Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	12th April 2024	**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 Adam Hill	Visit Chair - Postgraduate Dean
Dr Alan McKenzie	Associate Postgraduate Dean for Quality
Ms Kate Bowden	GMC representative
Dr Philip Bright	College representative
Dr Carol Blair	Training Programme Director
Mr Yatin Patel	Foundation Programme Director/Consortium Lead (North)
Dr Thomasin Mackie	GP Training Programme Director
Dr Clementina Calabria	Trainee Associate
Mr Edward Kelly	Lay representative
Ms Vhari Macdonald	Quality Improvement Manager
In attendance	
Ms Claire Rolfe	Quality Improvement Administrator
Ms Helen Pratt	Quality Improvement Manager (shadowing)

Specialty Group Information	
Specialty Group	Medicine
Lead Dean/Director	Professor Adam Hill
Quality Lead(s)	Dr Greg Jones, Dr Alan McKenzie, Dr Reem Al Soufi
Quality Improvement Manager(s)	Ms Gillian Carter Ms Vhari Macdonald

Unit/Site Information	
Non-medical staff in attendance	2
Trainers in attendance	6
Trainees in attendance	7 FYs; 1 GPST; 5 IMTs; 1 LAT

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

Date report approved by Lead Visitor	21st June 2024

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 2023. The requirements arising from the visit were:

- 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'.
- 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.
- 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 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.
- Staff must behave with respect towards each other.
- 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.
- Staffing levels in wards must be reviewed to ensure that workload is appropriate and does not prevent access to learning opportunities.

This visit aimed to review progress against these 7 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 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 face-to-face hospital induction when they commence work which is led by a consultant. At the August changeover consultants do not have clinics for 1 week to allow them to support departmental inductions. Trainees who are not able to attend the initial induction are followed up with catch-up induction.

FY: All trainees present had attended departmental induction.

IMT/GPST: Trainees reported they received an induction to medicine on their first day which was then followed by departmental inductions. Trainees highlighted the General Medicine, Respiratory Medicine and Rheumatology inductions as very good. One incident of a trainee not receiving a departmental induction because they started their post whilst on-call was highlighted.

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

Trainers: Trainers reported that within medicine there are 1-hour teaching sessions that take place twice per week and 3 times per week for FY1 trainees. Teaching sessions take place on Tuesday, Wednesday and Friday of each week. Wednesday teaching was highlighted as FY1-specific and bleep-free. The local postgraduate administrator monitors teaching attendance and sends reports to educational supervisors every 3-4 months to ensure consistent attendance is maintained.

FY: Trainees reported that they are offered 1-1.5 hours of local teaching per week. Trainees described clinical work as a factor which sometimes prevented them from attending teaching. Overall trainees felt the teaching programme was good and they could attend sessions most of the time without interruption. Trainees did not appear to be aware of any access to simulation teaching in Medicine.

IMT/GPST: 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. Tuesday teaching was usually trainee-led and Friday teaching consultant-led. The trainees felt the Friday teaching was more curriculum relevant than the

Tuesday sessions. Trainees' attendance at teaching could occasionally be impacted by ward work or attendance at clinics.

2.3 Study Leave (R3.12) – Not asked.

2.4 Formal Supervision (R1.21, 2.15, 2.20, 4.1, 4.2, 4.3, 4.4, 4.6) – 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 on the wards and reported they encourage trainees to contact them whenever they need them. Trainers share their contact details with trainees and ensure they are familiar with who is first- and second-on during each shift. Trainers were not aware of any incidents where trainees have had to work beyond their competence or experience.

FY: Trainees reported they knew who to contact for support whilst working both during the day and out of hours. They did not raise any concerns in regard to working beyond their competence or experience.

IMT/GPST: Trainees reported they knew who to contact for support whilst working both during the day and out of hours, however there were some concerns raised around a lack of senior cover for Gastroenterology, particularly during periods of consultants' annual leave.

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

Trainers: Trainers felt they had general familiarity with their trainees' learning needs, however some Cardiology practical competences were highlighted as quite difficult to provide as the opportunity for them didn't arise on a regular basis.

Trainers reported that trainees are allocated clinics on the weekly rota, and they monitor attendance numbers. They thought that all trainees were meeting their curriculum requirements for clinic numbers. Trainers felt most of the activities that trainees are involved in are of educational benefit or can be perceived as having educational benefit including bloods, handover lists, ward rounds and tutoring and teaching at handovers.

FY: Trainees felt this post allowed them to develop their skills in managing acutely unwell patients, however it was felt this was mostly at night, with most of their work during the day highlighted as administrative work. Trainees were reportedly able to access clerking shifts in the Critical Assessment Unit (CAU), however they felt in reality they followed the consultant around and had a lack of time to clerk patients.

IMT/GPST: 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 to inform their learning was also sometimes variable. Feedback was provided if sought.

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

Trainers: Trainers reported opportunities for trainees to complete their Workplace-Based Assessments and were not aware of trainees having any difficulties getting them signed off.

FY: Trainees felt access to Workplace-Based Assessments was good and they reported no difficulties in getting them signed off.

IMT/GPST: Trainees reported challenges in completing Acute Care Assessment Tools (ACATs), particularly due to the structure of the receiving units and the requirement to get 5 patients in the same area. The GPSTs felt there was also possibly a lack of familiarity locally with their curriculum.

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 felt they try to do ACATs and other ticketed Workplace-Based Assessments when asked to by trainees.

FY: Trainees reported that they get feedback when they ask for it and it is usually through Workplace-Based Assessments, otherwise more generalised informal feedback was felt to be less frequent.

IMT/GPST: Trainees reported that they get feedback when they ask for it, but it is rarely given spontaneously. The quality of feedback is variable, but some consultants were noted to give very good feedback when asked.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: Trainers reported that trainees could give feedback via the junior doctors' forum which takes place every 2 months and is attended by the local chief residents. The local chief residents then have a meeting with local management, including trainers and the rota co-ordinator to discuss and try and resolve trainee concerns.

All Trainees: Trainees were aware of the different local chief residents and the trainee forum, where they felt they could raise any concerns around their training. They also received updates on progress of the issues they raised through the chief residents and their interactions with local management.

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. Trainers highlighted a system of anonymous feedback for non-clinical issues. This consisted of a box for notes in the doctors' room where they can place anonymous notes with issues.

All trainees: Some concerns were raised in regard to perceived undermining incidents which have been highlighted to the DME outside the visit process.

2.13 Workload/ Rota (1.7, 1.12, 2.19) – Not asked.

2.14 Handover (R1.14)

Trainers: Trainers felt the handover process was robust and provided safe continuity of care for patients. They highlighted a proforma that is used to go through issues that should be raised and also covers the allocation of roles at handover. A new system where an ICU doctor comes to morning handover with any issues overnight from the critical care area was also highlighted.

All Trainees: Trainees felt handovers were mostly robust and safe, although a lack of written handover was highlighted.

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: Trainers reported that Datix was used to record serious concerns and that individualised feedback was provided to trainees who raised them. Morbidity and Mortality meetings took place every 3 months with cases summarised, presented and discussed at the meetings with trainee involvement.

All Trainees: Trainees would raise any concerns with their immediate seniors, the on-call consultant or the ward manager. More serious concerns were then raised through Datix by the consultants. A concern was raised by trainees specifically in relation to patients being missed off a referrals board and put on an 18-hour wait after they arrive to A&E. Trainees said someone had come to harm because of this and a Datix was raised.

2.19 Patient safety (R1.2)

Trainers: Trainers reported that their local boarding policy has recently been updated with the trainee team putting significant input into the process. Trainers felt they reacted to feedback from trainees to continually improve the process. Trainers highlighted some of the routine systems which are in place to monitor the safety of patients including patient lists which are reviewed every morning. These included overnight patients, patients in critical care and also any patients who have been moved. Trainers felt overall that patient safety was good.

All trainees: Trainees felt that continuity of care was an issue; a high workload and a lack of staffing was felt to have the potential to impact patient safety at times, with some of the wards hosting significant amounts of boarded patients and having a lack of consultant cover to assess them. Trainees reported incidents where patients could wait over a week to be seen by a consultant, which was highlighted to be at a time of consultant annual leave. Trainees reported that there was a list of boarded patients, but that sometimes patients were missed off the list. Although these concerns were raised about the care of boarded patients, trainees felt the new boarding policy had improved the care of boarded patients over the last 6 months or so, however more time would be required to assess its impact.

2.20 Adverse incidents & Duty of Candour (R1.3 & R1.4) – Not asked.

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 such as the care of boarded patients and departmental induction, whilst hearing about some ongoing concerns due to workload and a perceived lack of staffing.

Positive Aspects:

- The creation of the Medical Education Governance Group is very good.
- Whilst the boarding policy has only just been implemented it has good trainee input.

- There have been real improvements in access to training opportunities.
- The junior doctors' forum is also good and functioning well.

Less Positive Aspects:

- As the new boarding policy has only just been implemented, we need to await an impact assessment.
- Unit induction is not always achieved for those that miss the initial induction.
- Trainees highlighted some concerns around the tracking of patients.
- Trainees reported some difficulties completing Workplace-Based Assessments.
- Some undermining concerns were highlighted and these have been reported to the DME outside the visit process.

Progress against 2023 visit requirements

Requirement	**Status**
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'.	Partially addressed; some concerns highlighted in regard to senior cover in Gastroenterology.
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.	Partially addressed; progress with new boarding policy however still some concerns related to delays in review of patients by consultants.
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).	Partially addressed.
The training opportunities for IMTs must align with the curriculum, including access to supervision and routine feedback to inform	Addressed.

learning from acute and downstream patient management, ACATs, access to sufficient numbers and variety of specialty clinic opportunities and support for QI projects.	
Staff must behave with respect towards each other.	Partially addressed; we acknowledge the work being done in respect to culture but some incidents were highlighted and raised with the DME outside the visit process.
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.	Addressed.
Staffing levels in wards must be reviewed to ensure that workload is appropriate and does not prevent access to learning opportunities.	Ongoing.

4. Areas of Good Practice

Ref	Item	Action
	Nil	

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
	Nil	

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'.	6th December 2024.	FY, IMT, GPST
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.	6th December 2024.	FY, IMT, GPST
6.3	Staff must behave with respect towards each other.	6th December 2024.	FY, IMT, GPST,
6.4	Staffing levels in wards must be reviewed to ensure that workload is appropriate and does not prevent access to learning opportunities.	6th December 2024.	FY, IMT, GPST
6.5	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).	6th December 2024.	FY, IMT, GPST