Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	21st & 22nd April 2022	**Level(s)**	FY1, FY2, IMT, GP & ST3+
Type of visit	Revisit	**Hospital**	Royal Alexandra Hospital
Specialty(s)	Medicine	**Board**	Greater Glasgow & Clyde

Visit panel	
Dr Reem Al Soufi	Visit Lead, Associate Postgraduate Dean – Quality
Dr Marie Mathers	Deputy Visit Lead, Associate Postgraduate Dean – Quality
Dr Fiona Cameron	Associate Postgraduate Dean & Foundation School Director
Dr Carol Blair	Training Programme Director - Gastroenterology
Mrs Hazel Stewart	Quality Improvement Manager
Mr Les Scott	Lay Representative
In attendance	
Miss Claire Rolfe	Quality Improvement Administrator

Specialty Group Information		
Specialty Group	Medicine	
Lead Dean/Director	Professor Alastair McLellan	
Quality Lead(s)	Dr Reem Al Soufi, Dr Greg Jones, Dr Alan McKenzie	
Quality Improvement Manager(s)	Mr Alex McCulloch	
Unit/Site Information		
Trainers in attendance	7 including clinical director	
Trainees in attendance	12 x FY1, 2 x FY2, 1 x GPST, 9 x IMT (1 unable to stay to end of session), 6 x ST	

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

Date report approved by Lead Visitor	13th May 2022 – Dr Marie Mathers Deputy Lead Visitor

1. Principal issues arising from pre-visit review:

The Royal Alexandra Hospital has been an area of concern for the past few years with persistent red flag negative indicators in the GMC National Training Survey and NES Scottish Training Survey. In preparation for the visit multiple sources of information were reviewed including the reports from two previous visits (2020 and 2021), pre-visit questionnaire and supporting documents provided by the department ahead of the visit.

Due to the level of concern following the 2021 revisit and review of all available information at the Quality Review Panel in October 2021, it was agreed that the Royal Alexandra Hospital would require a further revisit to review the progress being made to meet the requirements and determine if further support is required to make the necessary improvements. A summary of the visit findings has been compiled in this report 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.

A very helpful and informative presentation was provided by the clinical director prior to the panel meeting with the trainers. This provided an update on what changes and improvements had been made since the 2021 visit and areas where work was still in progress. Information from the presentation has been incorporated into the report below.

Please note that to protect the anonymity of the only GPST and 2 FY2 doctors who attended the visit the report will incorporate the responses from the pre-visit questionnaire.

2.1 Induction (R1.13):

Trainers: The trainers reported that a new induction and educational lead, Dr McAdam, had been appointed with dedicated time to make the required improvement and liaise with trainees. Trainers confirmed that there is a plan for the August 2022 induction to record information about each specialty to provide specific guidelines to trainees. Role cards and recorded explanations are now being provided at induction to explain each of the on call roles. During the presentation it was reported that all induction information is available to trainees on the rota Teams channel and that the

junior doctor handbook had been updated by trainees. The department also confirmed that trainees within surgical wards, that cover medicine out of hours, are also now invited to attend the medicine out of hours induction.

FY1: Trainees reported that they received a useful hospital induction and found the information within the foundation survival guide document helpful. Both the hospital and some departmental inductions were provided to the trainees during their shadow week. The trainees were aware of the role cards for on call shifts but did not feel that this was necessary for their level and they were clear of what their role is during out of hours. It was suggested that some medicine departments could provide more specific details such as direct admissions to respiratory, but reported that the general medicine induction was of good quality and provided trainees with the information they needed to start work.

FY2: Trainees reported that they received a good hospital induction which provided information regarding the hospital at night, and they were provided with the required information such as ID badges and IT access. They confirmed that information about the site is also available in the handbook provided. It was felt that the departmental induction is also helpful to ensure trainees could undertake the tasks required. It was suggested that a further improvement to the induction could be a short presentation from a middle grade trainee to make the information a bit more relatable to the work they will carry out on a day-to-day basis.

GP: All trainees received a hospital & departmental induction. Suggested improvements included:

- Clarity around their role when on-call
- Clarity on the admission and review process, and
- Improved ward cover on induction day to reduce workload burden.

IMT: Most trainees reported that they received a hospital induction. A planned catch-up induction for those unable to attend was cancelled with no alternative date provided. Trainees felt that at the time of their induction, information regarding their role on-call was too brief and it took some time for trainees to understand their roles and responsibilities in the department. Some were aware of the recently developed role cards, but indicated that they were difficult to locate. Trainees suggested that it would have been useful to have more clarity around the clinical services available on the islands and their referral process to enable them to prioritise patients who urgently needed transferred to the RAH.

ST3+: Trainees reported that they received an adequate hospital induction which provided them with the information necessary to start their job. It was felt that departmental inductions to specific medical specialties provided useful information, the general medicine induction was of poor quality due to the lack of clarity around the various admissions routes into the hospital as well as an outdated induction handbook.

2.2 Teaching

Trainers: Trainers reported that the teaching sessions had been reintroduced in the past few months. Following feedback from trainees the timing had recently being changed to be delivered at lunchtime and this had improved attendance. There is acute medicine teaching on Thursday afternoons for which trainees are strongly encouraged to attend regardless of ward work. However, it was acknowledged that FY1 trainees are unable to attend these sessions as it clashes with their regional teaching. Trainers reported that teaching is bleep free for all bar the 3 trainees who hold on-call pagers. During the presentation it was indicated that more teaching opportunities are planned, including the re-introduction of the grand round with the aim that this be more trainee led in the future, to ensure the content is appropriate to the trainees' education. Trainers advised that they ask trainees what their learning needs are to better inform the teaching sessions.

FY1: Trainees reported that local teaching sessions had restarted a few weeks prior to the visit. Those who were able to attend found the sessions useful to their education and the change in timing from 8.30am to 12.30pm aided their ability to attend. It was suggested that having a large volume of tasks to complete would prevent them attending, despite encouragement from trainers, as this added to their stress due to having to catch up on the work and often stay late to complete the outstanding tasks. Trainees suggested that they are able to attend at least 50% of their foundation specific teaching in real time and can watch those which are missed at a later date.

FY2: Trainees reported that there is weekly teaching within care of the elderly. Some trainees indicated that a clinical fellow was due to commence teaching the week after the visit but none of the trainees interviewed had an awareness of the 12:30 Wednesday teaching session. Not all of the trainees felt able to attend their foundation specific teaching session due to low staff numbers on the ward and a lack of usable space to watch the teaching session uninterrupted.

GP: Trainees reported that there is weekly departmental teaching on a Wednesday. Some found this difficult to attend when it began at 8.30. Other barriers to attendance were reported to be working on-call or having a high workload. Trainees reported that regional teaching is protected and bleep free. One trainee felt that more regional teaching should be provided, but they had managed to attend at least 2 teaching days[1].

IMT: Trainees reported that they had managed to attend 2 out of 5 or 6 regional IMT teaching sessions since August. Trainees felt that their rota often prevented them from being able to attend teaching sessions in real time. They highlighted that when working on call nights or back shift they do not have the ability to take study leave in real time. It was reported that the rota team were informed of all the regional teaching dates in August and were informed that they would only be able to obtain some. Trainees suggested it would be beneficial to their education if the teaching sessions were built into their rota.

ST3+: Trainees reported that they are told they must be on the ward at all times, resulting in challenges to have study leave approved to attend regional teaching. The majority of trainees indicated that they often catch up on regional teaching in their own time. At least one trainee ensures they've had study leave approved to catch up on missed teaching. However, this may result in not meeting the required number of teaching sessions by the time of the Annual Review of Competency Progression (ARCP).

2.3 Study Leave (R3.12)

Trainers: Trainers believed that all study leave requests had been approved providing the request was submitted with enough notice.

FY1: Not applicable

FY2: Trainees who had applied for study leave did not report any issues with their requests being approved.

[1] *GP Regional teaching whilst in hospital posts totals 6 full day sessions over 18months of hospital posts, averaging 2 per post.*

GP: Most trainees felt it was fairly straightforward to access study leave, but at least one indicated they'd had some of their requests denied due to rota issues.

IMT: Many of the trainees reported that they have stopped applying for study leave to catch up on teaching due to staffing shortages and the potential for their leave to not be approved. One of the trainees noted that the ability to take study leave had improved when copying their specialty lead into the leave request.

ST3+: See response in teaching.

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

Trainers: Trainers reported that they have access to the Deanery online teaching however they have difficulty in finding time to do so. Trainers acknowledged that although they have time in their job plans the high workload and consultant vacancies result in this time being converted into direct clinical care. It was also highlighted that many if not all consultants had not been able to have study leave for their own educational development for the past 2 years.

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: The trainers felt that it is clear who trainees need to contact for support in hours. They reported that trainees are told of the on-call consultant to contact when working out of hours. There is also now an escalation process for each role provided on the recently developed role cards. Trainers felt that where there is a concern about a specific patient, trainees know who to contact for support and are not working out with their own competence. However, trainers felt that where the concerns relate to managing patient flow, systems and coping with overcapacity issues then trainees can feel overwhelmed. Some trainers highlighted concerns about the lack of standard operating procedures and guidance for patient flow in the medical admissions unit but acknowledged there is a working group currently trying to develop this.

FY1: Trainees reported that they know who to contact for supervision and escalate concerns to the on-call team during the day. Some trainees felt that they were unclear for who to approach when in the gastroenterology ward as the foundation doctors may be the only medics on the ward. However,

trainees did report that they always receive help when it is sought. Trainees indicated that they know who to contact for support for boarded patients within medicine but suggested this was less clear when a patient is boarded in a surgical ward and the day-to-day care is provided by the foundation doctor within surgery. Trainees suggested part of the issue is that foundation doctors in surgery wards do not have access to the boarders team channel for medicine. Although trainees did not feel they are left to cope with problems, they found it challenging working in the acute medical unit (AMU) at the weekend. This is due to caring for patients awaiting admission to the high dependency unit (HDU), after doing little to no clinical work during in-hours shifts and no consultant ward round.

FY2: Trainees reported that they are aware of who to contact for supervision through the daily morning safety huddles, which confirm who is on call and where they are located. At least one trainee felt that they had to cope with problems beyond their competence through being asked by bed managers to identify patients suitable for boarding when working on call. Trainees felt that their senior colleagues were very supportive when support was requested.

GP: Most trainees are aware of who to contact for supervision support, but at least one trainee indicated that they are only aware some of the time. Some had felt they've had to cope with problems beyond their competence, in particular when they are on-call at night or weekends as they require to cover cardiology, giving cardiology advice to GPs, with little to no cardiology experience. In addition, trainees will review sick patients in medical wards, cover referrals from A&E and inter-hospital transfers. One trainee had a less positive experience when contacting the on-call consultant but raised their concerns and felt they were addressed. However, in general, trainees felt that when they seek help, senior staff are very supportive and approachable.

IMT: Trainees reported that they know who to contact for supervision both during the day and out of hours. Some trainees felt that they've had to cope with problems beyond their experience, this included:

- Having to provide cardiology advice to the emergency department when on-call, with little to no cardiology experience.
- Having no contactable consultant over the weekend on more than one occasion, despite highlighting this as a concern to the department.

- Unsupportive feedback from on-call consultant when following out of hours procedure for HDU admission. However, trainees did state that the overwhelming majority of consultants are very supportive when contacted.

ST3+: Trainees felt that consultants are very approachable and happy to listen to trainees, but that consultants are under severe clinical pressure due to workload and a 30% gap in consultant numbers. Trainees reported that the very supportive nature of consultants meant that they'd not felt out of their comfort zone when managing a patient. However, trainees highlighted that they do find the high workload, such as starting a nightshift with 70 patients waiting in the emergency department, and being short staffed to be both stressful and challenging. Whilst trainers are very supportive and approachable, trainees suggested that it is not always clear who to contact for support in certain situations. Trainees reported there is no on-call cardiology consultant cover and only an on-call cardiology registrar for the Glasgow city hospitals. It is therefore unclear to medical trainees in RAH if they can contact the on-call cardiology team for support. Trainees also found that due to there being multiple consultants on, and helping out, the MAU during the day, they are not always clear on which consultant the patient is aligned to. Trainees also highlighted challenges within gastroenterology as there is only one locum consultant. Trainees praised the availability and approachability of Dr Haq, however due to the lack of gastroenterology consultants on-site and cross cover from consultants within the city hospitals, it is not always clear who to contact in situations, such as a gastrointestinal bleed.

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

Trainers: Trainers acknowledged that access to outpatient clinics continues to be a challenge. All clinics were suspended for 6 weeks over the Christmas period due consultant staff shortages. They described trying to enable trainees to observe clinics or participate in virtual clinics as a work around to the lack of available clinic space. Those in acute medicine reported that the ambulatory care service, which can contribute to clinic numbers, had been significantly reduced resulting in it being much more challenging to provide clinic opportunities to trainees. Trainers reported that senior trainees are trying to develop a list of clinic opportunities, however workload challenges and staff sickness absence can often result in a trainee being unable to attend the clinic.

FY1: Trainees felt it was quite easy to achieve their learning outcomes with the exception of significant learning events that need consultant input, due to the workload pressures on consultants limiting their availability. However, trainees indicated that almost 100% of their time in-hours was spent undertaking tasks for service as only FY2 trainees and above clerk in patients during the day. Trainees felt that out of hours, they are exposed to a variety of duties that benefit their development. Trainees reported that they had recently been added to the medical admissions unit rota at the weekends but, in reality, this was only to undertake tasks such as phlebotomy and ECG.

FY2: Trainees had no concerns about achieving their intended learning outcomes and those based within geriatric medicine had the opportunity to attend clinics. Trainees felt they had lots of exposure in their post to developing their skills in managing acutely unwell patients, particularly when on-call, due to being able to clerk patients. Trainees felt that when they are on-call the majority of their time is spent on tasks which are of benefit to their development, but only 25% of the time when working on the ward.

GP: Some trainees were not confident that the post supports their progression towards curriculum competences. However, at least one trainee had managed to attend 2 clinics in the past 2 months and make management plans when clerking patients in.

IMT: Trainees reported that they are rarely able to attend outpatient clinics. Another trainee indicated that they'd requested training ahead of working in HDU for procedures such as line insertions, but this was only provided to them after starting their shifts within ITU. There is simulation training provided, but it was felt that more hands-on experience would be beneficial to their training. It was reported that when help is sought from the critical care team it was very supportive. Some trainees felt that their time within critical care was the main educational area of the hospital, however due to ITU being moved to HDU trainees were undertaking a lot of jobs, with no educational value due to the lack of FY1 within HDU.

ST3+: Trainees reported that it is extremely challenging to attend outpatient clinics. Clinics are not built into their rotas with the exception of respiratory medicine. However, trainees reported that if the ward is short-staffed, they cannot attend clinics. Trainees reported that they are unable to attend clinics when they are on-call. Following a review on trainees' shifts, a trainee reported that there is a significant disparity in the number of on-call shifts trainees are allocated with some specialties

carrying the page 66% of the time versus 20%. This is resulting in some trainees reporting that they are struggling to meet their required competences. It was reported that some trainees are encouraged to attend clinics, such as cardiology, but they are struggling significantly to attain their curriculum requirements in general medicine. Trainees felt that staffing levels in MAU are insufficient to cope with the workload and resulted in them having to use a higher proportion of their time undertaking tasks of no educational benefit.

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

Trainers: Trainers reported that due to the current set up of the receiving units it is still very challenging to enable trainees to complete their ACAT assessments as patients that trainees manage are reviewed by various consultants.

FY1: Trainees reported that they are able to have their assessments completed based on their experiences during out of hour shifts.

FY2: Trainees felt it was very easy for them to complete their workplace-based assessments particularly when on call as the senior trainees will often offer to complete an assessment for them.

GP: Some trainees reported no issues completing their workplace-based assessments, although one trainee felt that the workload and staffing issues presented barriers to completing assessments.

IMT: Trainees reported that they find it challenging to complete their assessments. The main challenges reported were:

- Lack of time and staff to supervise undertaking a procedure when working on the ward.
- Difficult to get feedback for their ACATs due to the various receiving areas and different consultants covering these areas.
- High workload for consultants resulting in assessments tickets expiring and having to be reissued.

Trainees reported that they felt supported to take on a more senior role on the rota, but it can be overwhelming due to the high patient volume and staffing levels.

ST3+: Trainees did not report any issues having their assessments completed.

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

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

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: During the presentation, the clinical director reported that the post take wardround has been brought forward from 9am to 8am to enable trainees near the end of their night shift to attend and receive constructive feedback.

FY1: Trainees reported that although there is nothing formal in place, they do receive feedback from the junior registrar. They did not feel that they make enough clinical decisions during the day to enable feedback to be given. It was suggested that feedback is more likely when an error has occurred rather than when there's a positive outcome. Trainees also reported that they undertake half of a ward round on their own with an FY2 undertaking the other half without supervision, but indicated that they can approach a consultant if they are concerned about a patient.

FY2: Trainees reported that they received feedback from the senior trainee when working in the medical admissions unit out of hours. They highlighted that feedback is more immediate as senior colleagues are checking their management plans with trainees at the time to ensure that they are appropriate. They reported that the AMU ward round is only attended by FY1 trainees and therefore does not provide the opportunity for feedback. However trainees stated that there is an afternoon board round in MAU and feedback can be provided during this or at hand over.

GP: Trainees reported they received variable levels of feedback from weekly to less than weekly

IMT: Trainees reported that they do not receive feedback on their clinical decisions, due to:

- reviewing different patients on the wardround from the consultant
- Clerking patients in multiple areas and consultant allocation to patients being split over the various areas.

Trainees suggested that if the MAU wardround was brought forward to happen before handover, it may enable opportunities to receive feedback on their clinical decisions out of hours.

ST3+: Trainees reported that they do not receive regular feedback on their clinical decisions as they rarely have the opportunity to undertake a joint wardround with a consultant. Trainees again stressed how helpful and supportive consultants are, but the demands on them are too great to enable feedback opportunities.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: Not asked due to time constraints.

FY1: Some trainees reported that they had provided feedback to management in relation to the rota, but did not feel that their concerns or suggestions were listened to or acted upon.

FY2: Trainees reported that they use the training surveys to provide feedback on their experience and some had attended trainee forum meetings. However, some trainees were not aware of the chief resident or the trainee forum.

GP: Trainees reported they were not aware of any opportunities to provide feedback on their experience in post.

IMT: Trainees reported that their feedback on their experience in the site had been sought recently from the clinical director. However, trainees felt this was too little too late as they were 2/3 through their year in post.

ST3+: See raising concerns section 2

2.12 Culture & undermining (R3.3)

Trainers: Trainers reported that they believe there are an approachable group and their visibility on the wards helps to provide trainees with a supportive environment. Some often check-in with trainees to ensure they are feeling okay. If any issue or concern is raised, support is provided to trainees. A trainer also stated that they will make a point of signposting trainees to whom they should raise concerns about bullying or undermining behaviours. During the presentation, it was highlighted that

they continue to roll out the “civility saves lives” presentation to promote communication skills and minimise the risk of negative behaviours.

FY1: Trainees feel that their colleagues in the senior team are very supportive but are clearly very stretched and stressed at not being able to deliver the programme that they want to. None of the trainees had experienced or witnessed any negative behaviours from the clinical team, but if they were to, trainees indicated they would be comfortable to approach a supervisor and believed this would be dealt with appropriately.

FY2: None of the trainees had experienced or witnessed any negative behaviours from the clinical team or senior colleagues. Trainees felt that they worked within a very supportive and approachable team.

GP: One trainee reported that they had a negative experience from a locum cardiologist. This was escalated to the trainee’s supervisor and felt to be dealt with appropriately. None of the trainees had witnessed or experienced any bullying behaviours since starting their post.

IMT: Trainees reported that formal complaints and concerns have been raised regarding a locum consultant. A very small minority of consultants were reported to be less supportive where trainees required to make several calls for support out of hours but stressed the majority of consultants are very good, supportive, friendly, and approachable.

ST3+: Some trainees reported that they had experienced some negative behaviours, these had been reported to the department and were currently being addressed. Another concern around communication issues was raised outwith the visit session and will be reported separately to the DME. Trainees again highlighted the positive support and approachability of the consultant team.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Trainers described various challenges with the rota and workload including:

- Additional ST level trainee in MAU at night can result in less time in their parent specialty due to the need for rest.

- A senior trainee can be required to provide support to IRH if the MAU nightshift rota at RAH is well staffed.
- Patients being diverted to the RAH from other hospitals in the Clyde area and no option to divert patients from RAH even when capacity is at its limit.

The clinical director reported that they are advertising for more clinical fellows for August, whose contracts will include working out of hours as well as other staff, such as phlebotomists, to reduce the burden of everyday tasks on junior trainees.

FY1: Trainees reported that they are able to raise concerns regarding their rota. Some highlighted suggested changes given to Lesley Allan were taken forward, but other aspects of the rota were outwith her power to change. Trainees were concerned when working at the weekend as there is only 1 FY1 within AMU who require to undertake all outstanding tasks and wardrounds for up to 30 patients. In addition, a new ward had been opened up due to ward pressures and trainees indicated that they are expected to take the additional tasks aligned to that ward but are not always informed when patients are allocated to the additional ward. Trainees also felt that the burden of tasks was exacerbated as Advanced Nursing Practitioners do not work in AMU and a lack of help from clinical support workers.

FY2: Trainees indicated that they felt they could discuss their rota but did not feel that they were able to suggest improvements to the rota. Some trainees found aspects of the rota exhausting when having to work seven days in a row with one rest day, followed by working a further seven days. Trainees also indicated that this contradicted the induction information which states they receive 2 days rest after a 7-day shift. They suggested that having these shifts broken up more or a longer rest period between the 7-day run would reduce the risk of exhaustion and burnout.

GP: Trainees reported that their rota is affecting their training, with some feeling unable to maintain their portfolio and another reporting that they have a large number of on-call shifts with no contact from seniors in the department or feedback on management plans. Other concerns regarding the rota and workload include:

- Working beyond natural breaks,
- Frequent feeling of burnout, and
- Large and intense workload particularly on-call out of hours.

IMT: Trainees felt that the rota does not appropriately allocate the different levels of trainees to provide the most optimal cover. They also felt the rota could be confusing with too many different shifts. Issues with the rota allocation included:

- IMT trainees on-call undertaking any role from FY2 level up to registrar
- Out of hours being staffed by an ST4 and ST6 level trainee one week, then an IMT2 being the most senior trainee out of hours another.

ST3+: Trainees reported that their workload is extremely high and they have no opportunities to engage with staff about their rota. They were aware of changes made to the foundation rota following feedback, but no changes have been made to their rotas. Some trainees reported challenges with their on-call rota, due to it being split between their parent specialty in the Glasgow city hospital on-call rota and the other half being in the Clyde general internal medicine rota. This was reported to cause frustrations due to the apparent lack of communication between Glasgow and Clyde rota co-ordinators and confusion as to who they require to request annual leave from. Trainees indicated that staffing issues has been a long-standing problem and that the gaps from trainees working less than full time not being filled and uplifted locum rates reportedly being held back contribute to rota gaps remaining unfilled.

2.14 Handover (R1.14)

Trainers: Trainers reported there is a hospital wide handover at the weekend which is working well. There is also a daily departmental handover during the week which is attended by consultants, trainees and nursing staff. During the presentation the clinical director highlighted a new checklist for the 4.45pm handover to ensure staff are aware of any patients of concern as well as departments that have no concerns or outstanding tasks to be completed. Trainers felt that there are concerns around the handover of boarded patients. Whilst boarded patients are listed on the Trakcare and the Teams channel, there is no clinical information provided to enable patient treatment to be prioritised and trainers were aware of regular inaccuracies with the information. It was felt that there required to be additional administrative staff to aid with logging and updating the information, but this was not something available to them at present.

FY1: Trainees reported that they attend the on-call handover which works well. They reported that the chief resident developed a sign in sheet for handover at 4:45 to try to ensure information about

patients are handed over effectively for all wards at the 4:45 handover. However, trainees indicated at the 4:45 handover is not well attended as trainees are often trying to get their tasks completed before finishing their shift rather than signing a sheet to confirm that their ward has no patients of concern.

FY2: Trainees reported that they are happy with the handover arrangements in place. They use a checklist to highlight safety concern. Trainees indicated that boarders are managed by senior colleagues and were uncertain about what handover arrangements are in place.

GP: Most trainees were happy with the handover processes in place. However, one trainee reported that the weekend handover is often incomplete.

IMT: Trainees felt that the 4.45pm handover was adequate but indicated a handover between the junior doctors would be better in person rather than text. Trainees suggested that there is room for improvement for the evening handover to help with workload overnight.

ST3+: Trainees reported that there is a structured handover in place. One of the trainees at the session had developed the check sheet for the 4.45 handover. It was felt that any concerns are flagged at handover, but recent feedback indicate that trainees feel the wards are too busy to enable them to sign the check sheet confirming there's no outstanding tasks or patient concerns. Trainees believed a new handover for boarders is now on Trakcare.

2.15 Educational Resources (R1.19)

Trainers: Not asked

FY1: Overall trainees felt that educational resources and IT equipment were adequate. However, an example was given where IT equipment was no longer functional, but there appeared to be reluctance to replace it.

FY2: Trainees reported that they are satisfied with the IT and educational resources available to them on site.

GP: Trainees that had used the educational resources available to them felt they were satisfactory to support their learning needs.

IMT: Trainees reported that facilities to support their learning are adequate and no different to other sites they've worked in. Trainees have access to simulation training on site to aide their development.

ST3+: 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)

Trainers: There is a committee chaired by one of the consultants which looks at the educational governance aspects of medicine within RAH. The newly appointed education and induction lead also attends these meetings.

FY1: Trainees reported that they are aware of the local training forum. Some have managed to attend a few of the meetings and are happy to contact the chief resident to raise a concern on their behalf. Trainees felt that although their concerns are taken on board there does not appear to be any changes implemented leading to a feeling that management are not listening to them.

FY2: Some trainees were unaware of the local trainee forum and were uncertain where they could raise concerns or issues relating to their training.

GP: Most trainees indicated that they were unaware of the local trainee forum. Trainees reported that they would raise concerns about their education and training with their supervisor.

IMT: Trainees reported that they are able to attend a local trainee forum led by the chief resident. Trainees felt able to raise concerns with the consultant body and whilst some had been addressed, trainees indicated that several concerns are unresolved. Trainees indicated there is a lack of feedback on action or discussions taken about their concerns leading to frustration. Trainees stated that a number of issues, such as clinic access, are long standing and despite being raised year on

year, there is little to no progress. This has led some trainees to feel raising issues is a pointless effort.

ST3+: The chief resident was in attendance and confirmed that they chair the local trainee forum. Trainees reported that there had been monthly meetings, however, this had now stopped due to low attendance as trainees were too busy to attend. Trainees reported that whilst concerns raised during the forum meetings are listened to, management and the consultant team are so stretched that the majority of the concerns raised remain unresolved.

2.18 Raising concerns (R1.1, 2.7)

Trainers: Trainers reported that they have an open-door policy for trainees to raise concerns. At least one trainer suggested that trainees feel able to raise concerns, but there is an issue around how the concern is actioned and managed when it relates to bigger systems issues, such as lack of space or patient volume. Trainers reported that they had similar concerns to the trainees and have raised significant site level concerns, such as the lack of physical space available, via regular senior board management meetings. They felt that although the concerns are being listened to, as yet no action is evident to address these large-scale concerns.

FY1: See Patient Safety

FY2: Trainees indicated that they are unaware of how they would formally raise a patient safety concern. However, at least one trainee had raised a concern to the clinical director which was acted upon to try and resolve.

GP: See Patient Safety

IMT: Trainees reported that they have raised patient safety concerns with the department. At least one had raised concerns with the clinical director, various consultants and management. However, it was felt that little progress had been made to address the concerns.

ST3+: Trainees reported that they have concerns about patient safety within the department and these have been raised with the consultant and management teams. Trainees reported that

significant concerns regarding the medical admissions unit had been fed back to the general manager. They were aware of a focus group which has started to look at how improvements can be made within the medical admissions unit to address the concerns. Trainees also raised concerns regarding the complicated admissions route into the hospital and poor communication around changes to this. On the second day of the visit, it was evident to trainees that SATA was being merged with and moved to MAU, but trainees had not been informed the move was taking place that day and no additional staff had been brought in to help manage the move. The concerns regarding the lack of communication had been raised by the chief resident.

2.19 Patient safety (R1.2)

Trainers: Trainers reported that whilst they would be happy for a relative to be cared for by any of the consultant team, they do have concerns regarding specialty cover out of hours. The lack of gastroenterology service at the hospital despite having a good locum and no reliable cardiology cover out of hours would give them cause for concern. Some trainers also had concerns about a potential 2 tier system where patients that have attended A&E could be assessed within 2 hours, but those referred from a GP to the medical admissions unit (who also wait within the A&E department) could be waiting 6 hours for an initial assessment. Trainers also reported concerns in relation to boarded patients due to:

- the high volume (approximately 100 boarders at the time of the visit),
- Lack of clinical information in MST channel to prioritise patients
- Number of inaccuracies within the Boarders MST channel.

FY1: Trainees indicated that they would be concerned about the quality or safety of care if a friend or relative was admitted to certain wards such as gastroenterology due to the lack of consultant specialists available. Some trainees felt that although every effort is made to care for patients the lack of staff results in them being unable to do the job as well as they could. Trainees reported that they have significant concerns about patients boarded within the surgical departments. Their main concern relating to boarded patients is due to foundation doctors within surgery not having access to the medical boarders list on teams and therefore may be unaware of patients that require tasks to be carried out.

FY2: Trainees indicated that they would not feel comfortable if a family member was boarded as they did not feel they'd receive the same quality of care. Although trainees were aware of the boarders MST channel, they reported that they had little involvement with boarders. One trainee raised concerns regarding the MAU when working on-call, noting that patients often wait over 10 hours to be assessed by a doctor and the lack of triage to prioritise patients to review.

GP: Whilst trainees felt that the ward they work in functions well, there were concerns about patient safety within the medical admissions unit. Trainees' main concerns were around the lack of triage and excessive waiting times for patients to be assessed.

IMT: Trainees described a number of patient safety concerns they have in the department. These include:

- Significant delays to assessing patients in MAU, waiting over 18 hours, with patients waiting up to 36 hours to be seen by a consultant.
- Lack of space, particularly within MAU which has no capacity to triage patients or waiting area
- Lack of an on-call medical consultant occasionally at the weekend resulting in patients waiting 72 hours for a consultant review
- Lack of junior medical trainee in the emergency department resulting in delays in progressing management plans of MAU patients initially assessed in the emergency department.
- Opening of a hyper-acute stroke unit which will require to be managed by medical department with no additional staff.

Trainees also described their concerns about patients boarded in the hospital. Their main concerns were:

- Regular inaccuracies on the boarders MST channel
- Late review of patients as well as some occasionally missed
- Random changes to who is responsible for a patient's care, due to each team having a set number of allocated boarders
- Boarding policy only shared with trainees in week prior to the visit
- Pressure from bed management to select patients for boarding out of hours, with the perception that this takes priority over assessing sick patients and always done out of hours.

ST3+: Trainees reported that they would have serious concerns and want a friend or relative moved to another hospital if they were in gastroenterology or cardiology out of hours, due to the lack of

consultant specialists. In addition, they would be concerned about a family member attending the medical admissions unit, due to the lack of triage, and patients regularly waiting between 12 and 20 hours for an initial assessment. Trainees also stated that they had significant concerns about the system for boarding patients and quality of care their receive. The concerns raised about boarders include:

- Poor communication about boarders where trainees remain unaware of multiple boarded patients requiring review near the end of a shift.
- Lack of consultant cover for boarders on Fridays due to providing cover for boarded patients at the Vale of Leven.
- Patient reviews undertaken much later in the day.
- No awareness from the surgical team of who to contact from medical team about concerns for boarded patients

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

Trainers: It was reported that there is currently a backlog of 1,000 unreviewed datix reports, of which 200 had come from acute medicine in the past 3 months. It was acknowledged that staff are trying to look through these reports but very busy due to patient volume and workload. Morbidity and mortality meetings, to enable shared learning from adverse events, had been cancelled for the past 2 years due to a lack of space and time to hold them. Trainers reported that the M&M meetings are due to be reinstated, but a medical lead is still being sought for this. During the presentation it was reported that trainees will often raise concerns via the chief registrar who regularly meets with the new educational lead consultant.

FY1: Trainees reported that adverse incidents should be recorded on the datix system. However, some indicated that they do not want to complete a datix report now, due to their awareness of the 1000 reports still outstanding for review. Several trainees confirmed that they had submitted datix reports and were yet to receive feedback. However, trainees did feel that if they are involved in an adverse incident support is given to them from senior colleagues.

FY2: Trainees were aware of morbidity and mortality meetings within acute medicine, but indicated that only a small group of staff are invited to these meetings. Some trainees were aware of the use of datix to record adverse incidents

GP: Trainees would report adverse incidents via datix. It was reported that there is a good debrief provided to them if there is a difficult arrest. Trainees reported that they are unaware of any meetings that would provide the opportunity for shared learning from an incident.

IMT: Trainees reported that adverse incidents are recorded on the datix reporting system. They believed that the vast majority of consultants would provide the needed support if they were involved in an incident. Trainees indicated that they had submitted several datix reports but are aware there is a significant backlog at present. Feedback is provided to trainees, although this often requires to be sought out, however trainee reported that the feedback provided to them is very supportive and helpful. Trainees reported that there are very few learning opportunities for shared learning from incidents due to the high workload preventing meetings taking place and/or having the time to leave the ward to attend a meeting.

ST3+: Trainees reported that adverse incidents should be recorded through the datix reporting system and support would be given to them from the senior clinical team. Trainees were aware of a backlog in reviewing datix reports. Some trainees were aware of a morbidity and mortality meeting taking place in May but that most departments, with the exception of acute medicine had not held any M&M meetings for some time.

2.21 Other

Trainees were asked to rate their overall satisfaction with the experience they had during their post ranging from 1 (poorest) to 10 (best). Due to challenges of virtual visits and aiming to prevent unconscious bias, it was decided that satisfaction scores would be taken from the PVQ.
FY1: Range 1 – 8, Average: 5 out of 10 (7.5 in 2021)
FY2: 3 out of 10 (Not available in 2021)
GP: Range, 1 – 4, Average 2.3 out of 10 (5.7 in 2021)
IMT: Range: 0 – 6, Average: 2.6 out of 10 (7 in 2021)
ST: Parent Specialty Range: 0-9, Average 6.5 out of 10
ST: GIM Range: 0 – 6, Average: 3 out of 10 (4.7 in 2021)

3. Summary

Is a revisit required?	Yes	No	Highly Likely	Highly unlikely

Despite the immense challenges being faced by the department, trainees once again could not emphasise more strongly the approachability and high level of support from the substantive consultant team. Clear efforts are being made to address the requirements and concerns from the previous visits, however, the panel continue to have significant concerns in relation to patient safety, boarding of patients and little to no progress being achieved to address the requirements from the previous visits.

The lack of progress to meet the visit requirements or demonstrate improvements that positively impact the trainee experience is of concern; the prospect of escalation to enhanced monitoring remains if progress towards resolution is not achieved. The Deanery will support the DME's team to develop their action plan against the latest requirements through the SMART objectives process. The situation will continue to be monitored closely.

Serious Concerns

Patient safety

1. Front-door admission routes remain a significant concern for patient safety:
    a. Long waiting times for triage and first assessment in the Medical Admission Unit (MAU) including patients waiting in the Emergency Department (ED) due to lack of space in MAU. Trainees stated it is not uncommon for patients to be waiting 12-18 hours for first assessment.
    b. Patients are admitted under Medicine using multiple routes: Acute Medical Admission Unit (AMU) for ED referrals, Medical Admission Unit (MAU) for GP referrals, Covid Ward 14, Hyperacute Stroke Unit and Coronary Care Unit (CCU). Trainees were both confused and overwhelmed by the breadth and complexity of front door routes and lack of workforce to provide sufficient cover (medical and nursing).
    c. Confusion around SATA closure: updated action plan from Nov 2021 suggested SATA had closed, presentation by Clinical Lead suggested it will close on Monday the 25th of April and some trainees were under the impression it was closing on Friday the 22nd of

April (the day of the visit). The issues identified in SATA during last visit are still transferrable to the new admission area due to shortage of staffing and the complex front-door model.

d. Concerns raised by trainers and trainees about two-tier system when MAU patients are waiting in ED due to lack of space in MAU. Those patients are not considered ED patients and are to be cared for by MAU team; this resulted in significant delays in executing plans by Med Reg (e.g. administration of medications), ED patients being prioritised for specialty beds and lack of ownership over the care of MAU patients while in ED.

e. Performance management of patient flow through MAU/AMU using Trak data is proposed as a part of the SMART measures for improvement. However, Trak training is yet to be established for this purpose and trainees stated that ward names on Trak do not match current use of the clinical areas (SATA vs AMU vs MAU) leading to inaccuracies.

2. <u>Boarding patients under Medicine remains a significant concern for patient safety:</u>
    a. High number of boarders due to limitations within the footprint of MAU/AMU, trainers stated having to cover 100 boarded patients per day.
    b. Frequent list inaccuracies; despite improved access to boarders' list the quality of data remains a work in progress resulting in delayed clinical reviews and near misses. If a patient is not allocated a consultant due to list inaccuracies it could be days before this is picked up, particularly if the patient is boarded in a surgical ward.
    c. Patients boarded in surgical wards are either on a different list altogether or the surgical FY1s who are responsible for undertaking the wardround tasks do not have access to the relevant list.
    d. There is no handover arrangements for boarders at all. The list on MST channel does not contain clinical information.
    e. Consultant cover Fri- Sun: Senior trainees were concerned about incidents when the boarders consultant for RAH required to work in VoL on Fridays leaving the boarders in RAH without consultant cover, this combined with lack of handover arrangements posed a significant risk to boarded patients over Fri-Sun.
3. <u>Concerns related to clinical governance: backlog in reviewing raised concerns and no learning from adverse incidents</u>

a. While trainers are approachable and foster a no-blame culture, trainees stopped engaging with Datix reporting system due to a backlog of 1000 Datix reviews, of which 200 were in acute Medicine over the last 3 months.
b. Morbidity and Mortality meetings were suspended for almost two years and no alternative measures were in place to share learning from adverse events.
c. Trainees who raised concerns directly with consultants or management felt their concerns were listened to, yet no tangible changes followed leading to frustration and lack of will to raise further concerns.

Less positive aspects of visit

1. <u>Trainees feeling they were frequently working beyond their competence:</u>
    a. FY1 conducting unsupervised ward rounds. While senior support is available on request, high workload means that FY1 doctors perform unsupervised ward rounds on half of the patients in downstream wards.
    b. GPST acting as 2nd on-call for CCU/Cardiology and providing specialty advice without previous cardiology experience was concerning for both GPSTs and senior trainees.
    c. Volume of patients poses a challenge to trainees' ability to multitask safely for all grades
    d. AMU has high workload, the unit is assigned 2FY1s on Saturday but only 1 on Sunday due to banding cost. This resulted in FY1s working on Sundays feeling overwhelmed by tasks and volume of patients

2. <u>Poor educational experience for FY1 doctors:</u>
    a. Significant time spent performing tasks of little or no educational value. FY1s only do "jobs", no clerking of patients unless working OOH and have completed their list of tasks
    b. Only able to do WBPA during OOHs due to lack of significant patient interaction in-hours
    c. No regular feedback to FY1s as "they only do jobs and do not see patients"
    d. Difficulty attending formal teaching live due to workload
    e. FY1s reported they occasionally provided care for critically unwell patients during OOH while awaiting HDU bed with seniors being stretched across different clinical areas with little direct supervision.

3. Lack of adequate access to clinics for all grades, particularly concerning for IMTs/STs
    a. Lack of physical space to run clinics within RAH
    b. Trainees unable to leave the wards to attend clinics even when rostered to do so due to high workload combined with rota gaps
    c. Ambulatory clinics in AIM have been reduced significantly
    d. Note that trainees based at COTE wards had a positive experience accessing clinics

4. Access to WPBA particularly ACATs and DOPS remain an issue despite consultants' commitments
    a. Post-take ward rounds in AMU starts at 8 am to facilitate ACATs. However, ST/IMT trainees would prefer if this was to take place in MAU as few patients seen overnight would have made it to AMU.
    b. Direct supervision of senior trainees during ward rounds and procedures is rare due to consultants being stretched covering service and their own rota gaps
    c. Trainees of more junior grades stated that consultants could take long time to complete assessment tickets and required frequent reminders. They were sympathetic to their consultants quoting service pressures and lack of protected time as cause for delay.

5. GI cover during out of hours is concerning since RAH lost their own GI team; senior trainees described difficulties managing bleeders due to delays in accessing GI service in QEUH

6. Rota and workload concerns:
    a. Rota monitoring was invalid for the last 3 rounds due to lack of responses by trainees. Given the significant rota pressures more serious efforts should be made to complete monitoring adequately.
    b. FY trainees described a stretch of 7 days including 3 long shifts followed by a single zero day then back for 7 days (on formal rota back to 5 days). They described feeling burnt out and recommended two-zero days after the 7 day stretch.
    c. 2 FY1 on AMU on Saturday but only one on Sunday despite service needs due to banding cost.
    d. Lack of CSWs/phlebotomy service added to the workload of trainees. 1 FY1 covering MAU on Sunday plus ward 15 if opened due to lack of capacity in MAU felt

overwhelmed as they had no ECG service, reduced phlebotomy service and lengthy ward rounds.

e. Locum rates were allegedly different for trainees covering ED versus Medicine gaps resulting in reduced uptake in Medicine
f. STs on multiple rotas (cardiology) having clashes in RAH rota and the specialty cover for GGC

7. Communication with trainees and trainers:
    a. Trainees welcomed the multiple formal and informal opportunities to raise their concerns with consultants, clinical lead and service manager. However, they are becoming increasingly disengaged due to lack of action based on raising such concerns.
    b. Trainees and trainers feeling significantly pressured to cope with service demands and staff shortage yet feel they have little say in service redesign including front-door, Trauma assessment relocating to RAH and a new hyperacute stroke service with no extra staffing provided.
    c. Trainees feeling inadequately informed about changes to the front-door and confusion around SATA/AMU/MAU areas
    d. Trainees and trainers feel more engagement from GGC senior management is required to achieve any progress as RAH resources have been exhausted and any further progress will require external support from the rest of GGC.

8. Undermining allegations:

    While the great majority of consultants were very approachable and commended by trainees, complaints against a locum consultant were reported by a number of trainees. The panel understood that these allegations were being investigated by RAH. There was another incident involving a service manager, details will be shared separately with the DME.

Positive aspects of the visit

1. Cohesive consultant team, supportive and committed to service and training despite a workforce gap of almost a third (18 on Rota out of 26 required).

2. Appointing a lead for induction (Dr Sally McAdam) resulting in significant improvements to induction such as role cards and signposting to pastoral support early.
3. Clear escalation plans and clinical supervision for FY1s, who always knew whom to contact
4. Quality Improvement project led by senior trainees resulted in the 4:45pm handover becoming more structured
5. Commitment to employ CDFs and incorporate them on night shifts to support trainees
6. Consultant-led weekly teaching at Wednesday lunchtime and popular AIM teaching on Thursday afternoon
7. Rota Governance Manager Lesley Allan praised for her engagement with FY1 to incorporate rota changes based on their feedback
8. Consultants are supportive when adverse events happen and trainees feel they work in a no-blame culture environment
9. All IMT doctors have passed their PACEs and all had ITU blocks arranged to allow meeting their curricular needs despite significant service pressures.
10. Trainers' job plans were reviewed to provide more protected time for training commitments. However, service demands and consultant workforce gaps meant consultants were providing direct clinical care in their protected time to maintain the service.
11. FY2 in COTE were able to attend clinics (stroke and Parkinsons)
12. Very supportive and approachable critical care consultants for invasive procedures and HDU support during OOH and weekends
13. Dr Haq commitment and approachability were commended by trainees as the sole GI consultant in RAH

Listed below are the requirements from the 2021 visit. Requirements 7.7, 7.9 and 7.14 were the unmet requirements carried over from the 2018 visit and 7.8, 7.11, 7.12 and 7.13 were unmet at the 2020 visit.

Ref	Issue	Progress to meet requirement
7.1	Measures must be implemented to address the patient safety concerns described in this report in relation to SATA/MAU and Boarding patients.	Ongoing Concerns

7.2	There must be robust arrangements in place to ensure the tracking 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.	Ongoing Concerns
7.3	There must be a policy in place, that trainees are aware of, regarding the selection of patients who are potentially suitable for boarding.	Some Progress
7.4	Trainees must receive adequate induction to all clinical areas they cover particularly out-of-hours, to allow them to begin working safely and confidently.	Significant progress
7.5	Doctors in training must not be expected to work beyond their competence.	Ongoing concerns
7.6	Alternatives to doctors in training must be explored and employed to address the chronic gaps in the junior rota that are impacting on training, particularly night shift gaps.	Some Progress
7.7	4:45pm handover processes to downstream wards must be improved to ensure there is a safe, robust handover of patient care with adequate documentation of patient issues.	Significant Progress
7.8	Barriers preventing trainees attending their dedicated teaching days must be addressed	No Progress (except for GPSTs)
7.9	Work must be undertaken to ensure that trainees are supported to attend clinics and other scheduled learning opportunities without compromise because of service needs.	No progress
7.10	WPBA requiring direct supervision such as ACATs and DOPs must be facilitated during the working hours of trainees by their trainers.	Little progress
7.11	All staff must behave with respect towards each other and conduct themselves in a manner befitting Good Medical Practice guidelines. Perception of breakdown in communication between ST3+ trainees and management, and allegations of undermining behaviour should be investigated by RAH and dealt with appropriately.	Significant progress

7.12	Support for acting up should be provided and agreed with trainees who are selected for acting up.	Progress.
7.13	General practice trainees must be given allocated time to meet with their educational supervisors who are based in GP practices and given study leave to attend mandatory teaching.	Achieved
7.14	Trainees must be able to attend the post receiving ward round in the acute medicine unit and when they do, the feedback they receive must be delivered in a constructive manner.	Little progress

4. Areas of Good Practice

Ref	Item	Action
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	N/A	

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	Measures must be implemented to address the patient safety concerns described in this report in relation to SATA/MAU and Boarding patients	Immediately	All levels
6.2	There must be robust arrangements in place to ensure the tracking of all boarded patients. In addition, for boarded	Immediately	All levels

	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.		
6.3	There must be a policy in place, that trainees are aware of, regarding the selection of patients who are potentially suitable for boarding.	Immediately	All levels
6.4	Trainees must receive adequate induction to all clinical areas they cover particularly out-of-hours, to allow them to begin working safely and confidently.	22 January 2023	All levels
6.5	Doctors in training must not be expected to work beyond their competence.	22 January 2023	FY1
6.6	Alternatives to doctors in training must be explored and employed to address the chronic gaps in the junior rota that are impacting on training, particularly night shift gaps.	22 January 2023	All levels
6.7	4:45pm handover processes to downstream wards must be improved to ensure there is a safe, robust handover of patient care with adequate documentation of patient issues.	22 January 2023	All levels
6.8	Barriers preventing trainees attending their dedicated teaching days must be addressed	22 January 2023	All levels
6.9	Work must be undertaken to ensure that trainees are supported to attend clinics and other scheduled learning opportunities without compromise because of service needs.	22 January 2023	All levels
6.10	WPBA requiring direct supervision such as ACATs and DOPs must be facilitated during the working hours of trainees by their trainers.	22 January 2023	ST3+ and IMTs
6.11	All staff must behave with respect towards each other and conduct themselves in a manner befitting Good Medical Practice guidelines. Perception of breakdown in communication between ST3+ trainees and management, and allegations of undermining behaviour should be investigated by RAH and dealt with appropriately.	22 January 2023	All levels

6.12	Support for acting up should be provided and agreed with trainees who are selected for acting up.	22 January 2023	FY2, GPST
6.13	Trainees must be able to attend the post receiving ward round in the acute medicine unit and when they do, the feedback they receive must be delivered in a constructive manner	22 January 2023	IMT, ST3+