Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	26th February 2025	**Level(s)**	FY, CT and ST
Type of visit	Triggered	**Hospital**	Glasgow Royal Infirmary
Specialty(s)	Plastic Surgery	**Board**	NHS Greater Glasgow & Clyde

Visit panel	
Ms Kerry Haddow	Visit Chair - Associate Postgraduate Dean – Quality
Dr Morag Hogg	Training Programme Director
Dr Surinder Panpher	Foundation Programme Director
Dr Aye Myat Doris	Trainee Associate
Mrs Natalie Bain	Quality Improvement Manager
Mr Bill Rogerson	Lay Representative
In attendance	
Mrs Susan Muir	Quality Improvement Administrator

Specialty Group Information		
Specialty Group	Medicine, Surgery, Anaesthetics, ICM & Emergency Medicine	
Lead Dean/Director	Dr Adam Hill	
Quality Lead(s)	Dr Reem Al Soufi Dr Fiona Drimmie Ms Kerry Haddow Dr Alan McKenzie Dr Phillip Walmsley	
Quality Improvement Manager(s)	Mrs Jennifer Duncan & Miss Vhari MacDonald	
Unit/Site Information		
Non-medical staff in attendance		
Trainers in attendance	10	
Trainees in attendance	2 FY, 3 CT's & 10 STs	

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

Date report approved by Lead Visitor	10th March 2025

1. Principal issues arising from pre-visit review:

Following review and triangulation of available data, including the GMC National Training Survey and NES Scottish Trainee Survey, a Deanery visit is being arranged to Plastic Surgery at Glasgow Royal Infirmary. This visit was requested by the Medicine, Surgery & AICEM Quality Review Panel. The visit aims to further investigate issues highlighted and to advise on steps towards addressing and resolving them where required.

Issues highlighted were:

NTS All Trainee

Red Flag - Educational Governance, Handover, Overall Satisfaction, Regional Teaching, Rota Design, Supportive Environment.

Pink Flag - Adequate Experience, Educational Supervision, Reporting System.

NTS ST Trainee

Red Flag - Educational Governance, Handover, Induction, Overall Satisfaction, Regional Teaching, Rota Design, Supportive Environment.

Pink Flag - Adequate Experience, Clinical Supervision, Clinical Supervision OOH, Educational Supervision, Feedback, Reporting System, Study Leave.

STS All Trainee

Red Flag - Discrimination, Educational Environment & Teaching, Equality & Inclusivity, Handover, Induction, Team Culture, Wellbeing Support.

STS Core

Red Flag - Educational Environment & Teaching, Handover, Induction.

Pink Flag - Discrimination.

STS Foundation

Pink Flag - Educational Environment & Teaching, Handover.

STS ST

Red Flag - Discrimination, Educational Environment & Teaching, Equality & Inclusivity, Handover, Induction.

3 Negative FTC (Core/ST) - Bullying/Undermining/Discrimination and Adequate Experience.

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.

Departmental Presentation: The panel would like to thank Mr Adam Gilmour for his very detailed presentation and the team for the work that went into it. The presentation provided an overview of the organisation and ethos of the department overall. The presentation detailed the areas of good practice, as well as the challenges faced by the department as highlighted by the NTS survey results.

2.1 Induction (R1.13):

Trainers: Trainers reported that induction is a formal process that inducts trainees well to work in Glasgow Royal Infirmary (GRI) and Royal Children's Hospital (RCH) but there is an awareness that there is a gap for inducting trainee into the Queen Elizabeth University Hospital (QEUH). Induction in now combined to include both junior and senior tiers of doctors. Induction is supported by the department and has various members of the medical team presenting to the trainees on induction day. It is noted that the Chief Resident is working with the management team to make induction more robust through utilisation of the Right Decisions pathway (RDS). This pathway with ensure a secure and easy access to the induction materials and guidance. The trainers also reported that they provide a separate induction to international medical graduates (IMG's) to ensure the best way forward for the trainees. It is also highlighted that the department use an induction checklist and as far as possible the rota is amended to allow trainees to attend induction, however there can be issues when doctors are on nights.

FY/CT Trainees: The trainees in attendance did not receive an induction to site. All trainees received an induction to the department. The induction was in relation to the structure of the department and the roles and responsibilities associated with their job. Multiple team members gave presentations throughout the day and they highlighted their roles within the department. The trainees were introduced to the staff member and salient points of their roles were given in order for them to begin in post. An induction booklet was distributed and was helpful to look back on following the formal induction. It was noted that a tour of the hospital would have been helpful to familiarise themselves with other areas of the hospital.

ST Trainees: A few trainees reported receiving a hospital induction, but it was limited to a presentation about TrakCare. It was noted the previous hospital induction was more in-depth and a full day that reviewed hospital guidelines and policies. Those trainees who were beginning in post out with standard change over times were not offered a follow up induction to site. Most trainees reported

receiving a departmental induction and felt it prepared them for working in the department. It was highlighted that there was no induction to QEUH or RCH and it was felt that this would be beneficial as it is seen as a major part of their roles. Trainees highlighted due to no induction at these sites, badges were having to be shared to gain access to the site.

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

Trainers: The trainers reported that Plastic Surgery teaching is a standardised nationally accessed programme and held online. Trainees are supported through the study leave policy to attend. The British Association of Plastic, Reconstructive and Aesthetic Surgeons (BAPRAS) held teaching is a half day and the trainees are able to attend local teaching for the remainder of the day. It was stated that there is a request by trainees to return to regional teaching and this is being looked at by the Training Programme Director (TPD). The trainers noted in reference to local departmental teaching, that the trainees are assigned an educational supervisor (ES) and there is multi-consultant reviews (MCR) with around ten consultant meetings per year to review the trainees in a non-biased format to support them through training. Foundation and Core competencies are met through their teaching. Trainees are allowed leave to watch a recorded session.

FY/CT Trainees: The trainees report that there is no dedicated time for teaching for the junior tier. There is registrar teaching that trainees can attend, but ward work doesn't allow for time to attend. The trainees are aware that the registrars are keen to develop a teaching timetable for juniors, however it has not been formalised to date. The FY trainees have their core teaching on a Friday, but they are not always able to attend due to the ward cover. The CT trainees do not have allocated time to attend their regional teaching, therefore most have not attended a sizeable portion of it.

ST Trainees: The trainees report that there is no structured local teaching, that in theory it should happen every other week, but it is variable when it does go ahead. When the local teaching does happen, the trainees are not always able to attend, due to clinical commitments. The trainees note that teaching could be improved by being held more regularly, currently it is paired with the national teaching, but this is reliant on the availability of the consultants. The trainees emphasise that if it remains combined with national teaching, it is not sustainable. Trainees note that they are unable to attend teaching when doing their 4-month rotation at the RCH, unless there is clinical fellow in place, due to covering trauma, clinics and referrals. There trainees report that there is a variable attendance

rate at national teaching, some have attended a substantial proportion of it, some have attended less due to clinical duties.

2.3 Study Leave (R3.12)

Trainers: The trainers reported that it is not difficult to support study leave, but sometimes it has to be granted retrospectively due to disorganisation of trainees. All mandatory courses are approved as long as they are submitted with the policy timescales.

FY/CT Trainees: The trainees reported that study leave was able to be applied for and granted to those to whom have needed. Others noted that they have received a day in lieu when they were unable to attend that for which they applied.

ST Trainees: The trainees note that there is a study leave process in place, however sometimes the trainees have to justify the reason for taking it, and the rota is a priority when trying to get study leave approved.

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

Trainers: Trainers report that all trainees have an allocated ES and no concerns have been highlighted to them. It is noted that most of the consultant staff are trainers, which is above the minimum guidance from BAPRAS. The trainers highlight that SPA time for these roles can be challenging.

All Trainees: All trainees reported that they have an allocated ES and have received appropriate supervision and meetings with their trainers.

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 report that it is a consultant led service, with the most crucial time spent in trauma and out of hours (OOH). The rota is manufactured well ahead of time and there are measures in place to ensure that there is always consultants present with trainees. The trainers highlight that it is stressed at induction that all new referrals are discussed with a registrar and it is stated that there

are two consultants on call who are happy to take calls if required. There is a hospital consultant on call 24/7, they are on call for RCH and GRI, they will conduct wards rounds every day and be available for trauma. They can always be in immediate contact with registrars; however, registrars are given chance to progress but consultants will always be there. OOH numbers are available to trainees, escalation policies are in place, registrars are always on rota and on site with a consultant. There is always a dedicated on-call for GRI and RCH.

FY/CT Trainees: The trainees reported that they are always aware of who is providing clinical supervision both during the day and OOH. The trainees do not have any concerns with working beyond their competence. All registrars are approachable, contactable and supportive when required.

ST Trainees: The trainees report that there were concerns raised about the consultant presence at RCH, which was highlighted by nursing staff and other specialties. This was escalated to the TPD and since been addressed. Most trainee report that there is support available both during the day and OOH.

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

Trainers: The trainers report that they feel that adequate experience is easily achievable in the department as all plastic surgery trainees must rotate though the unit in order to meet certification standards, but it is recognised that the COVID-19 pandemic definitely impacted some trainees.

FY/CT Trainees: The CT trainees report that they have had good exposure to theatre and happy with the progress since beginning in post. The FY trainees state that most of their competencies can be achieved through the ward work and they have not struggled in achieving these so far. The FY's note they are frustrated about the limited exposure to theatre experience. The CT trainees highlight that they are given more personal development (PD) days to get more theatre and clinic experiences. All trainees report that they do a high percentage of duties (80-90%) that are for service provision.

ST Trainees: Most trainees report that the nature of the job in post covid times has changed and there is less opportunity across the board, but Glasgow is better to achieve the case numbers in comparison to other regions. The trainees state that elective hand surgery and Dupuytren cases are difficult to come by. Trainees highlight that there is plenty of educational opportunities, but a lot of time is spent doing service provision, especially at RCH. The trainee noted that they believe this is

the time spent in certain areas for comparison, it was assessed over 100 sessions over a 3-month period excluding school holidays/consultant meetings and excluding trauma and LTFT.

- 2016: Consultant list 43%, OPLA 14%, Admin 15%, Teaching 4%, Clinic 23%
- 2024: Consultant list 52%, OPLA 23%, Admin 3%, Teaching 2%, Clinic 20%

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

Trainers: The trainers report that they are all involved in the Plastic Surgery curriculum and are aware of any changes. The core trainees have found it a lot easier following covid to get logbook numbers required for minor procedures and workplace-based assessments (WPBA). The rota is issued 6 weeks in advance and the rota is matched with the trainees indicated needs and curriculum requirements. The senior tier of trainees will present their logbook numbers at Annual Review of Competency Progression (ARCP) and this would help guide their following years requirements. It is noted that there are challenges with the junior rota with trying to give adequate exposure to theatre and clinics, as this might reduce the number of theatre sessions available to the core trainees. The trainers report that the new general manager in post is looking to recruit advanced nurse practitioners (ANP's) to manage ward tasks, which would free up trainees to attend more clinics and theatre sessions. All trainees have allocated ES and no concerns have been raised about gaining WPBA's.

FY/CT: The CT trainees report that they have not been in post long enough to comment on the ability to get WPBA's. The FY's note they have been able to complete assessments, but due to the nature of the ward work, the trainees mainly work with registrars and this can make getting a consultant TAB difficult.

ST: The trainees have no concerns in getting assessments completed.

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

Trainers: Trainers reported that are various multidisciplinary team (MDT's) meetings held that plastic surgery are involved in and trainees are able to attend. There is also a specific burns MDT that is held weekly on a Wednesday for doctors and the wider team to attend. The department actively support the AHP programme in conjunction with the University. The training programme itself is a multi-specialty experience, as there is a lot of cross specialty relations and education.

FY/CT: The trainees report that the work closely alongside the nursing staff and can attend MDT's, but they have not attended many of them.

ST Trainees: Not formally asked, but no concerns raised.

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

Trainers: Trainers reported that there is a representative that has a database of national guidelines and national collaborations. Trainees are able to choose and audit or stand-alone project depending on their interest and requirements. There is a formal process in place that approves the projects and the assessment of it. Trainees have the opportunity to present their work, and those who have moved post can still return and present online, in order for them to complete their project.

FY/CT Trainees: The CT trainees report that there are mandatory projects that trainees are expected to do and they are encouraged to get involved in audits. The FY trainees have had less involvement but have been asked by registrars to be involved.

ST Trainees: The trainees report that there is availability to do the QI project but there is not a culture in the department to present or take on a project. It is also stated that there is limited admin time to take it on.

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: The trainers noted that all trainees are assigned CS dependent on what rotation is required. Day to day feedback is given and WPBA's are completed. The AES can complete MCR's to get specific feedback, this allows for a transparent way to formally give and get feedback for a resident. The discussions are feedback by the AES and juniors are also included in this process. Nurses and other members of the wider team will formally email any concerns about a resident doctor and this would trigger a process for the AES (PDP etc).

FY/CT Trainees: The core trainees report that they receive feedback during their meetings with their AES, but there is limited feedback day to day as they don't get much feedback on the ward. They

highlight that they do receive feedback from the registrar when on-call. The FY's note that they receive some informal feedback but they are not making clinical decisions on the ward to gain feedback.

ST Trainees: The trainees report that when they ask for feedback, it is given. Generally, feedback is good, but when the trainees are doing lots of service provision (OPLA operating) there is no supervision or feedback opportunities.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: The trainers report that there is a chief resident that feeds back into the consultant system. Previous chief resident conducted a survey that allowed the site to see flags before they are flagged in deanery surveys. The chief resident meets regularly with the trainees and will highlight any concerns to the management team.

FY/CT Trainees: The trainees report that there are no formal mechanisms for feedback, but the chief resident has expressed that he is available to be contacted should any concerns arise. The chief resident will take on any concerns and feed them back to management.

ST Trainees: The trainees report that they give any concerns to the chief resident, who attends the management meetings and they are happy for any issues to be tabled at these. The trainees have limited knowledge about MCR and the feedback mechanisms from this.

2.12 Culture & undermining (R3.3)

Trainers: The trainers highlight that they have a multicultural, multi-faith and diverse consultant group, and to date there have not been any concerns raised to the team. A culture survey was undertaken last year and it highlighted potential areas of concerns. In response to this, the department initiated Active Bystander training, appointed a Civility Champion as well as developing a wellbeing booklet. The clinical director is also not an ES, to ensure trainee can go directly to them with any concerns.

FY/CT Trainees: The trainees noted that the registrars are very approachable, but the CT's highlight that they have limited interactions with the consultants. No issues were raised regarding undermining or bullying behaviours. All trainees would feel comfortable to approach their ES if they had any concerns.

ST Trainees: The trainees report that it can be mixed how supportive consultants are, as some are less supportive than others. It was noted that trainees have witnessed behaviours by a small number of consultants that are bullying and undermining. The trainees note that there can be a lot of hostility towards trainees in theatre and at times a feeling of not being respected for the work they do. The trainees state that the cultural and pastoral side of the department requires to be addressed in a formal way. The trainees are aware of the work done by the previous chief resident and the civility champion.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: The trainers highlighted the rota in the presentation and noted that they have fully collaborated with the trainees regarding the rota design. The current rota was introduced in 2024 with oversight from the relevant people in NHS GGC. The trainers state that the trainees felt the new rota would benefit their training needs. However, from the survey data, they have reassessed this and will move back to shift-based rota's from August 2025. This will be done in a collaborative and co-ordinated approach as it is more sustainable and aligns with the trend in NHS GGC surgical specialities. The trainers note that there is a major issue with the number of trainees that are less than full-time (LTFT) with no back-fill from the Deanery. The trainers also highlighted that there is a lack of notice from the Deanery about rota gaps, particularly with FY and CT trainees.

FY/CT Trainee: The trainees reported that they have 11 trainees on the rota, with no current gaps, but there are trainees who are LTFT. The FY trainees state that the rota allows for trainees to complete their curriculum requirements for the post. The ward-based work allows for full coverage and the OOH trauma shifts help with completing a mini-cex. The CT note that the allocations for the rota's are done on a 3-week basis. This is where they will be assigned to theatre and PD days. The trainees are unsure if they will be able to complete their logbook numbers due to being unaware of where they will be allocated. The trainees are not involved in the design of their rota's, but they do have the choice to express an interest for their PD days. It is emphasised that if a trainee is on a PD

day and have to cover sick leave, they are not given their PD day back. The trainees state that annual leave is only taken during the PD allocated days. Annual leave that is taken out with PD days have to be swapped. Annual leave is not fixed but can only be taken when not on ward shifts. The rota is not flexible and trainees have had issues with swapping PD days to attend a funeral. Teaching days are also taken out of the trainees allocated PD days.

ST Trainees: The trainees report that there are no current gaps on the rota. It is adequately staffed, although the gap created by LTFT is not filled. The rota accommodates learning opportunities with regular learning and procedures. Trainees feel they would like to attend more clinics, but the rota allows for a lot of theatre time and this achieves requirements. The trainees are perplexed as to why the rota design was flagged in the national training survey. The trainees are satisfied with the current 24-hour rota and did not wish to change from this, but have a feeling there is pressure from management to convert them back to nightshifts.

2.14 Handover (R1.14)

Trainers: The trainers reported that handover is a consultant led service, and it is part of the rota for both junior and senior trainees. There are trauma rounds where a consultant is present. Continuity of care is consultant delivered within the plastic surgery service. There is always consultant presence on both GRI and RCH to ensure that continuity of care is delivered. The trainers highlight that the nature of the work is heterogeneous and will only be an educational opportunity dependent on the case being handed over, but it is always a communicational learning opportunity. It is stated that the best educational experience is from the trauma round with a consultant.

FY/CT Trainees: The trainees report that there is a morning and evening handover, and those who attend are appropriate for the time. The ward registrar takes the morning handover. There is not an agreed structure, but there is a handover document that the trainees complete. The trainees believe that handover provides safe continuity of care to the patients, but there are a few different handovers (junior handover/ senior handover) that there can be the potential to miss important things. All trainees do not perceive handover as a learning opportunity.

ST Trainees: The trainee report that there are various handovers that take place between the junior and senior trainees, trauma and RCH. Some handovers are face to face and others are via a

telephone. There is no agreed structure to handover but there are written handovers that are updated throughout the day. All trainees do not perceive handover as a learning opportunity.

2.15 Educational Resources (R1.19)

Trainers: Not formally asked, however no concerns were raised in data and pre-visit questionnaire.

All trainees: Not formally asked, but no concerns raised and trainees are happy with the facilities provided.

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

Trainers: Not formally asked, but the presentation given by Mr Gilmour detailed various areas where support is offered to trainees.

All Trainees: Not formally asked, but no concerns raised in the survey data or pre-visit questionnaire.

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

Trainers: Not formally asked, however no concerns were raised in data and pre-visit questionnaire.

All trainees: Not formally asked, but no concerns raised.

2.18 Raising concerns (R1.1, 2.7)

Trainers: The environment is a consultant led service and GGC have a policy for escalation. There are process to ensure patient safety at all times. There are clinical governance meetings, as well as audits and morbidity and mortality meetings (M&M's).

FY/CT Trainees: The trainees report that they can escalate their concerns appropriately through the correct channels and they are aware of who to go to. The trainees have not had any reason to raise concerns.

ST Trainees: Trainees are aware of how and who to raise concerns to and feel that they would be addressed.

2.19 Patient safety (R1.2)

Trainers: Not formally asked.

FY/CT Trainees: The trainees report that they have no concerns about the quality or safety of plastic surgery patients. The patients are seen on a regular basis by a consultant when required. The ward rounds are ran by the registrars. There are many boarders on the ward and the trainees are to support the patient without a medical handover. It can be unclear what is required for the patient. There is sometimes no communication with the surgical teams who are looking after them with limited information and handover from the teams. The trainees feel like they cannot answer all the questions as they have not received an appropriate handover. There is limited information as to who looks after boarded patients and who completes the tasks for these patients.

ST Trainees: The trainees report that there is no concern for the care of the plastic surgery patients, however they are concerned about the care of boarded patients.

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

Trainers: Not formally asked, but incidents are reported via DATIX and there are M&M's held regularly.

FY/CT Trainees: The trainees report that they would use DATIX to report any adverse incidents. No trainees were involved in an adverse event to comment about the support they would receive.

ST Trainees: Some trainees report that when involved in an adverse incident they were not fully supported through the process. Other trainees have no concerns relating to this.

2.21 Other

- The FY trainees note that although they are happy to contact a registrar for referrals as per the guidance, it is not always easy to contact them, especially if they are in theatre. It would be more helpful for a registrar to be in clinic to attend to the referrals.

3. Summary

Is a revisit required?	**Yes**	**No**	**Dependent on outcome of action plan review**

Positive aspects of the visit:

- The panel recognise the work that has gone into training and that the formal educational and clinical supervision processes are good and well received.
- Departmental induction and its associated booklet were noted as good. It would be beneficial to ensure that those who are non-standard starts have an induction to the department. The panel liked the idea of the induction material being held on the RDS platform going forwards. The panel also were impressed with the extra induction process for international graduates.
- It was noted that there is good access to audit and quality improvement projects.
- The senior trainees praised the surgical experience available.
- The panel were impressed with the group of enthusiastic, collaborative trainee focussed group of trainers.

Less positive aspects of the visit:

- Exposure to hospital induction was variable and the majority of junior and senior trainees did not attend a site induction.
- The panel heard that departmental teaching was very limited with some sessions not running and trainees not having the ability to attend when it did. The junior trainees were not aware of any teaching available to them.
- The panel were concerned about the access to mandatory regional or national teaching. The majority of junior trainees are unable to attend their teaching sessions as they are not built into their rota. Although trainees are offered time in lieu to catch up online, this would cut into their personal development days. The senior trainees found issues being

free to attend. It is felt that forward planning with FPD's and TPD's will create more freedom for the juniors to attend regular teaching.

- The panel felt that more regular M&M meetings would be beneficial as the trainees see the educational value of them.
- It was found that the junior trainees have a very ward based rota with a significant amount of non-educational tasks associated with that. The suggestion of ANPs may help with that. It was highlighted that trainees have a number of personal development days but these days are also used for study leave, teaching and leave so the actual exposure they get to theatre and clinics is less than they would wish.
- The senior trainees rota has improved since last year with their consultant theatres list exposure improving and what they consider service based OPLA and skin cancer lists reducing but they have expressed some concerns about the fragmented nature of their rota and how busy other units, particularly the children's hospital can be.
- The panel noted that the senior trainees still have some concern about planned rota changes and the panel believe there is more work and collaboration to be done on this .
- Clinical supervision on a day-to-day basis is generally good and supportive. However, the trainees did highlighted a couple of issues. The junior tier take the emergency calls and have been instructed to contact the senior tier about each call. The practicalities of that can be tricky and would benefit being reviewed. At a senior level there are inconsistencies about consultant cover particularly at the children's hospital.
- The panel heard that overall handover was generally suitable and safe, however there did not seem to be any agreed protocol for the senior tier handover.
- The panel heard concerns from all trainees about the care provided to patients boarding in the unit. Formal management plans and escalation processes for these patients can be obscure and leave the juniors feeling vulnerable and isolated.
- The panel were aware of the work done to address any culture and civility concerns in the department. However, the panel were made aware of a few incidents and these will be discussed separately with the DME.

4. Areas of Good Practice

Ref	Item	Action
4.1	Departmental induction and the proposed plans to host on the RDS platform are excellent	
4.2	The department have a group of enthusiastic, collaborative trainee focussed group of trainers.	
4.3	Good access to Quality Improvement projects and audits.	

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		

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	A process must be put in place to ensure that trainees receive hospital induction to all sites they cover	26th November 2025	All
6.2	Establish departmental teaching for all grades of trainee.	26th November 2025	All
6.3	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.	26th November 2025	All
6.4	All trainee cohorts should be made aware of M&M meetings	26th November	All

	and when they happen, increasing the frequency of the meeting could be of benefit.	2025	
6.5	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.	26th November 2025	All
6.6	The Rota pattern must be reviewed with the trainees who are on the rota to identify ways to address their concerns in relation to moving from the 24-hour shift.	26th November 2025	ST
6.7	The department should ensure that there are clear systems in place to provide supervision, support and feedback to trainees when managing referrals.	26th November 2025	FY/CT
6.8	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.	26th November 2025	All
6.9	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.	26th November 2025	All