Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	26th April 2023	**Level(s)**	FY, GPST, IMT, ST
Type of visit	Enhanced Monitoring re-visit	**Hospital**	University Hospital Ayr
Specialty(s)	General Internal Medicine	**Board**	Ayrshire and Arran

Visit panel	
Professor Alastair McLellan	Visit Chair - Postgraduate Dean
Dr Alan McKenzie	Associate Postgraduate Dean for Quality
Ms Kate Bowden	GMC representative
Dr Phil Bright	College representative
Dr Carol Blair	Training Programme Director
Mr Yatin Patel	Foundation Programme Director/Consortium Lead (North)
Dr Jennifer Craig	GP Training Programme Director
Dr Clementina Calabria	Trainee Associate
Ms Gayle Kennedy	Lay 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 Alastair McLellan
Quality Lead(s)	Dr Greg Jones, Dr Alan McKenzie, Dr Reem Al Soufi
Quality Improvement Manager(s)	Ms Gillian Carter

Unit/Site Information	
Non-medical staff in attendance	2
Trainers in attendance	6
Trainees in attendance	FY 7; GPST 3; IMT 6; ST 1

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

Date report approved by Lead Visitor	4th May 2023

1. Principal issues arising from pre-visit review:

General Internal Medicine (GIM) at University Hospital Ayr has been under the GMC Enhanced Monitoring process since 2016.

The Deanery last visited the department in April 2022. The requirements arising from the visit were:

- A process for providing feedback to FY, IMT and GPSTs on their input to the management of acute cases must be established (including completion of ACAT assessments for IMTs).
- 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.

This visit aimed to review progress against these 2 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 would like to thank Dr Hugh Neill and Dr Victor Chong for a detailed and informative presentation describing steps taken by the department to address the previous visit requirements as well as current challenges and priorities within the department.

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 reported that trainees who are new to the department have a full day of bleep-free hospital induction when they commence work which is led by a consultant and the rota co-ordinator. At the August changeover consultants do not have clinics for 1 week to allow them to support departmental inductions. An extended induction is offered to International Medical Graduates (IMGs) as part of the "Softer Landing, Safer Care" scheme.

FY: Trainees reported that they did not receive induction when rotating into medicine for the first time except an informal introduction from ANPs. Nonetheless, trainees felt they understood most hospital

systems from previous jobs in surgery and felt staff in medicine were approachable when they had queries. They felt it would be useful to have an induction at the start of each block for those new to medicine.

GPST/ST: Trainees reported that they received an induction to medicine on their first day which lasted about 45 minutes. This covered their on-call duties and involved showing them to their base ward. Trainees felt inadequately prepared to commence a long day or night shift following this induction.

IMT: Induction to medicine was inconsistent – some reported receiving no induction. Inductions to the wards were lacking. Some reported IT issues which took several days to resolve.

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

Trainers: Trainers reported that within medicine there is trainee-led teaching for 45 minutes on a Tuesday and consultant-led teaching for 1 hour on a Friday. The Friday teaching is also available on Microsoft Teams and includes lunch. The first Friday of every month is a journal club and otherwise topics are chosen based upon consultant availability. They try to start the year with general topics and cover different specialties throughout the programme. Suggestions for topics also come via the junior doctors' forum which meets every 2-3 months and from informal trainee feedback. The postgraduate administrator, Audrey Gallacher, monitors trainee attendance at the Friday teaching and shares this with supervisors to identify any issues. Trainers have tried to make local teaching bleep-free, however this has not been possible thus far. Regional teaching is also provided for FYs and GPSTs at the site.

FY: Trainees reported that they are offered 2 hours of local teaching per week plus 1 hour of regional teaching of which they can attend on average 1.5-2 hours in total. Trainees described clinical work, emergencies and unsupportive seniors as factors preventing them from attending teaching. Trainees reported that seniors sometimes ask them to stay on the wards rather than attending teaching and if they go to teaching they will often be paged repeatedly while there. Sometimes bleeps are taken by the postgraduate administrator to prevent trainees being paged during teaching, but this does not always happen. Trainees felt the teaching programme was good when they were able to attend.

GPST/ST: Trainees were offered 2 hours of local teaching per week on a Tuesday and Friday which they could attend unless off work or on-call. They felt the balance of different specialties within the programme was good. Trainees were also able to attend regional teaching, although GPSTs needed to give 6 weeks' notice to be released.

IMT: Trainees described local teaching being available on a Tuesday and Friday and felt they could attend on average 1.5 hours in total. This was a mixture of peer-led and consultant-led teaching and trainees felt it could be improved by involving more consultants or external presenters. Trainees were sometimes prevented from attending by ward rounds which could run until 1:30pm or later. Trainees estimated they could attend around 50% of local teaching and 1 trainee had missed all available teaching due to being on Annual Leave, nights, a zero day or on-call. The fixed rolling rota makes it hard for trainees to swap shifts and there is a lack of ST cover available. Whilst teaching is recorded, trainees struggled to watch recordings due to workload and exam preparation. This has been raised with the rota co-ordinator, Janet Stephenson, who has confirmed trainees will be given time off in lieu to watch recordings of teaching.

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)

Trainers: All trainers reported having time in their job plans to supervise their trainees. The number of substantive consultants in the department is small and locum consultants do not supervise trainees so sometimes trainees are supervised by consultants working on different wards. Nonetheless, trainers reported that they see their trainees regularly even if not working directly with them. Trainers felt they could identify trainees with difficulties quickly and adopted a joint approach to supporting them.

Trainees: Not asked.

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 felt they were visible and reported that they encourage trainees to contact them whenever needed. Trainers share their contact details with trainees and ensure they are familiar with

who is first- and second-on during each shift. Whilst there are few substantive consultants in the department, 5 out of 8 locum consultants are long-term locums so trainees have some consistency. Trainers reported that they model high standards and expect locum consultants to follow these. Trainers were not aware of any incidents where trainees have had to work beyond their competence or experience, although recognised this post could be a learning curve for IMTs who may have come from larger hospitals where they have less responsibility. Trainers reported that they try to support IMTs with any learning needs and encourage IMT1s to act up with senior support to prepare them for their roles as IMT2 and IMT3.

FY: Trainees reported they were always working with seniors and knew how to escalate concerns. They felt they sometimes had a lot of responsibility due to lack of middle grade trainees, but could source help when needed. Trainees found most seniors approachable with a small number being less visible.

GPST/ST: Trainees found trainers to be very accessible and helpful both in and out of hours.

IMT: Trainees rarely felt directly supervised and did not feel anyone was “looking after them”. Trainees reported there was a consultant on-call every day, trainees generally knew who to contact if help was needed and seniors were generally very supportive. A small number of seniors were noted to be difficult to get hold of and took too long to locate; when finally located, they were not necessarily helpful or supportive. On occasion trainees had to look to other specialties for support.

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

Trainers: Trainers felt they had general familiarity with their trainees’ training needs, but were not entirely familiar with all of the changes in the most recent curricular developments. Trainers were aware of training provided by NES regarding the summary narrative and Placement Supervision Group (PSG) required for Foundation trainees and noted that they read updates received from NES about curricula. They would check with the postgraduate administrator if uncertain about curriculum requirements.

Trainers reported that trainees are allocated clinics on the weekly rota and they keep an eye on numbers attended. They thought that all trainees were meeting their curriculum requirements for clinic numbers, but felt the variety of clinics offered could be improved.

Simulation is offered at University Hospital Crosshouse to allow trainees to practise procedures which are not seen frequently at the site, for example chest drains, lumbar punctures and central lines. Last year the trainees used a procedures pager to distribute procedures amongst those who needed them, but they elected not to do that this year. Sometimes trainees also co-ordinate opportunities to do procedures via a WhatsApp group.

FY: Trainees felt this post allowed them to develop their skills in managing acutely unwell patients, however it could be hard to leave clinical duties for other educational activities due to lack of staff. Trainees reported they often missed opportunities to undertake procedures due to busyness and felt they had to ask their seniors repeatedly to get workplace-based assessments (WPBAs) signed off.

Only FY1 trainees were present at the visit and there was no requirement to attend clinics; no FY2s were present. Trainees felt overall around 90% of their work was not educational but rather service-orientated such as completion of immediate discharge letters and referrals of patients who were not known to them.

GPST/ST: Trainees felt this post allowed them to develop their skills in managing acutely unwell patients and they received informal feedback on cases they had seen. Trainees struggled to complete certain procedures such as chest drains and central lines. GPSTs reported having scheduled clinics of which they had attended between 0 and 2 thus far. STs did not have scheduled clinics. Trainees felt most of their work was not educational. Ward rounds were done by FY1s alongside the consultant so more senior trainees did not benefit from these and the lack of STs in the hospital prohibited handing over pagers to them to take advantage of educational opportunities.

Training opportunities in Cardiology were commended.

IMT: Trainees felt this post provided many opportunities to manage acutely unwell patients, but the level of consultant supervision they received while doing this was variable, and feedback (see below) to inform their learning was not routinely provided. Feedback was provided if sought. Trainees

reported challenges in completing Acute Care Assessment Tools (ACATs). The challenges around supervision and feedback were greater because there are no Acute Medicine consultants in the hospital. They had limited opportunities to undertake practical procedures such as pleural procedures and central lines as these are rarely done at the site. Trainees felt it was hard to complete quality improvement (QI) projects as the Health Board does not have electronic records and there is little senior support or encouragement to do so.

The rota co-ordinator, Janet Stephenson, has a key role in scheduling clinics and monitoring clinic attendance which was noted and appreciated by trainees. Trainees described being allocated to clinics and were given time away from wards to attend these, however the scope of clinics was limited to Rheumatology and Respiratory Medicine, and only 4-5 clinics were running each week.

Trainees felt at least 80% of their work was not educational.

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: Trainers reported they were visible to trainees both during the day and out of hours with consultants attending handovers in the morning and afternoon and doing ward rounds twice per week. Trainers struggled to give feedback to trainees following nightshift and knew that trainees struggled to complete ACATs when on nights, but they have tried to improve availability of formal feedback by starting ward rounds at 8am and giving trainees an opportunity to present patients of their choice where possible. They try to do ACATs and other ticketed WPBAs during this time. Provision has been made for trainees to get feedback and also to complete ACATs during the afternoon as clinical teaching fellows take bleeps between 2pm and 5pm to allow trainees to present patients bleep-free, although consultants noted they sometimes struggled to be available by 2pm as they could still be completing ward rounds at this time. Nurses also contribute to giving feedback.

FY: Trainees reported that they get feedback when they ask for it and it is usually helpful unless consultants are very busy. Feedback was available from substantive and locum consultants.

GPST/ST: Trainees reported that they get feedback when they ask for it, but overall this is on less than 10% of their cases. Feedback following a night shift was limited, but sometimes there were opportunities to present patients to consultants in the morning. Trainees felt feedback was meaningful, when provided.

IMT: Trainees reported that they get feedback when they ask for it, but it is never given spontaneously. The quality of feedback is variable, but 3 consultants were noted to give very good feedback, when asked; the variability in feedback did not reflect a division between substantive and locum consultants. Trainees reported that feedback on downstream ward rounds was limited to FY1s as FY1s went on ward rounds with consultants while the IMTs did ward rounds on their own.

Most trainees were struggling to complete sufficient ACATs and most were unaware of the opportunity to present patients between 2pm and 5pm. Trainees who were aware of this opportunity felt it was not a helpful time for ACATs as they did not always have patients to present at that time, but it could be useful for case-based discussions (CbDs).

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: Trainers reported that trainees could give feedback via the junior doctors' forum. They also sometimes arrange a meeting with managers instead of Friday teaching which trainees can attend. There are 3 chief residents with whom trainers engage, comprising 1 for senior trainees, 1 for junior trainees and 1 for IMGs.

FY: Trainees felt they could give feedback via end of block surveys, speaking informally to supervisors, via the postgraduate administrator or rota co-ordinator or via chief residents. Trainees were aware of the different chief residents and had been invited to attend a meeting organised by them for FY1s. They were also aware of a group organised specifically for IMGs.

GPST/ST: Trainees felt they could give feedback via end of block surveys, individual meetings with supervisors or the junior doctors' forum. They were aware of their chief residents and knew they could contact them if unable to attend the junior doctors' forum.

IMT: Trainees felt they could give feedback via end of block surveys or the junior doctors' forum, however the latter was infrequent and often had poor attendance. Trainees were aware of their chief residents and knew that they fed back to 2 consultants of whom 1 is in medicine. Chief residents were not involved with management including the medical director or DME.

2.12 Culture & undermining (R3.3)

Trainers: Trainers reported they have a zero-tolerance attitude to bullying and undermining and have an open-door policy for trainees to raise such concerns. Trainers take action to address concerns whenever they are raised by trainees and involve the trainee's supervisor and the wellbeing team.

FY: Trainees felt their clinical colleagues were very supportive, but described being put under pressure to discharge patients by bed managers which was challenging when there were more urgent tasks needing to be done. They felt some discharges could be unsafe for this reason. They reported that out-of-hours Advanced Nurse Practitioners (ANPs) could be dismissive of Foundation trainees, an issue raised with ward-based ANPs. Some trainees reported experiencing discrimination by patients based on race or age but had called these episodes out at the time as well as raising them with their supervisor later.

GPST/ST: Trainees felt their clinical colleagues were very supportive and they had not experienced any bullying or undermining.

IMT: Trainees felt their clinical colleagues were pleasant, however sometimes they felt under pressure from bed managers to discharge patients who were not safe to discharge to maintain patient flow. Trainees reported a recent episode of a FY1 being in tears following an interaction with non-clinical senior managers.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Trainers felt there was a tension between training and service provision. Numbers were insufficient on the senior rota with currently 8 trainees instead of 9 so support was needed from locums who were often internal. Trainers recognised that trainees could have difficulty training due to their workload.

FY: Trainees felt the rota was well-staffed with full numbers, but any Annual Leave or sickness made the department under-staffed. Trainees felt the usual CAU staffing of 2 FY1s was manageable, but it was not manageable when 1 was off. The rota co-ordinator was commended for being effective and for trying to fill gaps.

GPST/ST: Trainees agreed that their rota was heavy and any absences made them under-staffed despite the rota co-ordinator trying to move trainees to fill gaps with their consent. Their rota included a lot of backshifts, long days and nightshifts and they felt they needed longer periods of rest after runs of long days. Trainees felt the rota was unsafe for both them and patients. Trainees did not have any time to work on their portfolio at work and needed to do this in their own time. ST trainees spent a lot of time in General (Internal) Medicine due to the lack of STs at the site which affects their specialty experience.

IMT: Trainees felt the staffing was insufficient for the workload and did not take into consideration trainees who require additional support or the need of all trainees to be able to leave the wards for training opportunities. There are gaps in the senior rota and almost all locums are internal. Trainees described the rota as “relentless” and felt it impacted on their wellbeing.

2.14 Handover (R1.14)

Trainers: Not asked.

All Trainees: Trainees felt handovers were effective and could sometimes be used as learning opportunities depending upon the seniors present.

2.15 Educational Resources (R1.19) – Not asked

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

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 asked

2.18 Raising concerns (R1.1, 2.7)

Trainers: Not asked.

All Trainees: Trainees would raise any concerns with their immediate seniors, the on-call consultant or the ward manager. They felt the patient safety concerns in the department were well known so did not tend to raise these.

2.19 Patient safety (R1.2)

Trainers: Trainers felt staffing levels were low, but safe. Numbers of substantive consultants were noted to be low and they had concerns about providing a receiving service given the gaps in certain specialties including Endocrinology and Diabetes and Gastroenterology. Trainers also had sometimes had concerns about boarded patients, however they noted there was a boarding policy which was reviewed regularly. Trainers reported that they highlight when patients are being boarded inappropriately. Boarded patients were described as usually being seen daily.

FY: Trainees felt the system in general was stretched and reported concern if a friend or relative was admitted to their department. They were concerned about the lack of consultants in particular specialties. They noted that workload pressures contributed at times to several day gaps between inpatient consultant reviews. Trainees had concerns about boarding of patients noting that sometimes patients were boarded despite consultants suggesting unsuitability for boarding.

GPST/ST: Trainees had some concerns about staffing at the weekends, although they felt that when the full complement of staffing was present it was sufficient. That was often not the case. They described long waiting times, particularly for consultant reviews for patients arriving via Accident and Emergency. Trainees also had concerns about patients being boarded inappropriately and often being boarded without consultant review.

IMT: Trainees reported potential concerns in relation to quality or safety of care of a friend or relative in relation to:

- The boarding policy - direct boarding from CAU to non-medical beds and the appropriateness and safety of that model. This was suggested to have been associated with at least one adverse outcome. Bed management was perceived to trump clinical considerations in relation to boarding-decisions.
- Pressure to discharge patients prematurely.
- Lack of access to certain specialty expertise to support the management of their acute patients.

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

Trainers: Trainers reported that all datix reports are sent to the clinical governance lead or the assistant medical director and feedback on them is given directly to trainees. Morbidity and mortality (M&M) meetings take place 4 times per year although there has been a gap recently. Trainers felt that trainees engage well with the clinical governance lead and bring relevant cases to her. Learning summaries are shared after incident reviews.

FY: Trainees reported that they can engage in discussions about adverse incidents at case review meetings. They were aware of 1 or 2 M&M meetings taking place in medicine since they started, but were not always able to attend them.

GPST/ST: Trainees were aware of adverse incidents being raised by colleagues, but did not have personal experience of this. Trainees were aware of M&M meetings, but GPSTs had not been able to attend any yet.

IMT: Trainees were aware of the datix system for raising adverse events, but had never received feedback on a datix report they had submitted. They were aware of M&M meetings in the department, but reviews of recent cases were often delayed “to let the dust settle” and it was suggested that reviews were too long after the event to be of benefit.

2.21 Other

Trainees were asked to rate their overall satisfaction with this post out of 10. Average scores were as follows:

FY - 6.1
GPST/ST - 5.5
IMT - 4

3. Summary

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

Overall, the panel recognised the work that had been done by the department since the previous visit, particularly given the ongoing clinical pressures they were facing. The panel noted improvements in some areas whilst hearing about some ongoing concerns around training opportunities, in particular for IMTs, but which were clearly articulated by all cohorts, particularly because of the fragile staffing.

Strengths

- The work the department has done around the “Softer Landing, Safer Care” initiative for IMGs is exemplary.
- Provision of local teaching opportunities is excellent, although there are issues around accessing these.
- Learning from adverse incidents is enabled and working well.
- The clinical governance lead role provides a hub for the learning opportunities available regarding adverse events.
- There is a willingness amongst the majority of consultants and enthusiasm to provide support to trainees when this is sought.
- Training opportunities in Cardiology were commended.
- The rota co-ordinator Janet Stephenson has a key role in scheduling clinics and monitoring clinic attendance which was noted and appreciated by trainees.

Weaknesses

- Feedback to inform learning around acute cases is limited and remains an opportunity for development.
- Whilst clear arrangements for departmental induction were described, trainees did not experience these.
- Patient safety issues were identified surrounding patient flow and it was noted that such issues are common across Scotland at present, however specific and concerning issues were identified regarding:
    - Boarding directly from the CAU.
    - Bed management being seen to trump clinical decisions regarding who should be boarded.
- There were concerns about the delivery of training to the IMT cohort who are lacking feedback to inform their learning. IMTs reported they were able to access clinics, although the range of available clinics was narrow.
- Willingness of senior engagement when help was sought by trainees was not reported to be universal.
- Dynamics between ANPs & FY1s could be improved.
- Staffing for workload was insufficient and there was a fragility in the workforce which generates issues when staff are on Annual Leave or unwell.

Progress against 2022 visit requirements

Requirement	**Status**
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)	Not yet met
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.	Not yet met

4. Areas of Good Practice

Ref	Item	Action
4.1	Scheduling of teaching opportunities including clinics into the rota.	
4.2	Support for IMGs including extended induction and appointment of a dedicated chief resident.	

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
	N/A	

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	Those providing clinical supervision must be supportive of trainees who seek their help and must never leave trainees dealing with issues beyond their competence or 'comfort zone'.	26th January 2024	FY, IMT, GPST, ST
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.	26th January 2024	FY, IMT, GPST, ST
6.3	A process for providing feedback to FYs, IMTs, GPSTs and STs on their input to the management of acute cases must be established. The feedback processes should also support completion of ACAT assessments for IMTs.	26th January 2024	FY, IMT, GPST, ST
6.4	The training opportunities for IMTs must align with the curriculum, including access to supervision and routine feedback to inform learning from acute and downstream patient management, ACATs, access to sufficient numbers and variety of specialty clinic opportunities and support for QI projects.	26th January 2024	IMT
6.5	Staff must behave with respect towards each other.	26th January 2024	FY, IMT, GPST, ST
6.6	Departmental induction must be provided which ensures trainees are aware of all of their roles and responsibilities and feel able to provide safe patient care.	26th January 2024	FY, IMT, GPST, ST
6.7	Staffing levels in wards must be reviewed to ensure that workload is appropriate and does not prevent access to learning opportunities.	26th January 2024	FY, IMT, GPST, ST