

Scotland Deanery Quality Management Visit Report



Date of visit	2 nd October 2018	Level(s)	FY, CT, GPST, ST
Type of visit	New site	Hospital	New Dumfries and Galloway Royal Infirmary
Specialty(s)	General Internal Medicine	Board	NHS Dumfries and Galloway

Visit panel	
Dr Alan McKenzie	Visit Chair - Associate Postgraduate Dean for Quality
Dr Peter MacDonald	Associate Postgraduate Dean for Quality
Dr Linsey Semple	General Practice Representative
Dr Olive Herlihy	Foundation Representative
Dr Antonia Calogeras	College Representative
Dr Ailie Grzybek	Trainee Associate
John Dearden	Lay Representative
Alex McCulloch	Quality Improvement Manager
In attendance	
Claire Rolfe	Quality Improvement Administrator

Specialty Group Information			
Specialty Group	<u>Medicine</u>		
Lead Dean/Director	<u>Professor Alastair McLellan</u>		
Quality Lead(s)	<u>Dr Alan McKenzie</u> <u>Dr Stephen Glen</u> <u>Dr Reem Al-Soufi</u>		
Quality Improvement Manager(s)	<u>Alex McCulloch</u> <u>Heather Stronach</u>		
Unit/Site Information			
Non-medical staff in attendance	3 – including Senior Nurse/Nurse Managers		
Trainers in attendance	12		
Trainees in attendance	6 - FY1	2 – FY2	1 – GPST 4 – Core
Feedback session: Managers in attendance	Medicine Trainers, DME, Chief Executive, Education Centre Manager, Lead Nurses and General Managers.		

Date report approved by
Lead Visitor

9th November 2018
Dr Alan McKenzie

A handwritten signature in black ink, appearing to read 'A. R. McLellan', written over a horizontal line.

Prof Alastair R McLellan – Lead Dean

1. Principal issues arising from pre-visit review

The purpose of this new site visit was to undertake an early review of the training infrastructure and training experience (as would be expected by the GMC) in this new LEP. As all of the Quality Management Groups within the Scotland deanery were required to visit the new Dumfries and Galloway Royal Infirmary (DGRI), a coordinated approach was adopted in collaboration with the site. This was to ensure disruption to services was kept to a minimum. This visit report is 1 of 4 that have been generated as a result of a 1 day visit to the specialty groupings of Medicine, Emergency Medicine, Anaesthetics, Surgery, Othalamology, Otolaryngology and Trauma and Orthopaedics.

2. Introduction

Dumfries and Galloway Royal Infirmary is the main hospital in Dumfries. The hospital serves both the town of Dumfries and the entire catchment area of South West Scotland, with a population of at least 148,190. The hospital is run by NHS Dumfries and Galloway (also known as Dumfries & Galloway Health Board). It has 344 staffed beds.

In 2012 it was announced that a new 350 bed state of the art hospital costing £200 million would be built at Dumfries By-Pass on the A75 close to the Garroch roundabout. The new hospital opened on 8 December 2017.

3.1 Induction (R1.13)

Trainers:

New induction documents were created following the re-location to the new hospital. Trainees received hospital site induction with an induction booklet issued to them and were given a walk-round tour of the hospital. Trainees were asked for feedback on their induction and changes were made to practice as a result of the feedback. Some of the induction talks were filmed and made available to trainees on the local intranet. If trainees missed induction, they would receive a 1-2-1 meeting with a clinical director to discuss some of the induction topics.

Foundation and General Practice Trainees:

All trainees present received hospital induction but had variable experience of departmental induction. Some trainees received departmental tours, but others did not. Some trainees had difficulties obtaining their IT usernames and passwords. They all received an induction booklet which they thought was good but would have appreciated it more in advance of starting their post. There was also a variation in experience of shadowing, some trainees received a message advising them they could shadow if they arrived a week early, others did not get this message. The trainees who were students at the University of Glasgow received a better experience of shadowing due to the medical school's Preparation for Practice programme.

Core Medicine Trainees:

All trainees present received hospital induction which included IT induction and they confirmed it was comprehensive. Feedback had been acted on from previous induction in April which improved the August 2018 induction. Departmental/ward induction was more variable, particularly if a trainee was on-call. The trainees based in the critical care ward did not receive departmental induction.

Nursing and Non- Medical Staff:

Nursing staff deliver sessions to the trainees at Induction regarding the hospital at night team (HAN) and how it works. They also cover handover arrangements. In the past a buddying system was operated, where an advanced nurse practitioner (ANP) supported the trainee through their first couple of weeks in post. This arrangement was not in place at moment, but they hoped to re-implement it in future.

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

Trainers:

Video link is provided to Glasgow for regional teaching such as COMEP (Core Medicine Education Programme). Foundation teaching is bleep free and trainee's pagers are collected in a trolley before they enter sessions. Nursing staff are briefed, and ward cover is provided to allow the foundation trainees to attend. It was stated that General Practice trainees were also released to attend their regional training days. Local teaching is delivered using a blended learning approach and trainees are asked for their input regarding topics. Local teaching is delivered to meet their needs. The weekly teaching timetable includes:

Monday – Case Discussion sessions – FY/GPST/CMT – trainee led

Wednesday – Grand rounds - consultant led

Friday – Journal club – all

Feedback is requested from trainees on all teaching sessions and the trainers confirmed lots of trainee interaction during the hospital grand rounds.

Foundation and General Practice Trainees:

Trainees described teaching sessions taking place on a Tuesday and Thursday with each session being 1-hour long. Their local teaching was timetabled and uninterrupted. Trainees estimated 1 -2 hours teaching per week and were all able to attend unless they were on annual leave or nights. Formalised FY2 teaching was delivered to trainees on a Wednesday. The General Practice trainee had been unable to get to any General Practice regional teaching sessions so far.

Core Medicine Trainees:

Trainees are able to access local teaching on a weekly basis, but it is not always bleep free. The weekly timetable includes:

Monday – Case Discussion sessions – FY/GPST/CMT – CT trainee led

Wednesday – Grand rounds - consultant led

Friday – Journal club – all (led by a F1 and CT)

Trainees attend the COMEP regional teaching for Core Medicine through a VC link to Glasgow.

Trainees reported difficulties attending COMEP teaching due to the organisation of blocks of on call within their rota.

Nursing and Non-Medical Staff:

Nursing staff provide ward cover for trainees during teaching and ensure they are not disrupted during it.

3.3 Study Leave (R3.12)

Trainers:

It can be a challenge to grant study leave to trainees due to vacancies on the rotas. However, effort is made to release trainees from their clinical commitments.

Foundation and General Practice Trainees:

Study leave is not available to FY1 trainees and the FY2 trainee present had not applied for it so far. The GPST had not applied for study leave and was unaware that they could apply for study leave to attend their GP regional teaching & courses at the deanery.

Core Medicine Trainees:

Trainees have no difficulties getting study leave approved, although it can be difficult if they are on-call.

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

Trainers:

The allocation of supervisors to trainees is conducted before the trainees arrive at the site. The trainers attempt to keep the same supervisors with the same cohort of trainees each year to build familiarity with the programmes and curriculums but advised it was not always possible to do this. The trainers themselves had attended the Scotland deanery educational supervision sessions. The University of Edinburgh also provide a clinical educator programme which the trainers attended. All trainers had time in their job plans to conduct supervision and there are 11 or 12 educational supervisors in the medicine department. All trainers received appraisal and revalidation through the SOAR system. Discussions around doctors with performance difficulties are conducted before a trainee starts and involves a discussion between the trainee's former supervisor and their current supervisor. Any concerns that merit further escalation are then discussed with the DME.

Foundation and General Practice Trainees:

Trainees had all been allocated educational supervisors, had met with them and had learning plans in place.

Core Medicine Trainees:

Trainees had all been allocated educational supervisors, had met with them and had learning plans in place.

Nursing and Non-Medical Staff:

Nursing staff felt the trainees could always receive senior support when they required it. They confirmed consultant support was visible and on the wards until the evening during the week and were contactable to the trainees on-call at the weekends and at nights. The nursing staff worked a 7-day week and support the trainees working on-call at nights and the weekend.

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

Trainers:

Trainers are aware of the requirements of various curricula through the e-portfolio system and that clinic experience is a challenge for trainees. It was stated that work is ongoing to improve clinic access for trainees. Most trainees are supernumerary at clinics and did not participate or run the clinics under consultant supervision. Trainees could obtain most of their curriculum competences and with the team being small, the trainers direct trainees to where to get some of the less frequent and more difficult to get clinical skills competences. A practical skills teaching session has been set up at 5pm on Wednesdays, however there has been limited uptake by trainees. Cross cover across grades to allow trainees to attend learning opportunities was flagged as a mechanism to access clinics/procedures etc. but did not seem to happen when trainees were asked.

Foundation and General Practice Trainees:

Trainees were able to achieve their competences but advised they had to be pro-active to do so. Some core procedures could be difficult for them to obtain and they noted simulation experience as difficult to get. The General Practice trainees present had not to date been to any clinics and neither had the Foundation trainees. Time spent completing non-medical tasks was raised as an issue by trainees. Foundation Trainees commented on limited support by other team members for administrative task completion.

Core Medicine Trainees:

Trainees noted their experience of working in medical receiving was good, particularly for completing Workplace Based Assessments and receiving feedback. Clinic access is an issue for Core Trainees and they did not receive protected time to attend clinics due to burden of providing cover for rota gaps. Trainees were not on track to meet the required number of clinics set by their curriculum. The trainees had raised this locally with their Educational Supervisors.

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

Trainers:

Trainers are aware of what assessments trainees are required to complete, through familiarity with e-portfolio. Trainees are able to achieve all of their portfolio assessments. Trainers were able to access Learnpro training modules on how to undertake Workplace Based Assessments (WBAs) and also through the the University of Edinburgh Clinical Educator Programme which allowed supervisors to participate in mock WBAs which were assessed by other educators and provided with feedback. Benchmarking of assessments is conducted at ARCPs and there is feedback provided from GP ARCP but not from CMT.

Foundation and General Practice Trainees:

Trainees described no difficulties with completing assessments in their posts although they noted DOPs (Direct Observation of Procedure) as difficult to get.

Core Medicine Trainees:

Trainees find it easy to complete WBAs. No concerns were raised.

Nursing and Non-Medical Staff:

Nursing staff contributed to the training of trainees by providing on shift 1-2-1 informal teaching on handover protocols. They also participated in workplace-based assessments for trainees, such as Direct Observation of Procedures (DOPs).

3.7. Adequate Experience (multi-professional learning) (R1.17)**Trainers:**

A weekly multi-disciplinary Meeting takes place within care of the elderly, where all staff in the department attend discussion and learning around cases takes place. All medicine staff participate in morning huddles which are conducted by the nursing staff. All staff in medicine are also invited to attend the monthly morbidity and mortality (m&m) meetings where Datix reports are discussed.

Foundation and General Practice Trainees:

Not covered.

Core Medicine Trainees:

Not covered.

Nursing and Non-Medical Staff:

Combined learning took place between nursing and medical staff. As student nurses were now required to complete some of the same WBAs as trainees, they attended some of the teaching sessions delivered for trainees.

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

Trainers:

An annual quality improvement poster competition takes place each year and trainees are encouraged to undertake projects, discussing ideas with their consultant colleagues and showcasing their work in posters. Trainers feel quality improvement is imbedded in the supervision process.

Foundation and General Practice Trainees:

Experience of audit is variable with some consultants approaching trainees with possible project opportunities. Of the trainee's present, 5 had quality improvement projects in progress.

Core Medicine Trainees:

Trainees are able to engage in quality improvements projects. No concerns were raised.

3.9. 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 a hands-on consultant team. They described issues with previous locum consultants who were made clinical supervisors being unaware of trainee requirements. Communication with them around this has improved. Due to the ward teams being small, communication between team members was generally good and trainers felt the trainees knew who to contact for advice and support both during the day and in the out of hours period. They are told by the duty consultant who finishes at 8 or 9pm who they should contact that night. The trainers described a situation of 2 trainees feeling out of their depth on their first weekend in post following changeover. The consultant covered the on-call night shift with trainees to ensure they were supported. Trainees are not allowed to take consent from patients for procedures in the hospital and this is written into the hospital induction pack.

Foundation and General Practice Trainees:

Trainees are in most cases able to access clinical supervision both during the day and in the out of hours period. The FY2's described feeling out of their depth sometimes at night, they described a situation where they are often the second on-call contact and as FY1 trainees have been unable to reach the on-call consultant locum, they have had to deal with problems beyond their competence. The trainees describe their consultant and nursing colleagues as generally very helpful and approachable. They feel the support they receive from locum consultants is variable.

Core Medicine Trainees:

Trainees can access clinical supervision both during the day and in the out of hours period. They did not report any instances of working beyond their competence. They feel their consultant colleagues are accessible and approachable.

Nursing and Non-Medical Staff:

Nursing staff differentiate between grades of trainees by introducing themselves to new cohorts of trainees when they start. They were not aware of the colour-coded badge system in place. They feel the trainees are generally well supported and were not aware of many instances where trainees had to cope with problems beyond their competence.

3.10. Feedback to trainees (R1.15, 3.13)

Trainees:

Feedback is provided on the wards during shifts to trainees and during formal meetings with their supervisors. Consultants also review patients with trainees present.

Foundation and General Practice Trainees:

FY2 and General Practice trainees receive feedback on the clerking of patients. Feedback for FY1 trainees is more difficult to get as they reported that they do not clerk newly admitted patients. Feedback was often only given if they make an error and it is thought to be administrative rather than on their clinical practice.

Core Medicine Trainees:

Trainees receive regular, informal feedback and post take feedback. Most trainees work with their clinical supervisors due to the small nature of the teams in medicine.

3.11. Feedback from trainees (R1.5, 2.3)

Trainers:

The trainers review the National trainers survey to gain feedback from the trainees.

Foundation and General Practice trainees:

Trainees noted the pre-visit questionnaire sent to them by the deanery visit team as an opportunity to provide feedback in addition to the national training surveys. They did not appear to have a trainee forum. They have also raised issues locally regarding the rota and a meeting was arranged to discuss the issues.

Core Medicine Trainees:

Aware of the national training surveys however providing feedback as a group can be difficult for trainees and they do not appear to have a trainee forum.

3.12. Workload/ Rota (1.7, 1.12, 2.19)

Trainers:

Trainers work closely with the trainees to ensure learning opportunities are maximised. There has been and continues to be difficulties with rota gaps. As the medicine team in the hospital is small any absences in the any of the trainee cohorts affect the trainees on shift. The trainers did note they supported trainees that were cross covering rota gaps with 1-2-1 teaching to support them. Trainers described difficulties attracting locums to fill their vacancies.

Foundation and General Practice Trainees:

The FY1 rota is manageable for trainees if there are no absences however even when fully staffed the job is busy. The FY1 rota consists of long and short weeks and they work every 2.5weekends. The FY2 and GPST rota is manageable for the most part for trainees. The trainees worked a 6 week on-call period which meant 3 weeks of working nights followed by 2 weeks annual leave which again was followed by another 3 weeks of nights. The F1 rota is currently fully staffed, trainees explained 1 FY1 trainee was allocated to each Medicine ward, with no cross-over. It was reported that there had been difficulties taking leave due to rota gaps.

Core Medicine Trainees:

Trainees feel their rota is manageable if there are no absences. In some departments it was reported that there had been difficulties recruiting consultant locums or with consultant locums changing on a regular basis and other locum doctors turning up on the wrong day or week. This has raised issues with regard to continuity of patient care and rota organisation / organisation of medical cover.

Some trainees feel they are being pressured to cover out of hours shifts when there are absences. The rota is described as very tight, which did not make it easy for them to swap shifts or for them to take annual leave. Overnight on call can be busy.

Nursing and Non-Medical Staff:

Nursing staff did not note any concerns regarding the impact of rotas on their trainee colleagues but advised they rotas could be difficult if there were short notice changes or absences that meant they had to cover unexpected gaps.

3.13. Handover (R1.14)

Trainers:

Trainers feel they are constantly working to improve handover, trainees are involved in daily nursing huddles. They described consultant presence at most handovers but not every day and in every ward. Handover took place in the morning at 9.00 am, in the afternoon at 4.30 pm and at night to the Hospital at Night team (HAN). There is no formalised process for recording handover, either written or electronic except for Friday afternoon weekend handover.

All Trainee Cohorts:

Trainees said handover took place at 9.00 am (morning huddle/MDT), 4.30/5.00 pm and 9.00pm which was the handover to the HAN team. Consultants were present at most evening handovers, but it was variable from ward to ward. They were sometimes in attendance at the morning Huddles/MDT meetings. The trainees advised handover was not recorded in most cases and was an informal process.

Nursing and Non-Medical Staff:

Nursing staff noted the morning 9.00 am huddle as a recorded handover with a further huddle at lunchtime. They felt consultant presence was variable at the huddles.

3.14. Educational Resources (R1.19)

Trainers:

This was addressed by the DME in his presentation to the visit teams. It was highlighted that the educational resources available to all in the new hospital were very good.

Foundation and General Practice trainees:

IT facilities were adequate for learning.

Core Medicine Trainees:

See above. VC facilities for COMEP teaching are available however as noted working patterns restrict access.

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

Trainers:

Trainees can feedback any concerns they have around their training to their educational supervisor or consultant colleagues. There were no less than full time trainees in post. Trainers feel they provide good support to trainees with performance issues.

All Trainee Cohorts:

Support for trainees is readily available and they noted their consultant colleagues to be open and approachable. They also noted the post-graduate centre and its manager to be very supportive. No trainees are currently working less than full-time, and no trainees had made any requests for reasonable adjustments but advised they would speak to their educational supervisor if they required any.

Nursing and Non-Medical Staff:

Nursing staff would raise any concerns about the performance of a trainee with their supervising consultant.

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

Trainers:

Covered in the DME presentation

All Trainee Cohorts:

FY & GP trainees described that there was regular feedback sought after all teaching sessions however they weren't aware in detail who was responsible for educational governance.

3.17 Raising concerns (R1.1, 2.7)

Trainers:

Trainees are aware they would use Datix to raise any concerns about patient safety in addition to discussion with their Educational or Clinical Supervisor. Trainees regularly attend M&M meetings and have input to them.

Foundation and General Practice Trainees:

Trainees report any concerns they have about patient safety through Datix. Some have concerns around the Datix reports not being anonymous and them being sent to the senior charge nurse. Trainees speak to their consultant if they had any concerns around their education and training. A trainee had submitted a Datix but did not receive feedback on it.

Core Medicine Trainees:

Trainees report concerns through Datix. Feedback was not received by the trainees who had submitted Datix reports.

3.18 Patient safety (R1.2)

Trainers:

The environment at Dumfries and Galloway Royal Infirmary is felt to be safe for patients and trainees. Rota gaps meant a heavy consultant presence on the wards up until 10.00 pm in the evening to support the trainees and to ensure the environment was safe for them and patients. The boarding of patients had been an issue in the past, but the site was continuing to review their processes for managing the care of boarded patients and a new proforma is being developed to support this. The hospital is also starting their winter planning process in the next 4-6 weeks to prepare for the expected, increased patient numbers in the winter.

Foundation and General Practice Trainees:

There were concerns raised around consistency of patient reviews within the clinical assessment unit (CAU) at Weekends. It was highlighted that on occasions there has been up to 48hrs between consultant reviews for patients as the process for review if patients remain in CAU is unclear. Handover of patients from CAU to wards was also highlighted as an area of potential weakness.

Core Medicine Trainees:

Patient care would vary depending on which consultant a patient was admitted under. They felt the quality of patient care delivered by locum consultants was not as good as the care delivered by permanent consultants. Trainees feel medicine patients boarded out to other wards do not receive the same level of care as those admitted to the medicine wards. Trainees based in critical care described a different educational experience when a medicine consultant is on shift in the unit which at present is only 1 week in 4.

Nursing and Non-Medical Staff:

Nursing staff felt the environment at DGRI was safe for patients. They described patient boarding as regular occurrence but felt the systems in place supported the care of these patients.

3.19 Adverse incidents (R1.3)

Trainers:

Incidents are reported through Datix. Trainees are provided with feedback on Datix reports they have submitted through their clinical supervisor. The local clinical services manager contacts the trainees clinical supervisor if a trainee is involved in an adverse incident and a meeting is arranged between supervisor and trainee to discuss the incident and to reflect on it.

All Trainee Cohorts:

Trainees report any adverse incidents through Datix, feedback was in-frequent and did not happen in most cases.

Nursing and Non-Medical Staff:

Adverse incidents were reported through Datix and learning from incidents was discussed at Multi-disciplinary meetings.

3.20 Duty of candour (R1.4)

Trainers:

Trainees and trainers complete a Learnpro module on duty of candour. When things go wrong the incidents are discussed openly and honestly with trainees.

All Trainee Cohorts:

Trainees are aware of duty of candour and thought they would be supported in an incident where things had gone wrong and would discuss incidents with their educational or clinical supervisor.

3.21 Culture & undermining (R3.3)

Trainers:

Trainers described a good awareness of what undermining and bullying behaviours are and they met to discuss any incidents. Trainees are informed at induction to contact their educational supervisor if they are subjected to undermining behaviours. They were also aware they could approach the local DME directly with any concerns. The board had formal policy which was available to all on their intranet site. Trainers described previous complaints had been made of an undermining nature regarding consultant locums and also members of the nursing staff, but these had been resolved at a local level and to the satisfaction of all parties. They did not describe any recent incidents.

Foundation and General Practice Trainees:

Trainees feel generally well supported by their consultant colleagues, although 1 or 2 individuals were highlighted as being short-tempered on occasions. The trainees have raised this at a local level, although not with the DME and are satisfied their concerns are being addressed. The trainees also had reported issues regarding a locum consultant in the past, which they again felt had been adequately addressed.

Core Medicine Trainees:

Trainees described a supportive environment and felt well supported by their consultant colleagues. They had not been subjected to any behaviours that they considered bullying or undermining behaviours. They would raise any concerns with a consultant they trusted or indeed their clinical or educational supervisor.

Nursing and Non-Medical Staff:

Nursing staff advised there had been occasions where nursing staff had questioned trainees, and these were perceived as undermining incidents by the trainees. These were described as “odd” occasions and they were dealt with at the time on a case by case basis and resolved to the satisfaction of the trainees and the Nursing staff.

3.22 Other

4. Summary

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

The visit team found the training environment within medicine to be of a good standard. There were many positive aspects of the visit and some areas which require follow up in the requirements below.

Positive aspects of the visit:

- Enthusiastic and engaged consultants
- Proactive Educational Supervision
- Foundation Trainees have protected teaching
- Opportunities for learning & 5pm skills sessions provide on Wednesdays.
- Quality improvement opportunities available to trainees
- Good support for trainees in difficulty

Less positive aspects of the visit:

- Departmental induction variable including for Critical Care
- IT system induction and pass word provision variable
- Handover – lack of consistent structure/standardisation/ written or electronic documentation/ senior presence
- Critical Care senior medical clinical supervision only 1 out of 4 weeks
- Inconsistency of patient follow up reviews of CAU patients at weekends.
- Feedback on clinical incidents via Datix - not consistent and no clear forum for learning
- Core Medicine Teaching Programme access
- Clinic access for CMT and GPST
- Rota co-ordination and planning – unclear who is responsible for cover of gaps
- No formal trainee forum
- Suggestion of exceptions regarding behavior on 2 occasions – rudeness possibly in context of stress – datix no feedback

5. Areas of Good Practice

Ref	Item	Action
5.1		

6. Areas for Improvement

Ref	Item	Action
6.1	Clinical supervision in the form of Medicine consultant presence in the critical care unit could be increased.	

7. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
7.1	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. Handbooks may be useful in aiding this process but are not sufficient in isolation	2 nd July 2019	FY/CMT/GPST
7.2	All trainees must have timely access to IT passwords and system training through their induction programme.	2nd July 2019	FY/CMT/GPST
7.3	All handovers within Medicine must become more structured and more robust also with written or electronic documentation.	2nd July 2019	FY/CMT/GPST
7.4	Appropriate outpatient clinic training opportunities must be provided for Core Medicine and General Practice Trainees. Clinic experience must be active participation (rather than merely observing) as is appropriate to the level of trainee.	2nd July 2019	CMT/GPST
7.5	Barriers preventing Core Medicine trainees attending their dedicated teaching days must be addressed.	2nd July 2019	CMT
7.6	A process for providing feedback to Foundation doctors in training on their input to the management of acute cases must be established (good for all except FY – see above comments) and feedback provided from incidents recorded on the Datix system. This should also support provision of WPBAs.	2nd July 2019	FY

7.7	A mechanism to allow trainees to safely raise concerns and provide feedback should be established.	2nd July 2019	FY/CMT/GPST
7.8	The consistency of patient follow up reviews must be improved in the Clinical Assessment Unit (CAU) at weekends.	2 nd July 2019	FY/CMT/GPST

