Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	8th June 2021	**Level(s)**	F1, IST, and Specialty
Type of visit	Revisit	**Hospital**	Inverclyde Royal Hospital
Specialty(s)	General Surgery	**Board**	NHS Greater Glasgow & Clyde

Visit panel	
Dr Geraldine Brennan	Visit Chair – Associate Postgraduate Dean (Quality)
Dr Shilpi Pal	Training Programme Director
Dr Karen Rose	Foundation Programme Director
Dr Ashley Thomson	Trainee Associate
Mrs Fiona Stewart	Lay Representative
Mrs Jennifer Duncan	Quality Improvement Manager
In attendance	
Mrs Gaynor Macfarlane	Quality Improvement Administrator

Specialty Group Information	
Specialty Group	Foundation
Lead Dean/Director	Professor Clare McKenzie
Quality Lead(s)	Dr Geraldine Brennan & Dr Marie Mathers
Quality Improvement Manager(s)	Mrs Jennifer Duncan
Unit/Site Information	
Trainers in attendance	4
Trainees in attendance	F1 - 4. IST – 1. ST - 3.

Feedback session: Managers in attendance	Chief Executive	0	DME	1	ADME	1	Medical Director	0	Other	7

Date report approved by Lead Visitor	02/08/2021 Dr Geraldine Brennan 02/08/2021 Professor Clare McKenzie

1. Principal issues arising from pre-visit review:

Following a Deanery visit in January 2020 a number of concerns were raised regarding Foundation training in General Surgery at Inverclyde Royal Hospital. Along with a number of requirements made in the final report the visit panel also stated their intention to return to the unit within 12 months.

Below is data from the GMC National Training Survey 2019 (NTS) and the Scottish Training Survey 2020 (STS).

NTS Data 2019

Foundation NTS data combines both General Surgery and T&O.
F1 – Pink Flag – Curriculum Coverage.
F1 – Red Flags – Adequate Experience, Educational Governance, Induction, Overall Satisfaction, Reporting Systems, Rota Design, Workload.

Core – Aggregate Pink Flags – Adequate Experience, Curriculum Coverage, Handover, Overall Satisfaction.

General Surgery – ST – Aggregate Pink Flags – Adequate Experience, Curriculum Coverage, Educational Governance, Educational Supervision, Feedback, Overall Satisfaction.

STS Data

General Surgery – Foundation – Pink Flag – Handover.
General Surgery – Foundation – Red Flag – Induction.

General Surgery – IST – All Grey Flags.
Core – All Grey Flags.

General Surgery – ST – Aggregate White Flags – Clinical Supervision, Induction, Team Culture, Workload.
General Surgery – ST – Aggregate Red Flags – Educational Environment, Handover, Teaching.

At the pre-visit teleconference the visit panel agreed that the focus of the visit should be around the areas highlighted in the previous visit report recommendations.

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.

Department Presentation:

The visit commenced with Mr Carsten Bolln delivering an informative presentation to the panel which provided an update regarding the progress against the previous visit requirements and the impact of Covid on the department.

2.1 Induction (R1.13):

Trainers: Trainers reported on trainee centred site and departmental inductions. A detailed handbook is also provided to all training grades which trainees get the opportunity to feedback on and updates are made regularly. Trainers commented on the challenges of keeping the handbook updated during Covid due to the continuous changes to guidance.

F1 Trainees: Trainees confirmed receiving a good quality hospital induction. They did not receive a formal induction to general surgery but were told to turn up to the department for a quick chat. No induction booklet was received, and trainees commented that this would have been very useful to have. They commented on having to rely heavily on previous trainees and middle grades for information on the department. Trainees have also not been asked to provide comments on an induction booklet for trainees due to start in the next training year.

IST/ST Trainees: A mixed response was received from trainees regarding induction; some considered it adequate and others stated they only received IT induction, a quick tour of the ward and no handbook was received. This is a particular problem if trainees begin posts out of sync with colleagues. Trainees commented that they would benefit from having logins for endoscopy and OPERA at induction as they received neither before starting their post.

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

Trainers: Trainers reported that F1 trainees are released for one-hour weekly teaching which is run via Microsoft teams. The departmental policy states that middle grade trainees should take the F1 bleeps however this does not always happen. Trainers are not aware of any issues with the release of IST or ST trainees for teaching unless they are on-call. Trainers consider all work in the department to be a learning opportunity for trainees. Safety huddles for example are used to expand knowledge. There is also a departmental teaching programme driven by IST and ST trainees for F1 trainees, which develops IST/ST leadership skills.

F1 Trainees: Trainees confirmed receiving one-hour of locally delivered teaching per week which is not bleep free. Regional teaching is delivered via Teams from GG&C and barriers to attending that are generally related to workload. Due to the volume of jobs it is not always possible for trainees to attend teaching and get all their jobs done by the end of the shift. The ANP is available to help however the trainees commented that it is not possible for one ANP to provide cover for 3 wards.

IST/ST Trainees: Trainees commented on attending a one-hour local educational meeting weekly and have no issues in attending unless on elective duties or on-call. Trainees find it difficult to obtain cover to attend regional teaching as there are only 4 ST3 trainees, which is the highest grade of trainee on site. As consultants provide most of the teaching, staff grades are stepping in to help provide ward cover to allow ST3s to attend.

2.3 Study Leave (R3.12)

Trainers: Not asked. No concerns raised in pre-visit questionnaire.

F1 Trainees: Not applicable.

IST/ST Trainees: Not asked. No concerns raised in pre-visit questionnaire.

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

Trainers: Trainers reported that F1s are randomly allocated to supervisors, with trainers also supervising a IST or ST trainee. Trainers reported that over the last 2 years the way in which Foundation trainees are allocated to supervisors has changed; Foundation trainees are now provided with a different educational and clinical supervisor per block. Trainers considered that the old approach, which involved Foundation trainees being allocated an educational supervisor for the training year and a different clinical supervisor per block, was more consistent and effective. Trainers confirmed having one session for supervision duties in their jobs plan, to cover medical students and all training grades although some do not consider this enough.

F1 Trainees: Trainees confirmed meeting with their designated educational supervisors twice in the block. Initial meetings were held a few weeks after starting in post and the second meeting later in post, which took place in preparation for end of year annual review of competence progression (ARCP).

IST/ST Trainees: Trainees confirmed meeting with designated educational supervisors 4 times throughout the post at the time of the visit.

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 the term SHO is no longer used. Colour coded name badges are used to differentiate between training grades of doctors. Ward staff are also very familiar with the competencies of F1 trainees. Trainers are not aware of any instances where a trainee has had to cope with a problem beyond their competence.

F1/IST/ST Trainees: Trainees confirmed knowing who to contact for clinical supervision during the day and out of hours. They are aware of escalation polices and have not had to work beyond their competence. Consultants are easily available and supportive.

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

Trainers: Trainers reported that they try to remain up to date on all curricula and are aware of the upcoming changes to foundation, IST and higher surgical training programmes. Trainers commented that there is a clinic/theatre template which should give IST and ST trainees the same opportunities to attend however responsibilities will differ slightly due to grade. Endoscopy lists have been impacted negatively due to Covid, however are now improving as more services resume. Trainers commented that work has been ongoing to ensure better balance between trainee development and non-educational tasks. They try to ensure F1 trainees do not spend significant amounts of time undertaking ECGs, discharge letters and taking bloods, however they are aware that this may happen from time to time in receiving wards. Improvements have been made so that F1 trainees no longer spend time in pre-assessment and a phlebotomy service has been introduced at weekends. F1s are responsible for writing theatre discharge letters and trainers try to make these into learning opportunities. Middle grade trainees are encouraged to get involved in administrative tasks such as reviewing results with input from trainers so that cases can be discussed.

F1 Trainees: Trainees reported no concerns in achieving learning outcomes for the post. They commented that quite a lot of their time is spent carrying out non-educational tasks. Although the F1s no longer have to attend the pre-assessment clinic, it appears several of the jobs from the clinic have been shifted to the ward, and the F1s are now expected to complete them in addition to their ward work.

IST/ST Trainees: Trainees reported that due to Covid there has been a reduced exposure to time in theatre and in endoscopy. Consultants have tried to help trainees in obtaining adequate case numbers, however this can be difficult due to service pressures. There are often less opportunities for IST trainees to attend clinics and theatre compared to ST, which has been discussed with trainers. Trainees also commented that they would find it useful to have an agreed learning plan before attending theatre.

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

Trainers: Trainers reported no concerns in trainees achieving their minimum assessment requirements. They state that there are ample opportunities provided, however some leave this until

the last minute. The department does not have an academic unit, which makes doing research difficult, however trainees are encouraged to undertake audits and quality improvement projects.

F1/IST/ST Trainees: Trainees reported no concerns in achieving their minimum assessment requirements for the post. Trainers are aware of and understand the different trainee curricular requirements.

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

Trainers: Not asked.

F1/IST/ST Trainees: Not asked. No concerns raised in pre-visit questionnaire.

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

Trainers: Not asked.

F1/IST/ST Trainees: Not asked. No concerns raised in pre-visit questionnaire.

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: Trainers reported that informal feedback is provided on the job and at the end of ward rounds when on-call. There is no formal feedback process, however as it is a small unit and trainers work closely with trainees they sit down and chat regularly. Trainees are also proactive in seeking feedback and are comfortable doing so.

F1 Trainees: Trainees reported receiving feedback from seniors when running cases by them during the day and out of hours. They find this to be constructive and helpful.

IST/ST Trainees: Trainees reported receiving regular feedback on clinical decisions during the day and out of hours. Feedback is generally provided whenever a trainee is presenting a patient with discussion and improvement made to management plans.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: Trainers reported that as a training group, trainees can feedback on their training experience via the chief resident or at the Friday educational meetings which restarted in January 2021. These meetings offer the opportunity for trainees to discuss any aspects of their training. The meetings also involve papers and audit presentations and morbidity and mortality (M&M) discussions.

F1/IST/ST Trainees: Not asked. No concerns raised in pre-visit questionnaire.

2.12 Culture & undermining (R3.3)

Trainers: Trainers commented that the department is made up of 3 main areas: acute receiving, elective ward and the surgical assessment unit (SAU). Consultants have adopted a very supportive environment, team culture and have a visible presence on wards. Educational meetings are an excellent resource for supporting a good team culture. They stated they were not aware of any instances of bullying or undermining within the wider team.

F1 Trainees: Trainees reported that support from IST/ST trainees differs on each ward. Getting support from the H South second on-call can be difficult. Foundation trainees believe there is a clear lack of interest and understanding between seniors and nursing teams about the roles and responsibilities of an F1. An example was shared of an F1 who received a complaint from a nurse, which came with a threat of putting a datix in due to them not completing a discharge letter, however the F1 was trying to prioritise the care of an unwell patient. It was suggested that nursing staff could do more to assist with routine workload e.g. doing ECGs or phlebotomy, which would lessen the burden on F1s. Trainees commented that if they had concerns with regards to bullying or undermining, they would discuss those with their colleagues and raise with their educational supervisors.

IST/ST Trainees: Trainees commented that the trainers within their department are very supportive, and they have not witnessed or experienced bullying or undermining. However, they also commented that it can be difficult to establish relationships with other departments, for example emergency medicine and that relationships can be poor due to stresses and pressures of working in busy departments. They described a situation where a patient required a CT scan to confirm their

diagnosis, however the trainee involved was met with extreme pressure from various sources within the emergency department to move the unwell patient to the ward before the scan had happened. The trainee felt that their medical opinion was ignored, and this was not good for patient care, as it may have been appropriate to move the patient to a different location depending on the scan result. Trainees confirmed they would raise any concerns with regards to bullying and undermining with their educational supervisors, clinical supervisors or the training programme director.

2.13 Workload/Rota (1.7, 1.12, 2.19)

Trainers: Not covered due to insufficient time available.

F1 Trainees: Trainees confirmed there are no gaps in the current rota. They stated that their workload can become unmanageable if they attend teaching as then they must stay late to complete their jobs. This is in part due to the time teaching is scheduled to take place. They do not believe the rota is impacting on their mental health.

IST/ST Trainees: Trainees confirmed there are gaps in the current rota. They commented that the rota supports them attending operating lists and endoscopy sessions however there are not enough opportunities within these at present. They consider their workload to be manageable, however commented that frequency and pattern of on-call is intense and overwhelming.

2.14 Handover (R1.14)

Trainers: Trainers described a new handover document which has recently been agreed and will be implemented soon. They believe it is sufficient and provides safe continuity of care for new admission and downstream wards. The new system will be monitored and revised depending on feedback on how it works. Trainers commented that there is ample opportunity within handover for learning.

F1 Trainees: Trainees reported there is no agreed structure to how patient information is handed over. They were aware that a new structure was due to be implemented soon and agreed that handover arrangements provided safe continuity of care. Handovers can be a good learning opportunity if trainees were able to attend, however often handovers occur around the F1 whilst they were completing other jobs and updating ward lists, especially at the start of the day.

IST/ST Trainees: Trainees reported that there is an agreed structure for handover which provides safe continuity of care for new admission and downstream wards. They commented that handover is not generally used as a learning opportunity as ST3 trainees are the highest grade in attendance, so there is no-one for them to learn from. They try to involve and encourage F1s to attend their handover to discuss lists and tasks however it is not always possible for them to attend due to other pressures on their time.

2.15 Educational Resources (R1.19)

Trainers: Not asked. No concerns raised in pre-visit questionnaire.

F1 Trainees: Trainees reported good resources in the department, however time does not allow them to complete their portfolio assessments whist at work.

IST/ST Trainees: Trainees reported good and accessible resources. They have no concerns around completing assessments during work.

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

Trainers: Not asked.

F1/IST/ST Trainees: Not asked. No concerns raised in pre-visit questionnaire.

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

Trainers: Trainers commented that there is no longer an educational governance committee to oversee the management and quality of postgraduate medical education and training. They described trainee committee meetings relevant to CT and ST trainees, that are held off-site. There are also weekly Covid meetings via Microsoft Teams however these are not structured to address training.

F1 Trainees: Trainees commented on a local trainee forum that takes place every 6 weeks with trainee representation. Trainees are encouraged to take forward any concerns with regards to the quality of training for discussion at the meeting.

IST/ST Trainees: Trainees commented on an informal meeting that takes place where trainees can raise concerns with regards to the quality of their training. These issues can also be raised via the Friday educational meetings.

2.18 Raising concerns (R1.1, 2.7)

Trainers: Trainers described a new escalation policy which has recently been agreed and will be implemented soon. Trainers are very approachable and encourage trainees to come forward with any patient safety concerns. All trainees are allocated to an educational supervisor who they meet regularly. During Covid they received concerns about training, including Endoscopy, however improvements have been made and trainers hope these have been well received by trainees.

F1 Trainees: Trainees commented that they would raise any concerns with regards to patient safety with middle grades depending on the severity and would follow the departmental escalation policies. They were confident that patient safety concerns would be addressed promptly and effectively.

IST/ST Trainees: Trainees stated that trainers are very approachable and easily accessible. They have no concerns in taking any patient safety concerns to them and believe they would be addressed appropriately.

2.19 Patient safety (R1.2)

Trainers: Not covered due to insufficient time available.

F1 Trainees: Trainees stated they would have no concerns if a friend of family member was to be admitted to the wards. The department have a huge number of medical boarders and staff often feel unsupported in looking after them. The current process for medical boarders is that they are reviewed by the medical team when they attend the surgical wards, who leave lists of jobs in patient notes. F1s undertake these jobs however they are not involved in the medical ward rounds. They commented

that boarding is chaotic, and they are not aware of any procedures or systems in place to manage these patients. A new process on who to contact for support of medical boarders has been implemented, which states F1s should call the second on-call medical registrar, however in practice this did not always work.

IST/ST Trainees: Trainees stated they would have no concerns if a friend or family member was to be admitted to the ward. They commented that they are aware of a system to manage medical boarders however their role does not require them to be involved, except in cases of emergency.

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

Trainers: Trainers reported that feedback to trainees after an incident rarely happens. Support is always available if a trainee is involved in an incident and wishes to discuss this with their designated educational supervisor. Trainers commented on monthly M&M meetings where all incidents and near misses are discussed. Cases are selected and F1s can be asked to present, which is considered to be an educational opportunity.

F1 Trainees: Trainees reported that if they were involved in an adverse incident, feedback is not readily available, therefore trainees must be proactive and seek feedback. They described discussing cases with middle grades however have no consultant input.

IST/ST Trainees: Trainees reported being well supported if involved in an adverse incident.

2.21 Other

Overall Satisfaction Scores:
F1 (3) – 5.3/10.
IST – not received.
ST (3) – 7.3/10.

3. Summary

Is a revisit required?	Yes	No	Highly Likely	Highly unlikely

The visit panel recognise and commend the efforts made to make improvements against the previous visit report action plan during the challenging period of the pandemic. Progress was noted against some of the requirements however there remain areas that require further improvement. The key areas of concern raised at the visit relate to handover, medical boarders, teaching, adequate experience and induction. Trainees are well supported and comment on a good team culture. Feedback, although not formal, is provided and well received. It is evident the department and DME team are motivated, willing and committed to improving the training environment. The visit panel are high likely to revisit within the next year to ensure ongoing progress is achieved and to validate the sustainability of improvements already implemented since the last visit.

Positive aspects of the visit:

- Approachable, enthusiastic, supportive and easily accessible supervisors.
- Good quality educational and clinical supervision.
- Adequate hospital induction.
- Good team culture.
- Frequent constructive feedback on decision making during the day and out of hours.
- Supportive consultant team in the event of an adverse incident.
- Trainers are aware of the curriculum needs of all training grades.
- Good departmental resources available to trainees.
- “Say no to SHO” appears to be working, with no use of SHO terminology during the visit

Less positive aspects of the visit:

- Recognise work put into handover document however there is no protected time to allow F1s to attend ST handover which is primarily due to competing demands for their time.
- Handover not considered a learning opportunity for ST trainees as they are the highest grade in attendance.

- Trainees are aware of escalation policies however these should be visible on wards and integrated into all future induction events.
- Attempts to address the escalation of seriously unwell medical boarders remains problematic, however the provision of a single point of contact is welcomed. The department should ensure that Medical bleep holders fully understand and fulfil their duty to provide relevant support when required.
- F1 teaching is not bleep free.
- F1s report being anxious to leave wards to attend teaching, due to volume of ward tasks to complete. Should they attend this means they must stay late to complete tasks. Should they not attend, trainees need to catch up in their own time out with the working day.
- The department have recently employed an ANP which is expected to improve F1 workload, however in the absence of backfill arrangements for this new post, the department should consider the challenges around workload and be realistic to ensure that changes are sustainable.
- F1 trainees reported that although they no longer work in the pre-assessment unit, some of the non-educational tasks associated with that role e.g. clerking patients on day of surgery, remains their responsibility and occur at a busy time of morning in competition with other workload.
- Recognise the impact Covid has had on formal training lists for IST and ST trainees. For example, endoscopy lists. These trainees report that Endoscopy training lists are not yet being arranged.
- IST and ST trainees would like more proactive approach to handing out passwords at start of post especially for surgical specific systems such as Opera and Endoscopy activity.
- Insufficient induction for trainees who start the post out of sync.
- Induction booklet is out of date and not widely known by all training grades. The department should consider a separate handbook for F1 trainees as their training experience is vastly different to that of IST and ST trainee. F1 trainees are keen to be involved in the creation or updating of an induction handbook that suits their needs.

DME Action Plan: Triggered Visit 28th January 2020 (Carry forward to new action plan not met/partially met)

Ref	Issue	Update October 2020 Action(s)	Requirement: Met, partially met, not met
7.1	Handover arrangements, especially between H@N and day teams, must be reviewed and improved to ensure there is a safe, robust handover of patient care with adequate documentation of patient issues. This should be used as a learning opportunity.	Structured handovers take place onsite between night – day staff at 9am with surgical patients being handed over at 08:30 to surgical reg. Evening handover is carried out at 5pm and a surgical patient board round is also carried out at this point. This highlights any issues with patients, outstanding tasks and is documented on the board with tickbox. Work is ongoing to improve the written handover process for.	Partially met (See Section 6, Ref 6.1)
7.2	Clarify escalation pathways for T&O and surgical patients who become medical unwell.	For High Dependency patients who deteriorate further there is a formal written SOP, but for surgical ward patients who deteriorate the SOP is just verbally given to juniors and we have not got it formally written down yet. This SOP is highlighted at induction regarding escalation when medically unwell. It is also documented that there will be a 2nd on registrar to cover juniors	Met. Ensure escalation policies are displayed in all wards.

		as well. If 1st on is likely to be in theatre. Ortho policies may be different. Junor staff made aware the process if patients become critical that if 1st or 2nd on call are busy/in theatre they can SBAR in theatre to discuss the patient directly but advice can also be sought from the anaesthetic ITU registrar.	
7.3	There must be robust arrangements in place to ensure the safe selection, tracking and management of all boarded patients. In addition, for boarded patients, there needs to be clarity which consultant and clinical care team are responsible, how often patients are reviewed and what the escalation policy is.	Tracking of boarded patients is undertaken by Bed Management on a daily basis across the whole site. Currently within General Surgery we do not board patients to other wards. Work is ongoing to ensure correct medical team review of medical patients on surgical wards. Information on teams/consultant is compiled by bed management. Surgeons are looking to hold daily Safety huddles to highlight medical boarders in Surgical wards and ensure correct and timely escalation to medical if not captured on/in boarder list.	Not met. (See Section 6, Ref 6.2)
7.4	Tasks that do not support educational and professional development and that compromise access to formal learning	Within the Clyde sector there is ongoing work to employ into ANP roles to give support and cover.	Partially met. (See Section 6, Ref 6.3)

	opportunities must be reduced (for example, ECGs and recordings at pre-assessment).	Within the IRH site phlebotomy service work 7days. Pre assessment clinic has now moved area and FY1 pull to the area has been significantly reduced to cover non educational tasks.	
7.5	Trainees must have access to the appropriate procedures, including endoscopy, to enable them to meet the requirements of the curriculum.	Within Clyde a there is access to simulator to further skills if trainees feel they require extra input this is widely known and free to access any time required. Endoscopy clinics run at IRH, there has been a culture shift that means trainees have better and more reliable access to endoscopy lists and clinics to allow them to meet the requirements. As a result of covid, the number of patients on scope lists has reduced – however this means an increase of one to one or one to two teaching pre and post patients. Trainees are discussed at cons meeting – inc training needs- highlights who has/need trainees needs. Proactive approach to ensure all trainees get appropriate access. ST3 have been prioritised for more scope exposure.	Partially met. (See Section 6, Ref 6.4)
7.6	Regional teaching should be reviewed to improve the quality of the VC and interactivity as well as	Surgeons show good attendance at teaching across all grades.	Partially met (See Section 6, Ref 6.5)

	reduce the cancellation of sessions. There must be a system to ensure teaching is bleep-free.	Teaching is encouraged to be bleep / interruption free. Teaching is also, at this time, being delivered on a digital format – via use of MS Teams with the Directorate of Medical Education also working to have unified platform to host all/any education resources and allow access to trainees. Registrars being available to take bleeps from trainees to ensure bleep free teaching.	
7.7	All references to “SHOs” must cease.	‘Say no to SHO’ programme embedded within Inverclyde site – this includes colour coded badges, posters and pop up banners. The trainers recently undertook specific and individualised ROT session with the ADME in Clyde the reasoning behind the term SHO disappearing from our vocab was discussed the trainers agreed that the term would be discontinued in all future documentation going forward. Medical Education are working with Facilities and wider board to eradicate this term from being printed on badges – although	Met.

		this may be a specific issue with Locum staff.	
7.8	There must be a process that ensures trainees understand, and are able to articulate, arrangements regarding educational governance at both site and board level.	The Directorate of Medical Education reports to the Board staff governance twice a year. We utilise the organisational online induction distributed to all trainees to highlight this process to them. share.dynamicbusiness.co.uk/2020/NHS_GGC/Ggc-Trainee-V5-Subs_HB.mp4 We have recently reinforced this with the distribution of an educational governance spotlight email. This included a word document explaining the structures and who's who.	Met.

4. Areas of Good Practice

Ref	Item	Action
4.1	“Say no to SHO” appears to be working, with no use of SHO terminology during the visit	n/a
4..2	Good departmental resources available to trainees.	n/a
4.3	Frequent constructive feedback on decision making during the day and out of hours	n/a
4.4	Supportive consultant team in the event of an adverse incident.	n/a

5. Areas for Improvement

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

Ref	Item	Action
5.1	2.5	Trainees are aware of escalation policies however these should be visible on wards and integrated into all future induction events.
5.2	2.6	IST/ST trainees would find it useful to have an agreed learning plan prior to attending theatre.
5.3		The department have recently employed an ANP which is expected to improve F1 workload. In the absence of backfill arrangements for this new post, the department should consider the challenges around F1 workload and be realistic about the impact of a single ANP to ensure that changes are sustainable.
5.4	2.1	The current induction handbook should be updated with input from trainees.
5.5	2.17	Look to reinstate the educational governance committee which oversees the management and quality of postgraduate medical education and training.

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	Handovers must include consultant input to ensure patient safety and learning opportunities for ST trainees. Handovers times must also be reviewed to ensure F1 trainees can attend.	31/03/2022	F1 and ST
6.2	F1 trainees must be provided with clearly identified seniors who are providing them with support during the day and out of hours for all medical boarders. Ward rounds for medical boarders must also include F1 trainees to ensure patient safety and learning opportunities.	31/03/2022	F1
6.3	Tasks that do not support educational and professional development and that compromise access to formal learning opportunities must be reduced (for example, involvement of F1s in pre-theatre clerking that takes them away from ward rounds with registrar).	31/03/2022	F1
6.4	Trainees must have access to the appropriate procedures, including endoscopy, to enable them to meet the requirements of the curriculum.	31/03/2022	IST/ST
6.5	There must be active planning of attendance of doctors in training at teaching events to ensure that workload does not prevent attendance. This includes an expectation for all trainees to attend regional teaching bleep-free during normal working hours. Trainees should not be expected to stay late to complete tasks to compensate for time spent in mandatory teaching events.	31/03/2022	F1
6.6	The department must have a clear process for supporting trainees who have been undermined from staff within and outwith the department. These trainees should be provided with feedback on actions taken to address this.	31/03/2022	ALL

6.7	All trainees must have timely access to IT passwords and system training through their induction programme. The specific systems not covered currently are for Endoscopy and OPERA.	31/03/2022	IST/ST
6.8	A process must be put in place to ensure that any trainee who misses their induction session or joins the department after changeover is identified and provided with an induction.	31/03/2022	ALL
6.9	Departmental induction must be provided for which ensures F1 trainees are aware of all of their roles and responsibilities and feel able to provide safe patient care. An F1 handbook or online equivalent may be useful in aiding this process.	31/03/2022	F1