Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	18th July 2019	**Level(s)**	Foundation, GP, Specialty Trainee
Type of visit	Revisit	**Hospital**	Dumfries & Galloway Royal Infirmary
Specialty(s)	Paediatrics	**Board**	Dumfries & Galloway

Specialty Group Information

Visit panel	
Peter MacDonald	Visit Chair – Associate Postgraduate Dean for Quality
Alastair Hurry	Trainee Associate
Tom Carey	Lay Representative
Hazel Stewart	Quality Improvement Manager
In attendance	
Fiona Conville	Quality Improvement Administrator

Specialty Group	Obstetrics & Gynaecology and Paediatrics
Lead Dean/Director	Alan Denison
Quality Lead(s)	Alastair Campbell & Peter MacDonald
Quality Improvement Manager(s)	Hazel Stewart

Unit/Site Information

Non-medical staff in attendance	4									
Trainers in attendance	7									
Trainees in attendance	6									
Feedback session: Managers in attendance	Chief Executive	✓	DME	✓	ADME		Medical Director		Other	✓

Date report approved by Lead Visitor	14/10/2019

1. Principal issues arising from pre-visit review:

Paediatrics was visited in July 2018 as part of the 5-year visit schedule and as part of a new site visit. During this visit it was noted that some areas of concern flagged up at a previous visit were still unresolved and ST trainees, in particular, were not gaining an adequate experience from the post with regards to access to outpatient clinics.

Following the visit last year, it was agreed that a revisit would be required. At the 2018 visit, 10 requirements were made, these related to clinic access, appropriate supervision, feedback, teaching, consultant disagreements, patient safety and possible undermining issues. On review of the pre-visit information, if appeared that the post was improving but some concerns, particularly consultant disagreements, remained. It was agreed that the focus of the visit would be around the progress made by the department in meeting the requirements made from the previous visit.

At the time of the visit, the panel were unable to meet with any specialty trainees. A follow-up session was held with the Paediatric ST trainees to ensure that the experience of all trainee cohorts was captured for this report.

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.

2.1 Induction (R1.13)

Trainers: Trainers reported there is a new induction in place. They felt this was effective for preparing trainees to undertake their work and included items such as:

- Resuscitation training (for FY2 and GP only)
- Where and how to locate guidelines, which have been updated.
- Prescribing

A personalised `induction is provided to trainees unable to attend the standard induction.

FY2/GP: Trainees reported that they received an induction. However, one trainee had not been informed that a new email account had been created for them and therefore missed a number of communications until they were made aware of their new account. Trainees felt induction covered the important learning points and that the resus training was very useful. They reported that being given more information regarding their role and involvement with the local teaching sessions would have been useful.

ST: Trainees reported that they received an induction. Although they felt this was limited it provided them with the necessary information to undertake work in the department. For the more recent trainees, this included information regarding where to find resus equipment.

Non-Medical: Staff reported that induction does enable trainees to undertake their work but felt it could be further enhanced by including advanced nurse practitioners (ANP) and advanced neonatal nurse practitioners (ANNP) in contributing to the induction.

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

Trainers: Trainers reported there is consultant led teaching on Thursdays and trainee led 'topic of the week teaching on Wednesdays. However, trainers acknowledged that poor attendance and lack of time for the Wednesday teaching had meant this often did not take place. Trainers were also aware that GP and ST trainees were often unable to attend local teaching due to being bleeped out and discussion was ongoing on how to resolve this issue. Trainers reported that study leave is prioritised for ST trainees to attend their postgraduate diploma teaching. They were not aware of regional teaching for GP trainees but reported leave would be given to enable attendance.

FY2/GP: Trainees reported there is weekly teaching but felt this had deteriorated over time. They reported that initially they were unaware that they were to be involved in preparing a topic for discussion and that often consultants were unaware of when they were due to support a teaching sessions. Trainees reported there was a lack of clarity regarding if the trainee or the consultant should lead the teaching session. Trainees reported that the weekly teaching sessions lasted for approximately 1 hour but disruptions, such as being bleeped out to attend baby checks or the assessment clinic, meant it was rare for trainees to attend the full hour of teaching. Trainees felt it would be useful to receive monthly email updates regarding who was allocated to provide each

teaching session and any potential changes e.g. swaps due to trainee and/or consultant leave. They also suggested that changing the timing of the teaching sessions and knowing what training level the different sessions were aimed at would be beneficial to maximise attendance at relevant sessions.

ST: Trainees reported there is local teaching following the Grand Round on Thursdays. They reported the weekly teaching is based on a case either a GP and ST trainees has been involved with or may be led by a consultant. Trainees reported that teaching provided was good and that they had the occasional opportunity to teaching FY2 and GP trainees and provide some ad hoc teaching during ward rounds. Trainees reported that teaching provided from one of the consultants prior to clinic was very useful, particularly for learning from complex cases. Trainees reported that they were able to attend teaching when on shift. They also reported that they can use video-conferencing to participate in regional teaching.

Non-Medical: Staff reported that clinical work is organised to be undertaken prior to teaching. They reported they are aware of when teaching sessions are taking place to minimise disruption.

2.3 Study Leave (R3.12)

Trainers and trainees reported there were no issues in approving or obtaining study leave.

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

Trainers: Trainers reported that there are specific supervisors allocated to each trainee cohort. They reported that they have weekly meetings with their ST trainees to discuss their learning objectives and any challenges they face. Trainers reported that there is time in their job plans for their educational role which is reviewed annually through their appraisal.

FY2/GP: Trainees reported they had useful meetings with their supervisors and met on a regular basis.

ST: Trainees reported they formally met with their supervisor at least 3 times during their post. They reported that an initial meeting, within the first 3 weeks in post, was very helpful in discussing their personal development plan and setting learning objectives.

Non-Medical: Staff felt there is always consultant support available to trainees when required. They reported that consultants are available and on-site to attend ward-round at the weekend and will remain on-site if there are any patient concerns.

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

Trainers: Trainers reported that being allocated a specific trainee cohort enabled them to be aware of the curriculum requirements for their trainees. Trainers reported that GP trainees have set weeks built into the rota where they can attend clinics. Trainers reported that trainees have their own clinics built in to the rota. They reported that trainees can discuss any patient with the consultant during their clinic and all patients are discussed and reviewed at the end of the clinic.

FY2/GP: Trainees reported that working in a small ward enabled them to get to know the team and improved clinical opportunities. They also felt that being provided training and supervision for undertaking baby checks improved their skills and confidence before having to undertake a check on their own. Trainees felt that reviewing GP referrals and attending clinics and the assessment unit was most useful to them. Although they found neonatal medicine interesting, trainees felt this was less relevant.

ST: Trainees reported that they found the variety of patients they get exposure to and access to outpatient clinics are very useful to their development. They reported they could attend at least 3 – 4 clinics per month and having administrative time built into the rota during clinics provided good time to undertake all tasks involved in outpatient clinic work. Trainees highlighted that discussion of patients with a consultant prior to their clinic was useful as this offers the opportunity to highlight which cases are particularly useful for their education and training. All reported that they do not undertake clinics in rural sites but are aware of what clinics are being held if they want to attend these clinics. Trainees felt that the balance between time spent developing as a doctor and other activities was better than other posts with good outpatient clinic opportunities and exposure to management opportunities.

Non-Medical: Staff reported that they are involved in providing neonatal scenario training to trainees.

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

Trainers: Trainers reported that they are sent a list of the ST assessment requirements from the deanery. They reported that they often ask GP and FY2 trainees, when at outpatient clinics, if there is a case they want to use for an assessment. They thought trainees could easily achieve their assessments, but some need to be reminded more often to submit assessment requests.

FY2/GP: Trainees felt it was difficult to complete their assessments but acknowledged that consultants complete their assessments when asked. Trainees felt that out of hours offered the easiest opportunities to undertake assessments but was not possible due to lack of consultants on site.

ST: Trainees reported that they found it very easy to get their assessments completed. They reported they were actively encouraged to complete assessments at the outpatient clinic and that their assessments were completed in a fair and consistent manner.

Non-Medical: Staff reported that they are happy to complete workplace-based assessments, such as multi-source feedback, for trainees when asked.

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

Trainers: Not asked

FY2/GP: Trainees reported there is resuscitation training on Fridays which involves the mutli-professional team.

ST: More recent trainees reported that the department has introduced neonatal simulation training.

Non-Medical: Staff reported that scenario and simulation training provide opportunities for joint learning with trainees.

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

Trainers: Trainers reported that all ST trainees are encouraged to undertake an audit whilst in post with consultant oversight.

FY2/GP: Trainees reported that they are asked if they want to participate in a quality improvement project, but they had already completed this in a previous post.

ST: Trainees reported the department are very keen on undertaking quality improvement. Those that undertook a QI project reported they were allocated time to undertake this work and supported by the department.

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: Trainers reported that the rota is split between more junior and senior trainees, which helps to identify the different levels of trainees. In addition, trainees are initially introduced with their training level, such as GP, as well as having badges to identify the different levels. Trainers were aware of a situation where a trainee had to deal with a very difficult situation. Following the event, the wider team reflected on this and the trainee reported at the time they had felt well supported. Trainers were not aware of any recent events where a trainee felt that had to cope with a situation beyond their competence.

FY2/GP: Trainees reported they always know who is supervising in the department and can contact them for support. Trainees reported that they hadn't felt they'd had to cope with a situation beyond their competence. However, at times they found situations difficult in relation to management plans. This related to trainees feeling that they have to advise locum consultants to adhere to a different management plan due to either local guidelines or the way particular consultants are known to manage different cases. Trainees reported that different consultants follow different guidelines which they found challenging as there is no explanation to enable to a trainee to better understand the reason for an alternative management plan.

ST: Trainees reported that they always know who is providing supervision and can access support when required. None of the trainees interviewed felt they'd had to cope with situation beyond their

competence. All felt their senior colleagues were accessible and approachable when support is required. ST trainees also reported that clinical guidelines are inconsistently applied with conflicting practices between consultants. At times trainees are asked to manage patients in a way that directly contradicts teaching in other placements within their programme in West of Scotland.

Non-Medical: Staff reported that there are colour coded badges to identify the different levels of trainees in the department. They felt that they could identify a trainee's level of competency quite quickly due to being a small department. Staff reported they were not aware of trainees having to cope with problems beyond their competence or experience as there is always support available.

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: Trainers reported they provide feedback to ST trainees during their weekly meetings. Feedback is also provided during handover regarding what went well and what could have been better or done differently in relation to management plans.

FY2/GP: Trainees reported that they receive feedback where improvements are required but could not recall having received positive feedback. Some trainees felt that feedback was delivered in a critical and accusatory way which at times could be upsetting.

ST: Trainees reported that feedback is provided to them during handover. There is also the opportunity for feedback when trainees contact the on-call consultant out of hours to discuss patient management plans.

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

Trainers: Trainers reported that the clinical lead has regular meetings with trainees to seek feedback on any concerns and action appropriately.

FY2/GP: Not asked

ST: Trainees reported that the clinical lead regularly asks them for feedback on their experience in the department.

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

Trainers: Trainers reported outpatient clinics are built into the rotas for ST trainees. They felt that the variety of sub-specialty clinics available to trainees and increase in patient numbers has improved the learning opportunities for trainees.

FY2/GP: Trainees reported that their out of hours shifts can be variable from being very busy to having little to no work to undertake. Trainees reported their rota does enable them to attend clinics but that those weeks also require them to take their annual leave. Trainees reported they had attended approximately 6 clinics since starting their post.

ST: Trainees reported that their workload was very manageable and there were no concerns regarding their rota in relation to patient safety. They felt their rota was well balanced. Trainees also reported that rota gaps were predominantly covered by locum doctors and they did not feel pressured to cover any additional shifts.

Non-Medical: Staff reported they were not aware of any trainee concerns regarding the rota.

2.13. Handover (R1.14)

Trainers: Trainers reported that there is an effective, structured handover in place which allows for discussion of every patient. They reported that patient cases are presented by the trainees and that handover is used as a learning opportunity. Trainers reported that some feedback is provided during handover, but if there is a learning need or significant issue regarding a patient management plan, this is fed back to the trainee separately.

FY2/GP: Trainees reported that there is a good, detailed written handover in place. They suggest it would be beneficial if the handover could start earlier as they required to attend the obstetrics & gynaecology handover as well due to FY2 and GP trainees covering both O&G and Paediatrics during out of hours. Trainees reported that if they are unable to attend the paediatric handover, a member of the team will provide an individual handover later.

ST: Trainees reported there is a structured handover in place which allows for discussion of all patients. Trainees felt it was useful to discuss patients due for discharge where they had queries, such as whether follow-up appointments are needed.

Non-Medical: Staff felt that there was effective handover in place with discussion of all of their patients in the ward.

2.14. Educational Resources (R1.19)

Trainers: Trainers reported there were no new resources since the deanery visit in 2018.

FY2/GP: Not asked.

ST: Trainees reported there are good educational facilities available to them including a library and lots of computers.

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

Trainers: Trainers reported that trainees can feedback concerns to their supervisor or clinical lead. Where there are concerns about a trainee's performance, trainers reported that they would raise this with the director of medical education who is very supportive.

Trainees: Trainees reported there is support available to them if they felt they were struggling either professionally or personally.

Non-Medical: Staff reported that if they had concerns about a trainee's performance, they would raise this with the consultant of the week and could escalate to the educational supervisor if required. Where their concern was immediate, staff reported they were comfortable to raise the concern directly to the trainee at the time.

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: Trainers reported foundation attendance at teaching is monitored through the local administrative team with feedback sought following this to quality manage the education being delivered. The clinical lead can feed any updates on the department and training through the specialty training committee but acknowledged there had been a lack of participation from the department.

FY2/GP: Trainees were unaware of the educational governance structure within the hospital

ST: Trainees reported that the clinical lead oversees their exposure to training opportunities.

2.17 Raising concerns (R1.1, 2.7)

Trainers: Trainers reported that trainees are encouraged to raise patient safety concerns through the Datix system

FY2/GP: Trainees reported that they would raise patient safety concerns with a specialty trainee or consultant. If there was a significant concern, trainees reported they would raise this through the Datix system. Where concerns relate to education or training, trainees reported they would raise this with a supervisor or the local postgraduate administrative team.

ST: Trainees reported that they would feedback any concerns to the clinical lead, or to the nursing manager if the concern related to nursing staff. Trainees reported that they were informed of the escalation policy during induction. If the concern related to education or training, trainees reported they would discuss this with their educational supervisor or clinical lead.

Non-Medical: Staff reported they can raise concerns about patient safety with the management team which can be added to the risk register to share information and discuss resolution.

2.18 Patient safety (R1.2)

Trainers: Trainers reported the environment is safe for both patients and trainees. Trainers reported they were aware that, due to use of both Greater Glasgow and Clyde and Lothian Health Board guidelines, it may be difficult for some trainees to accept a particular management plan. Trainers reported that concerns relating to guidelines can be raised with the supervisor or clinical lead. Trainers also reported that a new consultant is currently updating the guidelines to be more in line with the West of Scotland guidelines due to the fact that the referral unit for certain cases would be in Glasgow.

FY2/GP: Trainees felt that whilst a relative would be cared for in the department, they would have some reservations about their management plans. This was due to trainees reporting that some consultants follow less current guidelines.

ST: Trainees reported they would have no concerns about the quality or safety of care a relative would receive if admitted to the department.

Non-Medical: Staff felt the department provided a very safe environment for patients. They reported that, in addition to handover, there are regular safety huddles and trainees are involved in these huddles.

2.19 Adverse incidents (R1.3)

Trainers: Trainers reported that adverse incidents are reported through the Datix system. There are structured regular meetings to review cases and trainees are encouraged to attend. Trainers reported that these Clinical Incident Review Group (CIRG) meetings aid in developing in a culture of learning from what went wrong rather than a blame culture. They reported that a summary of learning points and an action plan is circulated to all staff.

FY2/GP: Trainees reported that adverse incidents are reported through the datix system. Some reported they received feedback from the clinical lead but they did not receive communications from and were not aware of the CIRG meetings.

ST: Trainees reported that adverse incidents are reported through the Datix system. They reported they were aware of the CIRG meetings and are encouraged to attend. Trainees reported that learning points are shared with them via email and individual feedback being provided if they had raised the concern.

Non-Medical: Staff reported that adverse incidents are recorded through the Datix system. The reports are now categorised for the clinic incident review group (CIRG) meetings where incidents are discussed and learning points noted. Following these meetings feedback provided to whomever submitted the report and were involved in the incident. In addition action plans and team-wide learning points are shared with the whole department via email.

2.20 Duty of candour (R1.4)

Trainers: Not asked.

FY2/GP: Trainees reported that if they were involved in an incident where something went wrong, a consultant would take the lead in discussing this. They reported that they would never be expected to address this issue on their own and would always have a discussion with a consultant before meeting a patient and/or parent.

ST: Trainees reported that if they were involved in an incident where something went wrong, they would receive support from the department.

2.21 Culture & undermining (R3.3)

Trainers: Trainers reported that following the last visit, work had been undertaken to address issues, such as consultant disagreements, which were impacting on trainees. They reported that the clinical lead has regular meetings with trainees and would follow up any concerns with the associate medical director. The clinical lead reported that no concerns had been raised with them. They reported there is a hospital wide policy to reports concerns in addition to raising with the clinical lead.

FY2/GP: Trainees reported that they have not experienced any bullying behaviours from staff. However, concerns were raised relating to interactions with certain consultants resulting in some

trainees feeling their confidence and self-esteem had been undermined. Further information regarding the concern was raised with the DME following the visit. Trainees reported they would raise concerns regarding bullying or undermining behaviours with the clinical lead or educational supervisor.

ST: Trainees reported they work in a supportive environment. A trainee did report have witnessed a very confrontational and negative interaction from a consultant to a nurse but no other concerns were raised. They reported that if needed, they would raise concerns regarding bullying or undermining behaviours with the clinical lead, educational supervisor or training programme director.

Non-Medical: Staff reported that awareness of the bullying, harassment and whistleblowing policies along with mandatory training help to reduce the risk of anyone experiencing these behaviours. Staff reported that bully and discrimination issues can be reported to human resources, who provide very good support, as well as raising concerns with their line manager. Staff were not aware of any trainees having received comments that were less than supportive but were aware of issues arising between consultants due to differences of opinion with management plans.

2.22 Other

Trainees were asked to rate their overall satisfaction in the post, ranging from 0 (worst) to 10 (best), in relation to their education and training.

FY2/GP – Range: 6 – 7, Average: 6.67
ST – Range: 6 – 7, Average: 6.67

As none of the trainees rated the post at 10, they were asked what change would make the most significant improvement to the post. The common theme from all trainees was the use of standardised guidelines and pathways being used by all staff.

All groups were also asked if they had anything they wished to raise with the panel. Both the nursing and FY/GP cohorts highlighted concerns regarding patients, such as Paediatric surgical patients, being boarded in the department. Both groups reported that there is a lack of communication to know

who is responsible for the care of the boarded patients, and who to contact if they become medically unwell to inform the relevant surgical staff.

3. Summary

Is a revisit required?	Yes	No	Highly Likely	Highly unlikely

It was evident at the visit and catch-up session with the ST trainees, that a significant amount of work has been undertaken by department to address the requirements. In particular, 1:1 management meetings and psychology meetings to ensure there is less conflict between consultants in the department, allocated clinics with time built in for discussion both pre and post clinic and the development of a teaching programme. It was however clear that there remain two dominant concerns:

- delivery of feedback and its tone (particularly during handover)
- inconsistent clinical practice with lack of adherence to guidelines.

Due to the ongoing concerns it was felt that a further revisit is required in 2020.

Positive aspects of the visit:

- Training and sign off for baby checks has improved FY2/GP trainee confidence in undertaking this task.
- Improved teaching programme.
- Good access to outpatient clinics for GP trainees & allocated clinics for ST trainees, with time built in for workplace-based assessments.

Less positive aspects of the visit:

- Lack of consistency in use of guidelines creating confusion for both patients and trainees. The resulting ambiguity of practice creates potential for patient safety issues, patient dissatisfaction and a confused learning/training environment. This was highlighted as the major issue by all groups of trainees.
- Some trainees perceive feedback as being delivered in a negative, blame-directed manner when something has not gone well. There remains a relative lack of positive feedback.

- Trainees are often bleeped out of teaching sessions which affects the flow of the session and attention of trainees.
- There is a lack of clarity and communication regarding roles and responsibilities for the teaching sessions. Also a lack of updates to any changes made as to who is providing a teaching session.

Requirements from previous visit

Issue	Progress
The department must ensure that disagreements between consultants do not negatively impact on trainee's experience or patient safety.	Partially met. Whilst the concern in relation to tension between consultants impacting on the trainee's experience had been addressed, concerns remained regarding adherence to guidelines and a lack of clarity from nurses, trainees and parents of patients due to conflicting opinions.
Those responsible for educational governance must investigate the allegations of undermining behaviours, and if upheld, put in place an appropriate action plan to address these concerns.	Not met. Concerns continue to be raised, largely in relation to the delivery of negative feedback.
A regular programme of formal teaching should be delivered, appropriate to the curriculum requirements for trainees.	Partially met. The development of the formal teaching programme is positive. However, lack of clarity around responsibility for delivering each session as well as poor communication has resulted in a number of cancelled or poorly prepared sessions.
Specialty trainees must have opportunities to undertake regular outpatient clinics with appropriate supervision for training level as per college guidance. As indicated at the previous visit trainees should have more access to rural clinics and there should be a formal structure which allows trainees to regularly and consistently attend a package of	Met. Significant improvements for all levels of trainee. In particular, outpatient clinics being built into the rota for ST trainees and ability to attend rural clinics has improved the trainees' educational opportunities.

clinics over the course of their placement.	
The department should ensure that there are clear systems in place to provide supervision, support and feedback to trainees working in clinics and undertaking clinics	Met Provision of double run clinics and no rural clinics being unsupervised was highlighted by both trainers and trainees.
Trainees should not undertake tasks beyond their level of competence or experience	Met. Provision of training for FY2 and GP trainees to undertake baby checks with a competency sign off from a consultant has addressed this requirement.
The burden of tasks for doctors in training that do not support educational or professional development and that compromise access to formal learning opportunities must be significantly reduced.	Partially Met. Trainees did not report any issues relating to non-educational tasks. However, they are being disrupted when attending teaching sessions.
Lack of access to clinics for GP trainees must be addressed to improve the training opportunities for these cohorts.	Met Trainees are now able to access clinics.
There must be a process that ensures trainees understand, and be able to articulate, arrangements regarding Educational Governance at both site and board level.	Not met. Trainees remain unaware of the governance structures and who is responsible for the quality of training and education delivered in the hospital.
The department should review the arrangement for out of hours cross-cover for junior trainees to ensure that responsibilities are clearly defined (especially in the context of neonatal resuscitation) and that there is no potential compromise of patient safety.	Requirement met. None of the trainees reported any concerns regarding cross-cover out of hours.

4. Areas of Good Practice

Ref	Item	Action
4.1	Patient safety	The department provides training to FY2 and GP trainees to undertake baby check and these trainees are not permitted to undertake an unsupervised baby check until being signed off as competent to do so.
4.2	Adequate experience	Outpatient clinics built into rota for ST trainees and opportunities now exist for GP trainees. All have appropriate supervision in place as well as time to undertake assessments.

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	Formal teaching	Regular communications to ensure trainees, particularly GP, are aware of what topics are being discussed and any changes due to staff leave.
5.2	Adverse Incidents	Foundation and GP trainees should be included in the email distribution of the action plan and learning points following CIRG meetings

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	Allegations of undermining behaviour must be investigated, and if upheld, put in place an appropriate action plan must be instigated to address them.	18th April 2020	**All cohorts**
6.2	There must be a process that ensures trainees understand, and are able to articulate, arrangements regarding Educational Governance at both site and board level.	18th April 2020	**All cohorts**
6.3	FY2 and GP trainee cohorts should be made aware of CIRG meetings and when they happen	18th April 2020	**FY2 and GP**
6.4	Measures must be implemented to address the (ongoing) patient safety concerns described in this report regarding guidelines and patient management plans.	18th April 2020	**All cohorts**
6.5	There must be active planning of attendance of doctors in training at teaching events to ensure that workload does not prevent attendance. This includes bleep-free teaching attendance.	18th April 2020	**FY2 and GP**