Scotland Deanery
Quality Management Visit Report

Date of visit	22nd May 2019	Level(s)	FY, GPST, Core & ST
Type of visit	Revisit	Hospital	Raigmore Hospital, Inverness
Specialty(s)	General Internal Medicine	Board	NHS Highland

Visit panel	
Dr Nick Dunn	Visit Lead, Associate Postgraduate Dean for Quality (General Practice)
Professor Adam Hill	Postgraduate Dean for the South East Region & co-lead for Quality
Dr Cieran McKiernan	Associate Postgraduate Dean for Emergency Medicine, Anaesthetics & Intensive Care Medicine, West Region
Dr Alison Garvie	General Practice Training Programme Director, West Region
Mr. Albert Donald	Lay Representative
Miss Kelly More	Quality Improvement Manager
In attendance	
Ms Lorna McDermott	Quality Improvement Administrator

Specialty Group Information		
Specialty Group	Medicine	
Lead Dean/Director	Professor Alastair McLellan	
Quality Lead	Dr Alan McKenzie, Dr Stephen Glen & Dr Reem Al-Soufi	
Quality Improvement Manager(s)	Alex McCulloch and Heather Stronach	
Unit/Site Information		
Non-medical staff in attendance	11 nursing staff including the lead nurse practitioner	
Trainers in attendance	9 including the associate medical directors of education and the training programme director	
Trainees in attendance	9 FY1s, 1 FY2, 3 GPSTs, 3 CT1s, 2 CT2s 2 ST3s & 1 ST4	
Feedback session: Managers in attendance	NHS Highland education quality manager, Raigmore head of acute services, the rota coordinator, service manager for haematology/oncology, deputy director of medical education, associate medical director NHS Highland and 2 of the nurse managers	

Date report approved by Lead Visitor	24/05/19

1. Principal issues arising from pre-visit review

Raigmore Hospital, Inverness was last visited in March 2017. A number of requirements were identified at that visit:

- Rotas must be issued in a timely manner
- ST3+ trainees must have greater regular and planned dedicated clinic time and distribution of tasks must be such that it is clear that ward tasks continue to be managed while they are at clinic, rather than being left for completion after clinic
- All CMT & GPST trainees regular and planned dedicated clinic time must be protected.
- Middle grade trainees must not be asked to make decant decisions at night.
- There must be regular predictable consultant review and feedback in respect of decisions taken by trainees for patients in Oncology and Gastroenterology.
- All trainees must receive Datix training as part of their induction.
- Department induction must be provided to all trainees including those that cannot attend the main hospital induction, departmental induction or ward induction.
- Induction must include information on how HDU works.

According to action plan submitted in November 2017 the majority of these requirements have all been met. Work was ongoing around an online induction and GP & CMT attendance at clinics.

Although results have improved for foundation and core medical trainees there are a number of red flags at GP level therefore it was decided at the general practice QRP that a revisit would take place.

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 includes numeric reference to specific requirements listed within the standards.

2.1 Induction (R1.13)

Trainers: Trainees are given a booklet outlining their different roles and responsibilities. They also get a tour of the hospital, given emergency contacts both in and out of hours. Trainees undertaking the senior role are given a more detailed induction about the on call role as they have more responsibility. If a trainee cannot attend an induction at the standard time they are given an ad-hoc induction. An administrator has been tasked with the role of co-ordinating this task.

Foundation Trainees: They all had a hospital and general departmental induction although the information provided by the stroke ward was more informal. The shadowing process worked well.

GP Trainees: They attended both hospital and departmental inductions. They felt that there was good information for all wards although a bit more information about working out of hours would have been useful.

Core Trainees: All the trainees had been in Raigmore before so did not require further inductions.

Specialty Trainees: They all had an induction where they received all the documentation they required including induction booklets.

Non-medical staff: Acute medicine nursing staff have input into induction and tell trainees how to access support and provide them with points of contact. Staff from different specialties have input into the induction booklets given to trainees when they start in the wards.

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

Trainers: All trainees have access to the grand round on a Friday lunchtime and to the middle grade teaching which takes place on a Wednesday lunchtime. Foundation year 1 trainees have 1 hour of teaching on a Thursday lunchtime, foundation year 2 and general practice trainees have a whole day of teaching every month and those in the acute common care stem programme have 6 days of teaching per year. Core medical trainees have 1.5 hours of teaching every fortnight, they link into Aberdeen via video conference for this. The regional whole day teaching is bleep free.

Trainees also have access to exam based teaching, outpatient clinical skills training and practical skills teaching as well as a monthly audit afternoon. Foundation trainees going to work in rural hospitals can attend a 3 day rural bootcamp.

Foundation Trainees: The FY1 programme teaching is every Thursday lunchtime for 1 hour. It is led by a senior trainee or consultant. They are also invited to attend the middle grade teaching and the grand round although these can be harder to attend depending on where they are working. The FY2 teaching is a whole day once a month. Generally, the teaching is of good quality and they can all attend at least 70% of sessions.

GP Trainees: They are invited to the middle grade teaching and the grand round. They have their GP specific teaching once a month for a whole day. They can generally attend around 70% of this teaching and the only barrier to attendance is the shift pattern in acute receiving.

Core Trainees: Core medical trainees have 1.5 hours of teaching every fortnight, they link into Aberdeen via video conference for this. The teaching is mapped to the curriculum and is bleep free but as it is via VC they do feel a bit ignored sometimes. They also have access to the middle grade teaching and the grand round. They can generally attend around 70% of this teaching and the only barrier to attendance is the shift pattern in acute receiving.

Specialty Trainees: They have access to the grand round on a Friday lunchtime and to the middle grade teaching which takes place on a Wednesday lunchtime. Some of them link into Aberdeen once a month for their specialty teaching. There are also evening updates from the Royal College. They have no major issues with attending teaching and have no suggestions for improvement.

Non-medical staff: Teaching times are a standing item on the daily safety briefings so nursing staff are aware of the trainees that will be away at teaching. Advanced nurse practitioners (ANPs) help cover wards & take bleeps where possible.

2.3 Study Leave (R3.12)

Trainers: Provided that a minimum of 6 weeks' notice is provided then there are no issues in approving study leave.

Foundation Trainees: There are no issues with accessing study leave.

GP Trainees: There are no issues with accessing study leave.

Core Trainees: There are no issues with accessing study leave.

Specialty Trainees: There are no issues with accessing study leave.

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

Trainers: General practice trainees keep their educational supervisors in their practice. The other trainees are allocated educational supervisors based on the experience of the team, many of whom have been supervisors for some time. There are also some newer consultants who chose to undertake the roles. They have all undertaken the relevant training.

The clinical supervisors are allocated depending on what ward the trainee will be working in. Information about trainees is discussed at the meetings set up for the various trainee levels. Trainee representatives are at these meetings but they are asked to leave when these discussions take place.

Foundation Trainees: They have all met with their supervisor twice per block.

GP Trainees: They have been given the necessary time off to go back to their base practice to meet their educational supervisor.

Core Trainees: They have all met their educational supervisors. Those supervised by Dr Bal said that she is great.

Specialty Trainees: Formally they have met them twice or 3 times. Informally they see them regularly as they work with them.

Non-medical staff: Trainees can access senior support when they need it although when working in oncology the consultants are often in clinic and there are no middle grades assigned to the ward.

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

Trainers: Staff are aware of the different curricula through communication with each other, links with Aberdeen and feedback from the training programme director (TPD). NHS Education for Scotland has issued a guide for those training GP trainees in their hospital placements. This has been shared with all clinical supervisors and there was a training day on this guide in February 2019.

Core, GP & specialty trainees have dedicated clinic time in their rotas. Due to gaps the shifts sometimes have to be covered by locums. In the longer term the plan to is have a tiered workforce, with band 4 nursing assistants, nurse practitioners, advanced nurse practitioners and physician's assistants. They will all be contributing to freeing up medical staff time.

Foundation Trainees: There are no issues with achieving their competencies although local anaesthetics can be harder to achieve as they do not have a placement in an emergency department. As it is a small department the staff get to know the trainees well and what they can do. They learn on the job and from the senior trainees.

GP Trainees: When working in oncology they learn about end of life care which is helpful. The community geriatrics post received glowing praise. They are able to attend clinics when working in acute medicine because they have at least 4 days set aside on the rota purely for clinic attendance. All posts are useful for learning communication skills. They attended a meeting a couple of months ago to discuss how training for GPs can be improved and felt this had been an excellent & worthwhile meeting.

Core Trainees: The post meets their training needs. They are able to attend sufficient numbers of clinics when working in CT2 and there is an expectation that they do so although this does depend on their workload.

Specialty Trainees: They have no issues in gaining their required competencies. They have to be more proactive about getting experience in more invasive procedures such as insertion of lines or chest drains. They have time to attend clinics and feel that staff are trying to minimise the time they spend on non-educational tasks.

Non-medical staff: ANPs are involved in clinical skills teaching for trainees.

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

Trainers: There are no issues with trainees getting their assessments signed off. In terms of benchmarking, GP educational supervisors had fed back that the assessments of GP trainees were not up to scratch so this was discussed with the assistant GP director at the training day in February which has been helpful.

Foundation Trainees: Senior staff are aware that their rotations are short so reply quickly to any assessment requests. The assessments are fair and consistent.

GP Trainees: It is very easy to get these done when working in geriatrics and respiratory although trickier in acute medicine due to the workload and in oncology as the consultants are not on the wards often. The assessments are fair and consistent.

Core Trainees: They have no issues in getting assessments completed. The assessments are fair and consistent.

Specialty Trainees: They have no issues in getting assessments completed. These are fair and consistent.

Non-medical staff: Staff complete multi-source feedback assessments as well as clinical skills assessments.

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

Trainers: Trainees get the opportunity to work with social workers, physios, pharmacy team, palliative care and radiology so there are lots of opportunities to learn from other staff.

Foundation Trainees: They can attend multi-disciplinary team meetings on the different wards they are working in. When working on the acute ward they are also invited to attend post event reviews.

GP Trainees: They work regularly with other disciplines.

Core Trainees: They work with other disciplines in every job and when working in medicine for the elderly they lead the multi-disciplinary team meeting.

Specialty Trainees: They can attend multi-disciplinary team meetings on the different wards they are working in such as geriatrics.

Non-medical staff: The renal ward has multi-disciplinary teaching as does ward 7A.

2.8. Adequate Experience (Quality improvement) (R1.22)

Trainers: Trainees are well supported to undertake project and audit work. They can present their work both locally and nationally.

Foundation Trainees: Trainees can take part in projects and attend audit days. One example of a project currently being undertaken is sodium measurement.

GP Trainees: They are working on projects or audits.

Core Trainees: They are working on projects or audits. There is an audit afternoon where a trainee or consultant presents an audit but this could be better advertised.

Specialty Trainees: They are encouraged to be involved in projects and also to work with more junior trainees on projects.

2.9. Clinical supervision (day to day) (R1.7, 1.8, 1.9, 1.10, 1.11, 1.12, 2.14, 4.1, 4.6)

Trainers: They do not feel that all staff can easily differentiate between the different levels of trainee. They are looking at how this can be improved. Levels of support and who trainees can contact is covered at induction. Trainees are encouraged to ask for help anytime they need it.

Foundation Trainees: They always know who to contact if they need support and there is always someone to help.

GP Trainees: They all know how to access support and who is providing that support. None of them have had to cope with anything beyond their level of experience. They felt that this is one of the most approachable departments they have worked in, if they call a consultant at home they will come in if needed.

Core Trainees: They all know how to access support and who is providing that support. None of them have had to cope with anything beyond their level of experience.

Specialty Trainees: They always know who to contact for support and will call a consultant at home if they need to. They haven't had to cope with anything beyond their experience and all the consultants are supportive.

Non-medical staff: Staff introduce themselves at the safety huddle but it can still be difficult to identify each grade of trainee particularly out of hours when there are a number of different grades on shift from across the specialties. As for infection control reasons the staff do not wear lanyards, a suggestion was different coloured uniforms as the nursing staff wear.

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

Trainers: On the acute medical receiving ward there is a positive postbox where any member of the team can provide feedback. This can then be used as evidence in the trainee's portfolio.

Foundation Trainees: They get feedback, it tends to be more informal and ad-hoc but if you ask for it, it will always be given.

GP Trainees: The provision of feedback depends on the consultant. Feedback is constructive when it is provided.

Core Trainees: Feedback can be given formally via an assessment or informally at the end of a shift.

Specialty Trainees: They get formal feedback via their assessments. Informally they will chat about patients and their plans on the ward.

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

Trainers: They speak to trainees informally throughout the year. There are also formal feedback sessions towards the end of the training year. An example of a change made following trainee feedback is that the GP trainees now have a clinical supervisor in each department they rotate through

Foundation Trainees: Trainees have been asked to provide feedback and they feel that staff are open and receptive to feedback.

GP Trainees: They recently attended a GP specific workshop where they provided feedback on all their placements in Raigmore Hospital, this was useful & they felt listened to.

Core Trainees: The consultants would be receptive to feedback if they gave it and some ask for it.

Specialty Trainees: They have been asked for feedback, when it is given it is well received and is acted upon.

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

Trainers: The number of senior trainees is limited. Hopefully in the future the numbers will increase and discussions around this are ongoing.

Foundation Trainees: The trainees spend 2 months on a medical ward where they work Monday-Friday and 2 months in acute receiving where they work night shifts and take their annual leave. Generally, things work well but there is a lack of middle grade cover on the senior rota.

GP Trainees: When working on the evening shift there is a lack of consistency about who will actually be on shift, sometimes it is 5 people and sometimes 2 people. Once you know who is working you then distribute the workload.

Core Trainees: The CMT2s working on call are given lots of support when working out of hours as they sometimes act up on to the senior rota. The way that the rota is structured means that they do not get a standard Monday to Sunday week of leave and have to take a Wednesday to Wednesday for example. They would prefer to have a standard week off for a better work life balance.

Specialty Trainees: They do feel that they work quite a lot of night shifts but recognise that there is learning from this type of work. The suggestion for improvement would be that there is more standardisation in who is working the evening shift from 1730-2100 as they never know how many people will turn up for the shift.

Non-medical staff: Staff on certain wards can be very busy so at times this has led to trainees feeling stressed. If this happens the nurses try to support them and suggest that they speak to someone about it such as their clinical or educational supervisor.

2.13. Handover (R1.14)

Trainers: The handovers between shifts works well and are well structured. These are led by a nurse practitioner. The handover from the acute to specialty wards could be improved.

Foundation Trainees: The hospital wide handover is written and works quite well. The handover at 1700 from the day to the evening shift can be slightly confusing as you never know how many people are due to be on shift.

GP Trainees: The departmental wide handovers are effective – they are structured and a written note is kept. When working in acute receiving a consultant will be present at the handover.

Core Trainees: see GP trainee section.

Specialty Trainees: Handover generally works well. There is a written record. It could be used as more of a learning opportunity.

Non-medical staff: Some wards have twice daily safety briefings. Hospital wide handovers take place, 3 times a day at 0900, 1700 & 2100. Due to time pressures there are not often learning opportunities at these handover meetings.

2.14. Educational Resources (R1.19)

Trainers: Trainees have access to the education room in the hospital and the clinical skills centre in the centre for health science.

Foundation Trainees: The IT system is quite slow especially the discharge system which also often crashes. They are aware of the library but do not often use it as the opening hours do not suit them.

GP Trainees: They have access to the online British Medical Journal and to the library.

Core Trainees: see GP trainee section.

Specialty Trainees: They would like a registrar room.

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

Trainers: If a trainee was struggling then the trainers would speak to the educational supervisor in the first instance. They are aware of the deanery performance support unit and occupational health.

Foundation Trainees: None of the trainees are less than full time or have had a career break. If they needed support they would contact their clinical or educational supervisor.

GP Trainees: Support is available for those that need it. None of them are less than full time or have had a long term career break. One trainee was off on sick leave and a return to work plan was drawn up for their return, was offered an alternative work pattern and they felt supported.

Core Trainees: see GP trainee section.

Specialty Trainees: One of the trainees was less than full time and they were supported when making these arrangements. If they needed any support they would speak to their clinical supervisor.

Non-medical staff: If a staff member had concerns about a trainee they would speak directly to the trainee or to their educational or clinical supervisor.

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

Trainers: Quality of training is managed by the director of medical education (DME). There is an educational governance committee attending by the DME, clinical directors and associate directors of medical education. They are trying to raise awareness of these structures via the lead trainee in medicine.

Foundation Trainees: There are trainee representatives on the foundation and trainee committees. Some of the trainees were aware of the DME structure.

GP Trainees: Dr Bal and Dr Scott work in the medical education department. Trainees were invited to attend the workforce medical group set up to discuss futureproofing the department. There are trainee representatives on each of the specialty group meetings. Also, there is a trainee group which feeds back to the consultants.

Core Trainees: see GP trainee section.

Specialty Trainees: The TPD is responsible and there is also a trainee representative that they can contact.

2.17 Raising concerns (R1.1, 2.7)

Foundation Trainees: They would raise any concerns with a member of the nursing team, a senior trainee or 1 of the consultants. They think that they would be dealt with. If the concern was about their training they would speak to their clinical or educational supervisor.

GP Trainees: If they had any patient safety concerns they would raise these with a consultant or nurse manager. If their concerns were about training these would be raised with their educational supervisor or one of the associate directors of medical education that work in the department.

Core Trainees: see GP trainee section.

Specialty Trainees: They would raise any patient safety concerns with any of the consultants and would be happy to do so. If their concern was about their training they would speak to their clinical or educational supervisor or the TPD.

Non-medical staff: Concerns can be raised at the daily huddles or via Datix. The route taken to report it would depend on the nature of the concern. Staff are not always confident that concerns regarding patient flow are acted upon.

2.18 Patient safety (R1.2)

Trainers: There are safety huddles each morning on some of the wards. The introduction of a post acute ward has led to a significant reduction in boarding numbers. There is a boarding standard operating procedure and the bed numbers are managed by the bed coordinator and the nurse practitioner. Although, boarding still does take place due to the hospital running nearly at capacity.

Foundation Trainees: They think the environment is safe. They do not think that boarded patients receive the same level of care as it can be hard to keep track of who is where which can lead to delays in patients being seen. There is also a lack of clarity around who is in charge of these patients.

GP Trainees: They would have no concerns if their friend or relative was treated in the department. Boarded patients can be difficult to manage but they try to do their best to hand these patients over effectively from team to team. They do think that the process could be tightened up but it has definitely improved since the introduction of the post acute ward. They know that consultants are aware of any issues around boarding and are trying to improve it.

Core Trainees: see GP trainee section.

Specialty Trainees: They think the environment is safe. Boarding is usually appropriate but not always as efficient as it could be. They do provide input into who they think is safe to be moved but due to bed pressures this is not listened to on every occasion.

Non-medical staff: Staff work hard to ensure that the environment is safe. Boarding of patients is a last resort due to lack of patient flow. This can lead to delayed discharge as these patients are often seen later in a doctor's shift.

As well as safety huddles, there are also safety audits and safety bundles covering falls and venflons.

2.19 Adverse incidents (R1.3)

Trainers: Incidents are recorded on Datix. The incidents are looked at by the quality and patient safety committee. Feedback is not always provided after a Datix is submitted. Any incidents are used as a learning opportunity.

Foundation Trainees: These are recorded on Datix or can be raised informally. These is a morbidity and mortality (M&M) meeting once a month. Also, there is a significant event reporting system, the findings of which are published on the intranet. Feedback from Datix is not always forth coming, you would have to be proactive to find out what had happened.

GP Trainees: How an adverse incident is reported depends on what the issue is, if the matter was urgent it would be raised with a consultant but if it was less pressing it would be recorded on Datix. If they submit a Datix they then receive an email outlining the outcome. There are also significant incident review team meetings and the output of these is shared.

Core Trainees: see GP trainee section.

Specialty Trainees: They are aware of Datix but haven't had to use it. They are also aware of the significant adverse event review process which is used as an educational tool and no blame is attributed.

Non-medical staff: Staff use Datix to record any adverse incidents but feedback is not always forthcoming.

2.20 Duty of candour (R1.4)

Trainers: They try to lead by example. Any incidents are discussed with the trainee.

Foundation Trainees: All of the consultants would be supportive if something went wrong.

GP Trainees: They feel that they would be supported if something went wrong both by the consultant they were working with and their educational supervisor.

Core Trainees: see GP trainee section.

Specialty Trainees: They feel that they would be supported if something went wrong, a consultant would back you up.

2.21 Culture & undermining (R3.3)

Trainers: No bullying or undermining behaviour has been highlighted in the trainee surveys. It is a standing item at the physician's meeting, a trainee representative attends this meeting. They are not aware of trainees having received comments that were undermining.

Foundation Trainees: All of the consultants are supportive and any concerns would be raised with a senior member of the team. There was an alleged report of a dignity at work issue regarding non medical staff which was later discussed with the Associate Medical Director out with the meeting.

GP Trainees: The environment across the department is very supportive. They have not experienced or witnessed any bullying or undermining behaviours. If they had they would call the helpline and/or address the issue with the person involved. They are confident that if they had an issue then it would be dealt with.

Core Trainees: see GP trainee section.

Specialty Trainees: This is a good environment to work in, it is supportive and they would raise any issues if they had one. They had not experienced or witnessed any bullying or undermining behaviours.

Non-medical staff: All staff are included so that they feel part of the team. There is a culture of an open door policy so that concerns about any bullying or undermining behaviours can be raised. There are human resource policies and a helpline to deal with any issues. The staff feel that this behaviour is less tolerated now than it may have been in the past.

2.22 Other

Foundation Trainees: In terms of overall satisfaction they scored the post between 7 & 9, with the average score being 8.

GP Trainees: In terms of overall satisfaction they scored the post between 7 &10, with the average score being 8.

Core Trainees: In terms of overall satisfaction they scored the post between 8 & 10, with the average score being 9.

Specialty Trainees: In terms of overall satisfaction they scored the post between 8 & 9, with the average score being 9.

3. Summary

Is a revisit required?	Yes	No x	Highly Likely	Highly unlikely –

This was a very positive visit with a clear amount of work been done to address issues raised on previous visits as well as ongoing issues such as workforce planning.

Positive aspects of the visit were:

- There is a clear team culture where colleagues are mutually supportive of each other.
- Trainees from all grades scored the post highly with the average score being 8 out of 10.
- The consultants are said to be engaged and approachable.
- The consultant body particularly the education leads should be commended for all their hard work in trying to address workforce issues – innovate solutions include a post-acute ward to reduce the number of boarders and a 3-tier workforce model.
- Trainees have access to a diverse range of teaching opportunities.

Less positive aspects of the visit were:

- There was no clear system of escalation policies and handover procedures in place for boarded patients.
- A mechanism should be introduced to ensure that all staff can clearly differentiate between different grades of trainees.
- The junior middle grade rota leave arrangements do not enable trainees to take a working week off (Mon-Sun)

4. Areas of Good Practice

Ref	Item	Action
4.1	Trainees from all grades scored the post highly with the average score being 8 out of 10.	n/a
4.2	The consultant body particularly the education leads should be commended for all their hard work in trying to address workforce issues – innovate solutions include a post-acute ward to reduce the number of boarders and a 3-tier workforce model.	n/a
4.3	There is a clear team culture where colleagues are mutually supportive of each other.	n/a
4.4	The consultants are said to be engaged and approachable.	n/a

5. Areas for Improvement

Ref	Item	Action
5.1	The junior middle grade rota should ideally enable trainees to take a working week off (Mon-Sun)	n/a

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	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.	9 months from date of the visit	all
6.2	A mechanism should be introduced to ensure that all staff can clearly differentiate between different grades of trainees.	9 months from date of visit	all
6.3	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 with the Associate Medical Director out with this report.	2 months from date of visit	all