Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	9th June 2022	**Level(s)**	FY/GPST/IMT/ST
Type of visit	Triggered	**Hospital**	Ninewells Hospital
Specialty(s)	General Internal Medicine	**Board**	NHS Tayside

Visit panel	
Dr Greg Jones	Visit Chair – Associate Postgraduate Dean for Quality
Dr Alan McKenzie	Associate Postgraduate Dean for Quality
Sarah Summers	Lay Representative
Dr Geraldine Brennan	Associate Postgraduate Dean – Quality and Foundation representative
Dr Corrine Coles	General Practice Representative
Dr Joshua Newmark	Trainee Associate
Alex McCulloch	Quality Improvement Manager
In attendance	
Claire Rolfe	Quality Improvement Administrator

Specialty Group Information	
Specialty Group	Medicine
Lead Dean/Director	Professor Alastair McLellan
Quality Lead(s)	Dr Alan McKenzie Dr Greg Jones Dr Fiona Drimmie
Quality Improvement Manager(s)	Alex McCulloch
Unit/Site Information	
Non-medical staff in attendance	N/A
Trainers in attendance	21

Trainees in attendance		FY1 - 12		FY2 - 6		GPST – 4		IMT – 19		ST - 12	
Feedback session: Managers in attendance	Chief Executive	☐	DME	☐	ADME	☐	Medical Director	☐	Other	Clinical Services Managers, Rota Managers, Medical Education leads	

Date report approved by Lead Visitor	 20th July 2022

1. Principal issues arising from pre-visit review:

On review of data at the Medicine Quality Review Panels in November 2021 the panel had concerns with regard to the red and pink flag negative outliers recorded in the GMC National Training Survey for Acute Internal Medicine, Gastroenterology, General Internal Medicine, and Geriatric Medicine.

As a result of this data the Medicine Quality Management Group triggered a visit to Ninewells General Internal Medicine and all associated dual training specialties. The data that led to the trigger is highlighted below:

NTS 2021 All Trainee Data for Acute Internal Medicine:

Red Flag for Overall Satisfaction and Educational Governance
Pink flags for Adequate Experience, Clinical Supervision, Clinical Supervision (Out of Hours), Curriculum Coverage and Regional Teaching.

NTS 2021 All Trainee Data for Gastroenterology:

Red flags for Adequate Experience, Regional Teaching, Rota Design and Teamwork
Pink Flags for Educational Governance, Educational Supervision, Induction, Overall Satisfaction, Reporting systems and Workload.

NTS 2021 Specialty Trainee data for Gastroenterology:

Red flag for Rota Design
Pink flags for Clinical Supervision, Educational Governance, Educational Supervision, Overall Satisfaction, Regional Teaching, Reporting Systems, Supportive Environment, Teamwork and Workload.

NTS 2021 All Trainee Data for General Internal Medicine:

Red flags for Educational Supervision, Induction and Supportive Environment.
Pink flags for Clinical Supervision (Out of Hours) and Curriculum Coverage

NTS 2021 Specialty Trainee data for Geriatric Medicine:

Red flags for Clinical Supervision (Out of Hours)
Pink flags for Educational Supervision, Facilities, Feedback, Handover, and Induction

This visit will take the opportunity to gain a broader picture of how training is carried out, particularly within the ongoing challenges posed by COVID-19, and discuss the concerns raised through survey data. It will also provide both trainees and trainers with the opportunity to highlight any areas that they feel is working well in relation to training.

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.

A very helpful and informative presentation was provided by local Clinical Director (Dr Monica Doyle) prior to the panel meeting with the trainers. This provided an update on what changes and improvements had been made to training since the last deanery visit in 2018. Information from the presentation has been incorporated into the report below.

2.1 Induction (R1.13):

Trainers: Trainers felt that extensive work was done to ensure that trainees were provided with induction. General hospital induction was confirmed to run every August and February and a new IMG induction was in place. Departmental inductions were conducted (inclusive of site/ward tours) when they were required. Induction was recorded and trainees were able to watch recordings if they couldn't attend the initial induction but could also receive face to face catch up sessions if required.

Foundation Trainees: Most trainees had received site induction, a couple of trainees who started on nights had missed the initial induction but had been able to watch the recorded sessions and had received the associated slides. Some trainees felt induction covered a lot of topics but was lacking in clarity in terms of the FY role, particularly whilst working out of hours. Departmental induction was described as variable by trainees in some departments. The Acute Medical Receiving Unit (AMU)

departmental induction was considered to be good including a departmental tour however trainees who were working in AMU and transferred into Medicine for the Elderly reported a lack of induction when they moved into the department. Trainees who were based in Respiratory Medicine also reported a lack of departmental induction.

General Practice Trainees: Most trainees present had received both site and departmental induction although some commented on a lack of induction in Medicine for the Elderly.

Internal Medicine Trainees: Trainees appeared to have a variable experience of induction and a couple of trainees hadn't received site induction, most trainees had received departmental induction.

Specialty Trainees: Most trainees present had received induction although a couple again hadn't received it. Trainees felt there was an assumption that if a trainee had worked locally in consecutive years, there was no requirement for an updated induction and therefore they weren't offered any.

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

Trainers: Trainers felt they made efforts to allow trainees to attend teaching with protected time provided for the national programme teaching sessions. Trainers also felt trainees could attend the general medicine teaching sessions, with teaching that was trainee led in most specialties. Trainers felt teaching had been impacted for some specialties by staffing gaps at consultant level.

Foundation Trainees: Trainees were unaware of the local teaching provided for them except when they were based in ward 4 and they also struggled to get to their regional teaching sessions due to workload on the wards. There appeared to be no cover provided by colleagues to allow them to attend. In summary, trainees estimated they got 0 hours of teaching on a weekly basis.

General Practice Trainees: Trainees felt there was local teaching available but getting to it was problematic for them. Again, workload and clinical commitments on the ward were highlighted as the main reasons they were unable to go to it. Trainees estimated they had attended 3 sessions so far over a 4-month period.

Internal Medicine Trainees: Trainees highlighted teaching as challenging to get to and this was

despite some teaching being planned into the rota, most trainees had watched recorded sessions rather than being able to attend in person and they done this in their own time as opposed to during their working hours. Trainees commented that local teaching was available every day in AMU.

Specialty Trainees: Trainees could access local General Internal Medicine teaching sessions and had been around 6 sessions so far in their post. Trainees said there was a lack of local teaching in some departments such as Renal Medicine, Respiratory Medicine, and Cardiology. Good access to local teaching was provided in Infectious Diseases, Gastroenterology & Renal Medicine had aligned monthly regional teaching to Glasgow via MS Teams.

2.3 Study Leave (R3.12) – Foundation doctors confirmed they had access to taster weeks.

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

Trainers: Trainers confirmed that trainees were generally allocated to their supervisors prior to them starting their post. In order to maintain continuity and familiarity with the curriculum, the same supervisors were allocated to foundation and general practice trainees each year.

All Trainee Cohorts: All trainees had been allocated educational supervisors and most had met with them to discuss their educational objectives.

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 confirmed that consultants were available in the AMU from 8.00 am in the morning until 10.00 pm in the evening, overnight there were on-call consultants that trainees could contact. Trainers felt they actively encouraged trainees to call the on-call consultants to discuss patients. Trainers highlighted a recent case of providing extra support for a doctor in difficulty and had a plan in place to support them due to pre-emptive notification of them arriving. Trainers advised a consultant of the week model of support was provided in the downstream wards, a cluster model of support was in place at the weekend in general medicine with 6 or 7 consultants on shift supporting trainees at a time. At the weekends various specialties operated consultant cover across the hours of 9.00 am – 7.00/8.00 pm., although most provided cover from 9.00 am – 5.00 pm.

All Trainee Cohorts: Trainees confirmed they were able to reach senior support when they required it both whilst working during the day and on most occasions out of hours, although the out of hours cover for the hospital was felt to be fragile, with one ST trainee being on site in the evening and a further based in the AMU. Foundation trainees were reluctant to contact the AMU based ST as often they would be too busy to respond quickly and appeared unaware that an on-call consultant was available to be contacted if support was required.

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

Trainers: Trainers felt they were familiar with the curriculum requirements for the grades of trainee they supervised. Trainers gave a specialty-based overview of the availability of clinics, in Medicine for the Elderly they said trainees were able to go to clinics on a weekly basis which were led by the same consultant. In Gastroenterology trainers felt they encouraged trainees to go to clinics where possible (prioritising IMT trainees) due to their curricular requirements, but the demands of the General Internal Medicine commitments had reduced the opportunity for trainees to attend them. In the Stroke unit attempts were made to timetable clinics and the consultants allocated to TIA clinics where they were available.

Foundation Trainees: Trainees felt they were getting enough experience to meet their curriculum requirements and that their posts provided experience of managing acutely unwell patients. FY2 trainees reported no access to clinics and that their roles were similar to FY1 colleagues. The trainees highlighted a good training experience was being provided for them in Acute Medicine, ward 4 and in the Stroke Unit. Trainees said a significant amount of their time was spent completing tasks that they considered to be non-educational, they described non-educational tasks as Immediate Discharge Letters (IDLs), taking bloods, siting cannulas, and conducting ECGs. Trainees said support was provided by a phlebotomy service to take bloods but recent absences in the team had affected their ability to provide support. Trainees highlighted good access to FY taster weeks.

General Practice Trainees: Trainees highlighted some competences as difficult to get, such as child safeguarding elements of the curriculum which was due to the requirement for reflection on a clinical case. Trainees said non educational tasks made up a large part of their workload and estimated they spent about 80% of their time completing what they considered to be non-educational tasks. Trainees described clinic access is minimal and estimated they had attended between 3 – 4 clinics since

starting their post in February 2022.

Internal Medicine Trainees: Trainees highlighted central line experience as difficult to get but noted they raised it with Dr Suzy Silburn and Dr Nik Rae who were currently developing a skills session to cover it. Some Workplace Based Assessments such as DOPs were felt to be challenging to get signed off, this was thought to be due to most departments in Medicine being so busy rather than a lack of willingness of trainers to sign them off. Trainees said they could get access to enough clinics across most departments to satisfy their curriculum requirements, however time to complete the administrative follow up tasks following clinics was felt to be limited. Trainees felt their posts provided them with enough experience of managing acutely unwell patients and did not raise any concerns with regard to the amount of time they spent completing non-educational tasks.

Specialty Trainees: Cardiology trainees reported some difficulties getting cardiothoracic ultrasound competences signed off and would plan to raise this with their Educational Supervisor. Trainees said they could access enough clinics to meet their curriculum requirements, with some specialties providing rota'd clinics (Respiratory Medicine, Infectious Diseases, Cardiology and Gastroenterology). Trainees described access to clinics whilst working in General Internal Medicine as difficult. Trainees felt their posts provided them with enough experience of managing acutely unwell patients and did not raise any concerns with regard to the amount of time they spent completing non-educational tasks.

2.7 Adequate Experience (assessment) (R1.18, 5.9, 5.10, 5.11) – Not asked

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: Trainers said increased consultant presence in most wards provided the opportunity for more infrequent feedback to trainees on a regular basis. Post night shift feedback was provided to trainees during morning ward rounds as trainees were often very tired after night shift, the discussion could often be more of a wellbeing check than feedback. Trainers felt they encouraged trainees to

use and formalise the feedback they were given into workplace-based assessments but said trainees often didn't take up the opportunity to do this.

All Trainee Cohorts: Trainees felt the feedback they received was variable and dependent on the ward they were based in. Feedback in the Stroke unit was felt to be good, as well as in the Medicine for the Elderly department & AMU, in other departments they said they had to seek it out. There was felt to be a lack of feedback whilst they were working out of hours. When trainees did receive feedback, they felt it was constructive and meaningful.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: Trainers confirmed a trainee forum was in operation which the trainees attended. As part of the implementation of the PCAT/We Care rota management tool, feedback was sought from trainees in the form of a survey. Reflective practice took place in the Stroke unit where consultants would discuss learning from cases and where improvements could be made. Other opportunities for trainees to provide feedback to trainers included their end of block clinical supervisor meetings.

All Trainee Cohorts: Some of the trainee cohorts were unaware of the local junior doctor forum or who their chief residents were, with the exception being the IMT and specialty trainees. They felt opportunities to feedback on their training would be at end of placement meetings or informally through their educational or clinical supervisors.

2.12 Culture & undermining (R3.3)

Trainers: Trainers felt they had a close working relationship with trainees and felt they operated a collaborative working environment rather than a hierarchical one. They said trainees were encouraged to make decisions on patient care and then discuss them, which they felt encouraged critical decision making. Various reflective based sessions took place in different departments throughout medicine, which in the current challenging clinical environment were felt to be a good opportunity to discuss and resolve disagreements or conflict.

All Trainee Cohorts: Trainees said most consultants and their senior colleagues were supportive and approachable, however instances of perceived undermining were highlighted to the visit team,

these were raised with the local Director of Medical Education (DME) out with this visit report.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Trainers highlighted the process for filling rota gaps, they were offered to trainees initially, then offered to the staffing bank, followed by attempts to fill with local locums. Trainers advised a standard operating procedure was used to manage gaps, however the most difficult issue to address recently had been the cover of short-term sickness gaps. Trainers had employed the use of PCAT (Professionalism Compliance Analysis Tool)/We Care system and were working on increasing the number of clinical development fellows employed which would reduce the burden of cover for gaps on trainees.

Foundation Trainees: Trainees said there were lots of gaps on their rota and for the most part cover arrangements would fall to them, which meant they were moved around wards frequently to provide cover. Trainees felt they spent about 60% of their time on their base ward and advised their rota did not incorporate any learning opportunities such as clinics or teaching. Trainees said they had completed a survey (which had been in relation to the rotas) but felt the management of gaps had changed since they had done this. Trainees had concern with regard to ward 5 which was not rota'd for medical cover on an occasion. This had been escalated by trainees as a patient safety concern, but trainees felt no follow up discussions had taken place to learn from what they considered to be a potential safety concern both from a trainee and patients' perspective. Trainees felt strongly that the rota was having an impact on their wellbeing and described long periods of long days, with infrequent rest days in between, they also said the AMU rota involved shorter days but with longer stretches with only 1 day off in between, this as well as a requirement to provide cover for gaps was having a significant impact on their wellbeing.

General Practice Trainees: Trainees said their current rota had gaps but were satisfied they were filled appropriately, although they felt the rota could be tight particularly whilst working out of hours. Trainees appeared unaware of a feedback survey in regard to the rota. Trainees did not feel the rota was having an impact on their wellbeing but did describe night shifts as heavy.

Internal Medicine Trainees: Trainees advised their current rota as having lots of gaps and these had increased in the past 2 years. Rotas gaps due to short term Covid related illness as well long-term

gaps were felt to be an issue, particularly in the out of hours period. Trainees described an increase in rota roles but no increase in staffing and this combined with a lack of locum cover for gaps, often meant trainees would have to manage cover for gaps themselves. Trainees felt there was no incentives for locums to cover gaps in Ninewells. Trainees appeared unaware of the PCAT/We Care tool or of attempts to get feedback on their rota through a survey. Trainees said their rota was unforgiving, which included 7 day stretches of long days, which they felt were very tiring. They also said their rota was sent on with little notice, which was estimated at around 4 days before starting their post.

Specialty Trainees: Trainees said there were lots of gaps on their current rota, with a lack of a rota co-ordinator to arrange for them to be filled. Trainees felt they often had to arrange cover for gaps themselves. Trainees felt they were also not compensated adequately financially for covering these gaps, which made them feel undervalued. Trainees appeared unaware of the PCAT tool or of attempts to gather their feedback through a rota survey.

2.14 Handover (R1.14)

Trainers: Trainers felt they had a robust process in place for handover, which was consultant led in the morning at 8.00 am daily and then again in the evening at 8.00 pm being led by the hospital at night team nurses.

All Trainee Cohorts: Trainees felt handover for new admissions into the AMU was robust but there was often frequent movement of both patients and trainees in the downstream wards and sometimes unaccompanied by handover, which made it difficult to maintain continuity. Hospital at night handover was considered to be good by foundation trainees). A lack of consultant input to morning HDU handover from night junior was highlighted by specialty trainees.

2.15 Educational Resources (R1.19) – Not asked

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

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

Trainers: Trainers told us there was a post graduate education governance meeting that ran regularly, with smaller directorate level groups that discussed training issues which were fed into the main meeting.

Foundation Trainees: Trainees appeared unaware of a trainee forum or who their local chief residents were, they also appeared unaware of the route for raising concerns but advised they would speak to their clinical supervisors if they had any concerns about the quality of their training.

General Practice Trainees: The GPSTs also appeared unaware of a trainee forum but were aware of a local general practice representative who they could approach with any concerns they had about the quality of their training.

Internal Medicine Trainees: Trainees confirmed if they had any concerns about their training, they would raise them with their educational supervisors or with their training programme director and had highlighted training issues with Dr Suzy Silburn in the past, who had worked to resolve them. Trainees were aware of a local trainee forum, but they felt accessing it was challenging, although they had raised concerns through it in the past.

Specialty Trainees: Trainees confirmed they could raise concerns about their training with their clinical supervisors and were aware of the local trainee forum.

2.18 Raising concerns (R1.1, 2.7)

Trainers: Not asked.

All Trainee Cohorts: Trainees said they would raise any concerns in the first instance with their clinical supervisor. More serious concerns relating to adverse incidents or patient safety they would raise through the Datix system.

2.19 Patient safety (R1.2)

Trainers: Trainers felt the environment within Medicine was safe for both patients and for trainees, with a robust escalation process to ensure critically ill patients were identified quickly and appropriate

management plans were put in place for their care. They felt they had a good reporting system in place to identify learning from adverse incidents and said education is a standing item on almost all management meetings. Datix involving trainees (organisation wide) were also collected centrally via the DME with themes of them shared within the educational governance structure.

Foundation Trainees: Trainees felt the environment within medicine was generally unsafe for patients. In the last couple of weeks, they highlighted pressure on beds and incidents where they felt patients were discharged without additional investigations and a lack of cover on downstream wards. Trainees said as they were often moved around at short notice which made it difficult to maintain continuity for patients and created a lack of medic-to-medic handover. Trainees felt they had a lack of awareness of the process for the management of boarded patients as it changed frequently.

General Practice Trainees: Trainees did not have any concerns in regard to patient safety and trainees present had not had any interactions with boarded patients so far but noted they were looked after by their own teams. They noted weekly safety huddles and multi-disciplinary meetings taking place regularly.

Internal Medicine Trainees: Trainees did not report specific patient safety concerns but highlighted their concern with regard to waiting times for assessment of patients in the AMU. They felt safety could be dependent on ward/specialty due to gaps in staffing. Trainees were concerned about the system for boarding and described it as changing regularly and sometimes on a daily basis, which made it difficult to become familiar with.

Specialty Trainees: Trainees had concern with regard to the volume of patients being admitted into the emergency department and of the flow of them into AMU, again this was related to patient waiting times for assessment and of a lack of accommodation for patients whilst they were waiting to be assessed. Trainees did not have specific concerns with regard to patient care in the downstream wards. Trainees noted safety huddles as a regular system for monitoring patient safety, they reported delays in the movement of patients boarded from AMU, often there was delays in the downstream wards being able to accommodate them due to being full to capacity.

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

Trainers: Trainers highlighted the Datix system as a formal method for recording adverse incidents, a report from Datix with learning notes attached was pulled from Datix and circulated to trainees. There had been delays in re-instating the main medicine morbidity and mortality meeting (M&M) due to the Covid 19 pandemic and a lack of access to the lecture theatre, but these had taken place for the first time in 2 years during March and April and were well attended by trainees. Departmental M&M had continued during this time.

Foundation Trainees: Trainees highlighted an incident that had occurred whilst working out of hours in the Medicine for the Elderly Department, where staff were left to cope with an aggressive patient who had assaulted members of the team, with a lack of security personnel available to support them in the out of hours period. Although this incident had been reported, they felt no change in practice had been made.

General Practice Trainees: Most trainees present hadn't been involved in adverse incidents but felt they would get the necessary support if they were and noted that consultants conducted reflective sessions with trainees. They were aware of the Datix system for reporting incidents.

Internal Medicine Trainees: Trainees highlighted the Datix system and the formal system for reporting adverse incidents, one had raised a Datix report and received feedback on it.

Specialty Trainees: Trainees were aware that Datix was the system used to report adverse incidents, some trainees present had raised concerns. One trainee had done so recently and was awaiting feedback on it.

3. Summary

Is a revisit required?	Yes	No	Highly Likely	Highly unlikely

Overall Satisfaction scores: Trainees scored their overall satisfaction with their post between 1 – 10:

Foundation Trainees: Scored between 3 - 7, with an average score of 4.8 out of 10.
General Practice Trainees: Scored between 6 – 8, with an average score of 7 out of 10.
Internal Medicine Trainees: Scored between 6 – 9, with an average score of 7.6 out of 10.
Specialty Trainees: Scored between 5 – 9, with an average score of 6.9 out of 10.

The visit panel found that Ninewells Hospital Medicine department is clearly under significant strain due to the combination of high patient volume and staffing shortages relating to COVID 19, which has clearly had a significant impact on the training experience being provided to trainees there. Staffing for workload and the management of both short term and long-term gaps was found to be a significant concern and which was particularly affecting the training experience of the foundation trainees. The flow of patients from the emergency department into AMU was another safety concern of the visit team. Undermining concerns were highlighted to the visit team and are being managed in a process out with the main visit report.

The visit team would like to acknowledge the commitment of the trainers in the Medicine team, a number of whom were highlighted by the trainees as providing excellent support for training.

Positive aspects of visit:

- Clear escalation process in AMU and downstream wards
- Use of FY1 leading on ward rounds were exemplars for learning and appreciated by trainees
- Specialty taster weeks were readily available for FY trainees
- Clinical and educational supervisors were allocated early and time in job plans was provided for trainers for supervision
- Most trainers highlighted were as supportive and approachable, some trainers were called out for their commitment to training and they were Colin Baines, Suzy Silburn, Nik Rae, and Monica Doyle
- Datix was working well, and feedback was given by trainers
- Work had been done on handover and trainees felt it had improved
- Clinic rostering in some specialties such as Renal Medicine, Gastroenterology and Infectious Diseases was highlighted by trainees

Less positive aspects of the visit:

- Serious deficiencies in delivery of teaching – FY trainees reported almost no local teaching and couldn't attend most of the deanery led regional teaching, there was also a lack of GP and IMT teaching
- Perceived undermining incidents were highlighted and will be fed back to DME after this visit
- Workload is significant for all and very high in particular for FY trainees
- Trainees spend large parts of the day doing non-educational tasks such as bloods and cannulas
- Departmental induction was highlighted as lacking in some departments
- Trainees who had previously been based in Ninewells were not invited for repeat hospital induction resulting in induction gaps of many years in some cases.
- Gaps in rotas and short notice frequent movement of trainees to cover those gaps was highlighted as detrimental to training
- There was a lack of ownership of management of gaps by consultants or hospital management and it felt to be left to trainees to manage cover for those gaps.
- Rotas issued at short notice

- Trainees were unaware of the use of the PCAT/We Care system and of attempts to get feedback from them in relation to rotas
- Some issues related to boarding were highlighted, included a lack of a clearly identified robust system, which was felt to be changed on a regular basis.
- HDU handover – Some concerns were highlighted in connection to patient safety
- The flow of patients into AMU, coming from the EM without a clear management plan

4. Areas of Good Practice

Ref	Item	Action
4.1	FY1 trainees leading on ward rounds with support and feedback from senior colleagues, is an exemplar for learning and is appreciated by trainees	
4.2	Specialty taster weeks were readily available for FY trainees	

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	Trainee forum	The FY and GPST trainees appeared unaware of the trainee forum, work could be done to increase the profile of it and to provide opportunities for trainees to attend it.

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	Staffing levels in wards must be reviewed to ensure that workload is appropriate and does not prevent access to learning opportunities including outpatient clinics.	9th March 2023	FY/GPST/IMT/ST
6.2	The unit should actively seek administrative resource to take on rota and leave management and all items relating to it.	9th March 2023	FY/GPST/IMT/ST
6.3	Departmental induction must be provided which ensures trainees are aware of all of their roles and responsibilities. The induction booklet or online equivalent should be sent to all grades of trainees before commencing in post and all trainees who continue in post must have access to an updated hospital induction.	9th March 2023	FY/GPST/IMT/ST
6.4	There must be active planning of attendance of doctors in training at teaching events to ensure that workload does not prevent attendance. This includes bleep-free teaching attendance.	9th March 2023	FY/GPST/IMT/ST
6.5	All staff must behave with respect towards each other and conduct themselves in a manner befitting Good Medical Practice guidelines. Specific example of undermining behaviour noted during the visit will be shared out with this report.	9th March 2023	FY/GPST/IMT/ST
6.6	Tasks that do not support educational and professional development and that compromise access to formal learning opportunities for all cohorts of doctors should be reduced.	9th March 2023	FY/GPST/IMT/ST

6.7	Handover processes in HDU must be improved to ensure there is a safe, robust handover of patient care with adequate documentation of patient issues, senior leadership and involvement of all trainee groups who would be managing each case.	9th March 2023	FY/GPST/IMT/ST
6.8	Rotas must be issued well in advance, usually 6 weeks, of trainees taking up their post, in keeping with national agreements.	9th March 2023	FY/GPST/IMT/ST
6.9	Rota patterns must ensure sufficient rest time for trainees in transition from night to day working and must avoid patterns which result in excessive fatigue.	9th March 2023	FY/GPST/IMT/ST
6.10	The discontinuity of ward placements for Foundation, GPST and IMTs must be addressed as a matter of urgency as it is compromising quality of training, feedback, workload, and the safety of the care that doctors in training can provide. The duration of ward attachments of Foundation doctor must be increased to be for at least 4 weeks.	9th March 2023	FY/GPST/IMT/ST
6.11	There must be a policy in place, that trainees are aware of, regarding the selection of patients who are potentially suitable for boarding.	9th March 2023	FY/GPST/IMT/ST
6.12	Measures must be implemented to address the potential patient safety concerns associated with the lengthy delays between arrival and definitive assessment of patients within the ED and AMU departments (this was related to patient waiting times for assessment and of a lack of accommodation for patients whilst they were waiting to be assessed in AMU).	9th March 2023	FY/GPST/IMT/ST