchtime and this has recently been re-designed. Feedback on this teaching programme is gathered by chief residents and some sessions are recorded. Departmental teaching is co-ordinated by chief residents who liaise with consultants to plan sessions which are useful for trainees. Trainees also have the opportunity to deliver teaching sessions under the observation of consultants who can give them feedback on their teaching.

FY: Trainees reported that they have 1 hour of general medicine teaching and 1 hour of departmental teaching per week and can usually attend both. Trainees noted that some of the content was repetitive, for example multiple antimicrobial lectures.

GPST: Trainees reported that they have 1 hour of general medicine teaching and 1 hour of departmental teaching per week which they can attend as long as ward cover is available. Trainees were also able to attend their regional teaching delivered by the Deanery.

IMT: Trainees reported that they have 1 hour of general medicine teaching and 1 hour of departmental teaching per week, although no departmental teaching was available in Endocrinology and Diabetes. Trainees felt local teaching was of mixed relevance. There was an opportunity to attend departmental teaching in other specialties, but trainees were generally too busy to do this. They also had 4 hours per month of regional teaching delivered by the Deanery and could usually attend this. If the rota prevented them from attending they were able to get time off in lieu to watch recordings.

ST: Trainees reported that they have 1 hour of general medicine teaching and variable quantities of departmental teaching. Trainees reported that general medicine teaching was from a range of specialties and included non-clinical topics such as professionalism and sustainability. Departmental teaching was described as available in Acute Internal Medicine, Gastroenterology and Renal Medicine, but limited in Respiratory Medicine. Trainees could also attend Grand Rounds.

2.3 Study Leave (R3.12) – Not covered

2.4 Formal Supervision (R1.21, 2.15, 2.20, 4.1, 4.2, 4.3, 4.4, 4.6) – Not covered

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 reported that there is a morning handover in the CAU at which trainees will be advised of the consultants working that day. There is a consultant available in the CAU until 8pm who will check on trainees before leaving and usually also phone at 10pm. Out-of-hours there is a general medical consultant on-call for all teams. Consultant rotas are circulated and can be found on the intranet. Some trainees had contacted the associate medical director regarding working beyond competence in smaller departments. These concerns are being addressed.

FY: Trainees reported that they were supervised by named supervisors and given their page number or mobile number. Trainees described challenges contacting consultants in a speciality department as some were difficult to reach and some asked trainees not to contact them. They felt this led to patient safety concerns as there was no ST in the department and they could not find support when a patient deteriorated. Trainees reported previous concerns with supervision in another speciality department, but noted this has improved following the appointment of a second consultant in the

department recently. Trainees described out-of-hours support as variable as rota gaps and ST absences could lead to a lack of senior support. They noted that there was a night when the most senior person working at the front and back of the hospital was an IMT1. Trainees did not feel they need to cope with problems beyond their competence or experience except in one of the speciality departments.

GPST: Trainees knew who to contact for supervision, but felt they had to deal with problems beyond their competence and experience in one of the speciality departments as they were expected to give opinions to general medical consultants. Consultant support was not readily available as consultants could be in clinics and their workload was high. They had raised this with consultants but were told the arrangement needed to continue as no-one else was available to perform this role.

IMT: Trainees reported that they always knew who to contact for support and could readily access support out-of-hours, but had experienced difficulties in some departments during the day. They noted that this was specific to departments with small numbers of consultants. Some concerns were described in accessing senior support in one of the speciality departments, however it was noted that a second consultant had recently been employed which should improve this.

ST: Trainees knew who to contact for supervision and felt consultants were approachable and accessible.

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

Trainers: Trainers reported that all trainees have dedicated development time and they are encouraged to use that time for whatever training need they have including attending clinics or completing procedures. There is an app which they can use to record clinic attendance. Some specialties offer additional clinic time beyond what can be done on trainees' development days and they try to provide clinics which are appropriate to grade. There are not many clinic opportunities in Geriatric Medicine so trainees are encouraged to use their development days to attend clinics in other departments or to experience Hospital at Home which has good uptake. Rapid Assessment and Care Unit (RAC) shifts have recently been introduced which gives trainees an opportunity to complete assessments such as Acute Care Assessment Tools (ACATs). These shifts have been particularly beneficial for IMT trainees. Trainees are also encouraged to attend a ward round from 8:30am to

9:30am to present patients and are advised to stop clerking patients prior to this to allow them to attend, however attendance remains variable. Trainers felt the biggest challenges in delivering the curriculum were lack of clinic space and observing procedures for senior trainees who are already competent, but need procedures to be observed for sign-off.

FY: Trainees felt that they got good experience of managing acutely unwell patients, but did not often instigate management plans unless clerking. They got good experience of clerking during their 3 weeks in the CAU. They felt that they were generally able to meet their curriculum competencies as the curriculum was quite flexible. Trainees noted that they had fewer learning opportunities in a speciality department and had few senior colleagues to observe them in this department as they were usually working with clinical development fellows who were new to the NHS and an IMT1 who was often called away. Trainees felt that 90% of their work was non-educational as they spent a lot of time completing immediate discharge letters, taking bloods and completing tasks during the night which were carried over from the day such as prescribing insulin. Trainees described a shift where the FY was expected to chase bloods for the whole shift without prior knowledge of relevant patients which they felt was non-educational and also a patient safety concern.

GPST: Trainees felt that they got good experience of managing acutely unwell patients and were able to attend clinics during their development time once per fortnight. Trainees felt their ward-based tasks were useful even if not all were educational and noted there was often support available from other healthcare professionals with tasks such as bloods and cannulas.

IMT: Trainees felt that they got good experience of managing acutely unwell patients and felt all trainees should be able to meet their curriculum competencies at this site. Development time was described as "excellent" and trainees described attending up to 55 clinics this year including seeing patients independently in most specialties and receiving feedback. Trainees felt they had to do a lot of work that was not educational, but felt this was normal in the NHS, particularly over the recent winter when service pressure was high. They described a culture whereby trainees follow-up their own tasks from ward rounds rather than leaving them all for FYs. Trainees described the experience in one of the speciality departments as minimally educational as they lacked supervision and worked with only an FY. Trainees reported that they had to do their own ward rounds every day in one of the speciality departments.

ST: Trainees felt that they got good experience of managing acutely unwell patients and got to go to as many clinics as they needed. Trainees in Acute Internal Medicine found it difficult to get Focused Acute Medicine Ultrasound (FAMUS) experience as the hospital has only 1 FAMUS supervisor, however they noted that other tasks would be moved around to accommodate this experience. Trainees described occasionally having to act down and felt the educational aspects of their posts were variable depending upon workload.

2.7 Adequate Experience (assessment) (R1.18, 5.9, 5.10, 5.11) – Not covered

2.8 Adequate Experience (multi-professional learning) (R1.17) – Not covered

2.9 Adequate Experience (quality improvement) (R1.22) – Not covered

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: Not asked.

FY: Not asked.

GPST: Trainees reported that they received spontaneous feedback and could ask if they needed immediate feedback on a case. They felt feedback was constructive and meaningful and were encouraged to attend the 8:30am ward round to present patients.

IMT: Trainees reported that they receive helpful feedback in most departments and particularly in Acute Internal Medicine. Trainees felt the feedback was less good in one of the speciality departments. They received feedback on night shifts however the percentage of cases on which they received feedback was variable depending upon how busy the shift was.

ST: Trainees reported that availability of feedback was variable, but they got feedback when they asked for it. They felt the Acute Internal Medicine consultants knew them well and gave valuable feedback.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: Trainers reported that trainees can give feedback using a QR code located in the RAC and can use a new app to give feedback about teaching. This is still in its infancy, but trainers had anecdotal evidence of its use. There is a trainees' forum led by the chief resident.

Trainees: Not asked.

2.12 Culture & undermining (R3.3)

Trainers: Trainers reported that they promote a culture where trainees feel safe speaking out and take concerns seriously. There is a clinical governance lead who supports trainees with concerns along with the associate medical director. Trainees are encouraged to contact their supervisor with any concerns and are told how to escalate concerns if they can't speak to their supervisor. There is also a widely circulated organisational whistle-blowing policy.

FY: Trainees reported generally good support from their senior colleagues, but described instances of under-mining and inter-consultant friction in a speciality department. Specific examples have been shared with the director of medical education (DME), medical director and associate medical director outside this report. Trainees also had concerns relating to CAU handovers as they felt a lot of people attended these, some of whom seemed superfluous, and under-mining comments could be made by bystanders. Trainees described their Foundation Programme directors as approachable about any cultural concerns, but felt senior management were unsupportive.

GPST: Trainees felt their senior colleagues were very supportive and had not experienced any bullying or under-mining. They would raise any concerns about culture with their supervisor or line manager.

IMT: Like FYs, trainees reported generally good support from their senior colleagues, but described instances of under-mining in a speciality department. Specific examples have been shared with the DME, medical director and associate medical director outside this report. They identified that the under-mining seemed to affect FYs more than themselves. Trainees described raising concerns with

hospital management, but felt these were not acted on so they had contacted the associate medical director instead.

ST: Trainees felt their senior colleagues were very supportive and had not experienced any bullying or under-mining. They would raise any concerns about culture with their educational supervisor.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Trainers reported that there are times when the number of trainees available is insufficient for the workload and they try to mitigate risk by doing additional ward rounds and moving trainees where necessary. They prioritise cover for night shifts as this is where trainees are most vulnerable. They also felt the backlog due to poor patient flow impacted upon trainee workload and could be challenging when night shifts began with a backlog. Trainers felt the RAC had helped to ambulate patients and they were trying to schedule patient arrivals, for example for GP referrals, rather than having patients waiting.

FY: Trainees noted that the shift where they had to exclusively chase bloods for the back of the hospital was draining. They also felt the shift pattern where they worked in CAU then commenced nights was challenging as they worked 22 out of 25 days including 3 weekends. They found the placement of night shifts challenging as they would often work 2 sets of nights with 3 days in the middle which they found exhausting. Concerns have been raised regarding access to breaks which trainees felt had led to partial improvement.

GPST: Trainees felt their on-calls were intense, but no worse than anywhere else. They felt the introduction of a cross-cover rota within the last 2-3 weeks has improved safety as they can see who is coming to help when needed.

IMT: Trainees felt the rota had improved from previous iterations and was fair with no more than 5 days worked in a row. They noted that staff try to fill rota gaps. Trainees felt the on-call block was intense and compromised their wellbeing.

ST: Trainees had no concerns about their workload or rota.

2.14 Handover (R1.14)

Trainers: Trainers reported that a handover takes place in CAU at 9am and is attended by all specialties. Handovers of additional information take place throughout the day.

FY: Trainees had concerns about superfluous attendance and under-mining at handovers which are described in section 2.12.

GPST: Trainees thought handovers were safe and effective.

IMT: Trainees described handover as a medicine-wide process and felt it was safe, but could be attended by too many people and took too long. They felt the quality of handover was variable depending upon who was in attendance.

ST: Trainees felt handover was adequate, but there was room for improvement. The sickest patients were always handed over first and the process ensured all items were followed up as needed.

2.15 Educational Resources (R1.19) – Not covered

2.16 Support (R2.16, 2.17, 3.2, 3.4, 3.5, 3.10, 3.11, 3.13, 3.16, 5.12) – Not covered

2.17 Educational governance (R1.6, 1.19, 2.1, 2.2, 2.4, 2.6, 2.10, 2.11, 2.12, 3.1) – Not covered

2.18 Raising concerns (R1.1, 2.7)

Trainers: Trainers reported that trainees are encouraged to raise concerns about patient safety in real time and are aware of the datix system. Consultants discuss difficult cases together to set an example and nurses or senior trainees will often raise issues on behalf of more junior trainees. As a result, trainers felt there was a positive culture regarding concerns. Regarding training issues, trainees are encouraged to make a personal development plan (PDP) at the start of the year with their supervisor and discuss any deficits with them throughout the year. Trainees are also encouraged to raise any training issues in real time with an available consultant or discuss them

during de-briefs at the end of ward rounds. There is a trainees' forum every 6 weeks which includes senior medical staff and management.

FY: Trainees felt concerns were not addressed effectively as they described raising concerns about a speciality department which they felt had not been addressed.

GPST: Trainees felt their senior colleagues were helpful and supportive regarding concerns.

IMT: Trainees reported that concerns were raised over winter when service pressure was high and they felt these concerns were noted, but there was little their senior colleagues could do to help.

ST: Trainees reported that they would raise any concerns with their supervisor or a charge nurse. They would also complete a datix.

2.19 Patient safety (R1.2)

Trainers: Trainers reported that they would prefer not to have boarded patients and accepted that the standard of care was poorer for these patients, but tried to mitigate risk by cohorting patients and ensuring that each area has a dedicated boarding team including trainees.

FY: Trainees were concerned that their workload could be a patient safety issue in terms of volume of wards they needed to cover, particularly when there were absences. They were also concerned about "push patients" arriving on wards when there was no bed available for them. They reported that these patients may not yet have been seen that day and they could not examine them properly due to lack of space and privacy when there was no bed available.

GPST: Trainees felt that patients in the CAU could receive a lower standard of care than those in the wards and felt it would be better if patients could be moved to wards more quickly. They noted that many beds on the wards were taken up by patients awaiting discharge.

IMT: Trainees had patient safety concerns regarding two speciality departments and the general medical ward 4B and would not want friends or relatives to be treated in these areas. Their concern about ward 4B was a lack of nurses. Trainees were also concerned about boarding processes as

they reported patients were often boarded without medical review and decisions about who to board were made by bed managers without discussions with medical colleagues. They noted a locum consultant has been responsible for the boarding team, but they are due to leave soon.

ST: Trainees had concerns about patients who were boarded in surgical wards and noted that one of the speciality departments had a lot of patients boarded in other wards. Trainees did not have concerns about patients in the CAU as they felt the care they received was good.

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

Trainers: Trainers reported that there are departmental morbidity and mortality meetings (M&Ms) and they are currently re-instating a medicine-wide M&M which was paused during the covid-19 pandemic. All grades of trainee are invited to M&Ms. Learning notes are also shared across the organisation following analysis of significant events. Trainees are encouraged to use the datix system and to reflect on adverse events in their portfolio.

FY: Trainees had some experience of completing datix reports, but had not found feedback helpful where this had been received. Trainees had attended M&Ms in Geriatric Medicine and Stroke Medicine and felt the culture at these was positive. Trainees had not received any learning notes about significant events.

GPST: Trainees who had completed datix reports had found the feedback helpful. Some trainees had attended M&Ms within Stroke Medicine, but could not remember receiving any learning notes.

IMT: Trainees who had completed datix reports had found the feedback to be defensive. They had not attended any M&Ms, but were aware of one in Stroke Medicine.

ST: Trainees had some experience of completing datix reports, but this was quite recent and no feedback had been received yet. They were aware of discussions about adverse events within their own departments, but had not attended any M&Ms. They remembered receiving learning notes by e-mail.

3. Summary

Is a revisit required?	Yes	No	Dependent on outcome of action plan review

Overall the panel found significant improvements within the department and commended the trainers on the delivery of high quality training and support despite service pressures. Nonetheless, some concerns remained and specific concerns emerged regarding training and culture in the one of the speciality departments which were discussed with the DME, medical director and associate medical director within a post-visit meeting as an immediate serious concern.

Positives

- Trainers and the management team were committed to delivering training despite service pressures.
- The protected development time of 1 hour per month for FYs and 1 hour per fortnight for other grades is accessible and valuable. This allows trainees good access to clinics as well as time to work on their portfolio and other competencies.
- Thorough curriculum coverage is available for all grades.
- Support and supervision was commended by trainees in most departments.

Negatives

- Concerns were raised regarding a speciality department and details have been shared with the DME, medical director and associate medical director separately to this report.
- Trainees found handover intimidating due to the number of individuals in the room, some of whom seemed to be superfluous. Trainees described some instances of under-mining comments being made by bystanders during these handovers.
- FYs described a high percentage of non-educational duties, including some shifts where they were expected to spend all day chasing bloods without any background knowledge of the relevant patients. This was described as a patient safety concern.

Requirements from previous visit

Ref	Item	Status
6.1	Staffing levels must be reviewed to ensure that workload is appropriate to ensure access to learning opportunities including outpatient clinics and local formal teaching sessions in order for trainees to meet the requirements of their curriculum.	Met
6.2	Measures must continue to be implemented to address the patient safety concerns associated with the lengthy delays between arrival and definitive assessment of GP referrals.	Met
6.3	All trainees must have access to IT passwords and system training through their induction programme by the time they start clinical duties.	Partially met
6.4	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 (including the significant amount of time spent competing blood test request forms).	Partially met
6.5	Feedback to all levels of trainees on their management of acute receiving cases must be provided to inform their learning and training (aiming for this in at least 40% of opportunities).	Met
6.6	The discontinuity of ward placements for Foundation, GPST and IMTs must be addressed as a matter of urgency as it is compromising quality of training, feedback, workload, and the safety of the care that doctors in training can provide. The duration of ward attachments of Foundation doctors must be increased to be for at least 4 weeks.	Met
6.7	The department must increase relevant training opportunities for GPSTs.	Met
6.8	The issue reported by trainees regarding the supervision arrangements within the Care of the Elderly Department must be fully addressed.	Met

4. Areas of Good Practice

Ref	Item	Action
4.1	The protected development time of 1 hour per month for FYs and 1 hour per fortnight for other grades.	

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	The site should review their boarding policy to ensure an effective system of safe selection, tracking and managing of boarded patients, ensuring appropriate clinical ownership and oversight of patient care.	
5.2	All trainees must have access to IT passwords and system training through their induction programme by the time they start clinical duties. This has been provided for most trainees, but processes should be reviewed to ensure this is provided to all trainees without delay.	

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	The site must address the concerns raised regarding training and culture in the speciality department discussed post-visit.	As soon as possible	FY, GPST, IMT, ST
6.2	Handover arrangements must be reviewed and all staff must behave with respect towards each other and conduct themselves in a manner befitting Good Medical Practice guidelines during handover.	2nd March 2024	FY, GPST, IMT, ST
6.3	The burden of tasks for FY trainees that do not support educational or professional development must be significantly reduced (including the shift which requires FY trainees to exclusively chase bloods).	2nd March 2024	FY