Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	20 November 2019	**Level(s)**	Foundation/Core/Specialty
Type of visit	Revisit	**Hospital**	Victoria Hospital
Specialty(s)	General Medicine	**Board**	NHS Fife

Visit panel	
Dr Fiona Drimmie	Visit Lead and Associate Postgraduate Dean (Quality)
Dr Alistair Douglas	Training Programme Director
Dr Robert Laing	Foundation Programme Director
	Trainee Associate
Ms Vicky Hayter	Quality Improvement Manager
Mr Stuart Holmes	Lay Representative
In attendance	
Mrs Gaynor Macfarlane	Quality Improvement Administrator
Mrs Jennifer Duncan	Quality Improvement Manager (Shadowing)

Specialty Group Information	
Specialty Group	Foundation
Lead Dean/Director	Professor Clare McKenzie
Quality Lead(s)	Dr Geraldine Brennan and Dr Fiona Drimmie
Quality Improvement Manager(s)	Mrs Jennifer Duncan
Unit/Site Information	
Non-medical staff in attendance	4
Trainers in attendance	10
Trainees in attendance	11 FY trainees, 3 GPs, 5 CT/IMT, 7 Specialty Trainees

Feedback session: Managers in attendance	10

Feedback session: Managers in attendance	Chief Executive		DME	1	ADME		Medical Director	1	Other	8

Date report approved by Lead Visitor	19 December 2019

1. Principal issues arising from pre-visit review

There was a visit to the unit in March 2019 which highlighted a number of concerns throughout the visit that pointed to a lack of confidence in patient safety. The panel were unanimous in their decision for a revisit within 6-9 months and if no improvements have been made by that time consideration will be given to escalation to the GMC's Enhanced Monitoring. The following is a list of recommendations from the previous visit held in March 2019.

- The site must develop an effective boarding policy of safe selection, tracking and managing boarded patients and ensuring appropriate clinical ownership and oversight of patient care.
- Handover processes must be improved to ensure there is a safe, robust handover of patient care with adequate documentation of patient issues, senior leadership and involvement of all trainee groups who would be managing each case.
- Solutions must be found to address the junior middle grade trainee rota, the intensity of which may have non-intended consequences on patient and trainee safety.
- Appropriate outpatient clinic training opportunities must be provided for General Practice Core Medical and Specialty Trainees.
- Barriers preventing trainees attending their dedicated teaching days must be addressed.
- Hospital and Departmental inductions must be provided which ensure trainees are aware of all of their roles and responsibilities and feel able to provide safe patient care.

In addition, due to a lack of data at the Higher Medicine QRP for specialty trainees based in Kirkcaldy we explored the training experience of that grade in order to reduce the visit burden for the department

A summary of the discussions has been compiled under the headings in section 3 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.

The panel met with the following groups:

Trainers
Foundation Trainees (FY)
Core Trainees (CT)
General Practice Trainees (GPST)
Specialty Trainees (ST)
Non-Medical Staff

Before the visit commenced the panel met with the Board Medical Director Dr Chris McKenna, who gave a presentation highlighting significant improvements within the General Internal Medicine department since the last visit. Specific examples given were: *Boarding*: Banish boarding event and introduction of Daily Dynamic Discharge has shown improvements although this is still a difficult area. There is drive and ambition to improve and the department are working tirelessly to find solutions. *Handover*: a new location, review of attendance and introduction of FEWS (Fife early warning score). *Rotas*: There has been a new appointment of a rota administrator and medical education e-rostering lead. *Clinics*: An attendance audit shows attendance is improving at clinics and this will continue to be monitored. *Workload*: Expansion of Phlebotomy and work on immediate discharge letters. A robust induction programme has also been introduced. Dr McKenna explained the department has an excellent training culture which is hampered by operational issues which they are trying hard to find resolve.

2.1 Induction (R1.13)

Trainers: Trainers stated that the trainees receive both a hospital and departmental induction. All trainees receive induction to each ward which states who to contact during the day and out of hours (OOH). Trainees receive face to face orientation around the wards and information regarding cardiopulmonary resuscitation (CPR). A talk regarding handover and a booklet stating how the system works was also given to the trainees. Trainees who are unable to attend the induction are met separately on their arrival. Induction is held 4 times a year and improvements are ongoing with the ambition to have an e-module.

Foundation Trainees: The majority of trainees advised they had received hospital and departmental induction with a couple of exceptions. One trainee did not receive induction due to nightshift and another had no IT access for 3 days. Trainees on shadowing enjoyed the half day on the ward however they would have preferred one full day so that they could understand the workflow during the whole day. Trainees advise they did not receive induction to specific wards which they rotate through.

General Practice/Core Trainees: All trainees stated they had received both hospital and departmental induction but would have benefited from a tour of the hospital.

Specialty Trainees: All trainees received both hospital and departmental induction.

Non-Medical Staff: The team reported that although they are no involvement in induction, they meet the trainees on the ward.

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

Trainers: Trainers reported the department use a tutorial booking system (TuBS) to record attendance at teaching. Trainees are released to attending teaching from the general/specialty wards, but it can be challenging from the admissions unit 1 (AU1). The foundation teaching is co-ordinated by the education centre while the specialty trainees are involved in regional teaching and grand rounds.

Foundation Trainees: Trainees can attend local foundation teaching but have difficulty attending additional teaching sessions. Trainee's also have opportunities to undertake courses on TuBS.

General Practice/Core Trainees: Trainees reported advanced medical teaching (ST3+) is held every week and all trainees are invited although it is aimed at higher trainees and is not bleep free. Regional teaching for CT trainees is held at the Royal College of Physicians Edinburgh (RCPE) and the majority of trainees can attend although the rota can make planning this challenging as it is not timetabled in. GP training sessions are Fridays for 1 hour and the trainees can attend.

Specialty Trainees: Trainees attend the advanced medical teaching on a Thursday for one hour which is useful and works well. Regional teaching is held at the RCPE and trainees attend with no issues. Trainees find it difficult to attend any additional specialty teaching whilst undertaking their general internal medicine block. Depending on the specialty some trainees are allocated one specialty session per week, however it is not always possible to take this when on-call or float days as trainees are expected to cross cover. Trainees reported a number of teaching opportunities, but it can be difficult to attend.

Non-Medical Staff: The team are aware of when teaching is being held and encourage trainees to attend.

2.3 Study Leave (R3.12)

Trainers: Trainers stated that there are currently no issues supporting study leave requests. It can be more challenging when there are gaps on the rota or not enough notice has been given.

Foundation Trainees: FY2 trainees advised they are given protected teaching time and there are no issues being granted study leave. Although study leave is authorised there is no cover provided on the rota and trainees ask their colleagues at short notice to cover.

General Practice/Core Trainees/Specialty Trainees: Trainees advised there are no issues receiving authorisation for study leave 6 weeks in advance, however the coordination for this on the rota is not well done and the need for cross cover is often a last-minute issue (24-48 hours' notice) and leaves trainees feeling worried about taking their study leave. Annual leave is only granted on float weeks which can be difficult if trainees require leave at a specific time.

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

Trainers: Trainers advised educational supervisors are only given one grade to supervise at any given time. The aim is for a supervisor to work clinically with their trainees, but this is not always possible as there are many trainees to supervise and some consultants are not in the wards as often.

Foundation Trainees: Trainees stated that they have met with their named educational/clinical supervisors. Not all trainees work closely with their supervisor but have had the initial meeting.

General Practice/Core Trainees/Specialty Trainees: Trainees reported they have all met with their allocated educational supervisor and agreed a personal learning plan.

Non-Medical Staff: The team stated that there is always someone available to provide support and supervision.

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

Trainers: Trainers reported all trainees know who to contact both during the day and OOH as it's a small team. Consultants attend handover at 8am and 8pm and are in the building till 10pm. Consultants make it clear before leaving they are the person on-call. Workload at night can be busy and Hospital@Night (H@N) nurses act as triage. Foundation trainees can sometimes feel overwhelmed at night therefore a track list has been introduced to prioritise patients (FEWS – Fife early warning score).

Foundation Trainees: The foundation trainees know who to contact OOH and have no concerns.

General Practice/Core Trainees: Trainees advised they know who to contact both during the day and OOH. Consultant are accessible and approachable.

Specialty Trainees: Trainees reported feeling exposed out of hours due to the high volume of patients as they cover all medical wards (10) and answer surgical queries, high dependency unit (HDU) and coronary care. During nightshift there can be over 45 admissions in one night therefore making it difficult to attend medical receiving. Consultants are contactable and supportive however having 2 middle grade doctors covering overnight would ensure more patients have timely senior review.

Non-Medical Staff: The team advised that NHS Fife have introduced a colour-coded badge system that identifies the grade of trainee, however not everyone in the team was aware of this. Advanced nurse practitioners (ANPs) offering support to trainees do not feel they have to cope with problems beyond their competence.

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

Trainers: Trainers stated they are aware of the required curriculum competencies. Cardiology trainees contribute to on-call and undertake 6 months cardiology and 6 months general internal medicine. For the cardiology trainees they alternate 5 weeks acute medicine with 5 weeks of cardiology. Trainees in renal, respiratory and gastroenterology are in Kirkcaldy for general internal medicine and have one clinic per week which can sometimes be difficult for trainees to attend. Trainees are encouraged to attend but there is often no-one to cover ward work or receiving.

Foundation Trainees: Trainees reported they are well protected in this post as nurses, phlebotomists and clinical support workers take bloods and cannulas both during the day and at night, 7 days a week. All foundation trainees advised they feel part of the team and if they request to go to a specific ward before the start of the attachment this can be accommodated.

General Practice/Core Trainees: Trainees reported some concerns in relation to the internal medicine training (IMT) curricula as central venous access training can be difficult to obtain as this is generally done by Intensive care consultants and this core competencies may not be met for annual review of competency progression (ARCP). Attending clinics is very challenging as not all trainees have allocated time. Trainees on the junior rota are allocated one week to attend clinics whilst those in stroke or rehab are allocated half a day a week. Cross cover for others or workload pressures from the ward often detracts into this allocated time.

Specialty Trainees: Trainees reported difficulties attending clinics as these are not consistently built into the rota. Due to the current ward structure often the specialty trainee is still completing a ward round and undertaking the same jobs as a foundation trainee and cannot leave the ward to undertake other more appropriate clinical activities.

Non-Medical Staff: The ANPs are involved in simulation and pulse training for the Foundation doctors. The team reported that informal training takes place daily on the ward.

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

Foundation Trainees: Trainees reported they must be proactive in completing the workplace-based assessments, but specialty trainees are very supportive and complete the majority of them.

General Practice/Core Trainees: Trainees reported it is very difficult to get acute care assessment tool (ACAT) assessments signed off as AU1 is extremely busy. The required 10 consultant workplace-based assessments (WPBAs) can be achieved but with some difficulty.

Non-Medical Staff: The team advised that they contribute to the trainees' assessment completion by completing their multi-source feedback and team assessment of behaviour (TABs).

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

Not discussed.

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

Foundation Trainees: Trainees stated that although there is no protected time there are opportunities to undertake audit which is supported by the Specialty trainees.

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

Trainers: Trainers advised trainees are regularly given feedback from the consultant group during the day. The 8am handover is used to feedback from OOH. There is a mechanism in place if concerns are raised OOH the trainee's educational supervisor will be emailed. There is also an anonymous appreciation box for positive feedback.

Foundation Trainees: Trainees reported a varied response regarding feedback. Some trainees received this as they work directly with consultants however not all trainees do. Trainees advised it is difficult to receive feedback when they do not have to make decisions very often. One trainee described having been proactively contacted by a consultant to be given positive feedback on care they had delivered

General Practice/Core Trainees: Trainees advised they receive informal feedback during the day but not OOH unless they actively seek it out. Some consultants provide feedback on ward rounds but not all.

Specialty Trainees: Trainees reported receiving feedback during the day when on-call in the admissions unit, but it is difficult on ward rounds. OOH can be challenging as there are 4

consultant ward rounds going on at the same time and they cannot attend all of them which makes it difficult to create an ACAT. In the morning they hand back night shift patients in several different places and therefore struggle to get feedback on their plans and decision making.

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

Trainers: Trainers reported that the trainees are asked to provide feedback at educational and clinical supervisor meetings. Trainees can also provide feedback via TuBS, the national trainee survey and the scottish trainee survey or informally at any time. The clinical director recently held 'catch up' meetings with trainees which was another opportunity to provide feedback. The chief registrars have been very engaged to meet with peers for feedback and have encouraged trainees to attend meetings.

Foundation Trainees: Trainees give feedback after teaching each week. Trainees had the opportunity for a catch up with the clinical director which they found very useful. They can also give feedback to higher trainees at handover.

General Practice/Core Trainees: Trainees advised that feedback is given after weekly teaching and also on TuBS. There is also the opportunity to provide feedback during coffee and a chat.

Specialty Trainees: Trainees can feedback via the chief registrars. The chief registrars reported that they have found it difficult to engage the other trainees despite a number of opportunities. There are known issues, but trainees suspect lack of engagement may be due to the length of post (trainees rotate each 4 months) or low morale.

2.12 Culture & undermining (R3.3)

Trainers: Trainers reported an approachable team. There is a talk at induction regarding setting expectations and professional behaviour. Trainers have recently introduced coffee and a cake to get to know the trainees.

Foundation Trainees: Trainees reported a supportive team in particular higher trainees and senior nursing staff. Trainees advised they had no bullying or undermining concerns.

General Practice/Core Trainees/Specialty Trainees: Trainees advised the majority of the clinical team and senior colleagues are supportive and would contact their educational supervisor to raise any concerns.

Non-Medical Staff: The team advised there are a variety of teams in the department all working at different levels which have good working relationships and work well together. Although there have been no bullying or undermining concerns staff would support each other and speak to the foundation lead or educational supervisor depending on the concern.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: The trainers reported a change of start time for specialty trainees on the rota which they are aware has not been popular. All grades start at 8.30am with the exception of specialty trainees who start at 8am. The 8.30am start for other trainees has enabled them to provide additional staff between 5pm-8pm. The rotas and numbers are tight, the trainees can engage with the rota master 6 weeks in advance. There are currently no rota gaps, the FY2/GPST/CT rota is a 12-person rota with 2 locums. The core trainees can operate on both the junior or senior rota depending on requirements and this varies from block to block.

Foundation Trainees: Trainees stated the rota is working well. The on-call block is 3.5 weeks and is self-contained and works well. There is a stretch of 4 long days, but they feel the payback of a decent interval off makes this the best option. Weekend work is intensive and having an additional junior member of staff would improve the workload. Consultants in renal and cardiology will sometimes see all their patients at the weekend which helps ease the workload, but this is variable.

General Practice/Core Trainees: Trainees advised that a gap in the GPST rota has been recently filled by a locum who can only be based at Queen Margaret Hospital. This has had an impact on learning opportunities and the ability to attend clinics for some trainees. The core medical training (CMT) days are available in advance therefore it would be more productive to build these into the rota so there is adequate cover. If there was always someone floating it would make training/attending clinics etc more achievable. The current rota does timetable a week of float to attend clinic, but this is frequently swallowed up covering for others.

Specialty Trainees: Trainees stated there are currently no gaps in the rota and float days are used to get to clinics if possible. The trainees raised some concerns about their start time of 8am when all other grades start at 8.30am/8.45am. This means that after receiving handover trainees are left waiting to the others start to handover again. Trainees advised that there are many constraints to taking annual leave as this must be on a floating week which is very difficult if you require a certain time to be off. Even if a specific need for leave is identified prior to starting in the hospital it is by no means guaranteed and they often have to swap into a place on the rota which makes workload excessive to achieve the desired leave.

Non-Medical Staff: The team reported that a new role of rota co-ordinator has recently been appointed in the last 2 months. The e-rostering system ensures rest requirements are fulfilled and monitoring is currently ongoing. There are currently 4 rotas in medicine – FY1, FY2 (can include CT1), GPST/ST (can include CT) and ST3+.

2.14 Handover (R1.14)

Trainers: Trainers advised there is a now a dedicated room for handover. The night team handover in the morning is from the 2 FY trainees, 2 hospital at night nurses and a medical registrar to the daytime registrars. There is a 4.30pm handover where the FY1 trainees' hand over to an FY2/CT1. There is another handover at 8pm. There is a handover working group which is run by 3 chief registrars and includes all levels of trainees. They are keen to improve the training and handover. The 4pm PAUSE has been introduced as a safety buffer across all medical wards and at this time the FY2/CT or registrars encourage the ward day teams to identify what they can complete and what is handed over to the night team. The consultant lead for handover is working with the hospital to get an IT system which will provide suitable handover support which will be effective – 2 systems are being considered and meetings are due in the next 2 weeks to decide which is the best one for the local team.

Foundation Trainees: Trainees reported a new streamlined safer handover with improved lists. The AU1 handover is well structured and there is a separate ward handover with specialty trainees. Trainees are part of the handover group. Trainees advised the attendance at the 4.30pm can be variable and the FY2 trainees can find that FY1's don't necessarily hand over all activity as they prefer to stay and get jobs finished.

General Practice/Core Trainees: Trainees reported a recently improved structured handover. The 4.30pm/5pm handover is led by a FY or CT and can be difficult due to a lack of attendance.

Specialty Trainees: Trainees reported there is no face to face handover at the weekend and are given a list of patients with no priority. Some trainees had worked with the recently improved list which contains FEWS scores. They had found this helpful, but the list still does not have any background or other information on the patient's requirements. A weekend list which gave some guidance on those who required weekend review was seen as something which would make a big difference.

Non-Medical Staff: The team advised that they encourage the use of the SBAR handover.

2.15 Educational Resources (R1.19)

Trainers: Trainers advised that there is a library with computers that trainees have access to with access to the intranet and a librarian who can help with literature searches. On level 8 there is a clinical skills centre with access to simulation.

2.16 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 if they had any concerns regarding a trainee, they would contact their educational supervisor. All trainers have attended the training course for trainees with performance support concerns and would contact the director of medical education (DME), associate postgraduate dean or deanery if they had any ongoing concerns.

Foundation Trainees: Trainees reported if they required any support regarding the job or health, they would contact their educational supervisor.

General Practice/Core Trainees: Trainees advised they would discuss any health or issues with the job with their educational supervisor. Trainees are aware of previous requests for reasonable adjustments which were agreed but difficult to put into place. Trainees were anxious that any requests for adjustments would put a strain on the rotas and impact colleagues.

Specialty Trainees: Trainees reported there was no formal system for support for junior trainees and suggested the introduction of a buddy system may be a welcomed introduction.

Non-Medical Staff: The team advised that any concerns regarding a trainee would be raised with trainee or consultant.

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

Foundation Trainees: Trainees are aware of the DME and the newly appointed chief registrars. Trainees advised that consultant are very approachable and higher trainees are very proactive.

General Practice/Core Trainees/Specialty Trainees: The majority of trainees are aware of the DME and chief registrars.

2.18 Raising concerns (R1.1, 2.7)

Trainers: The trainers reported a flat departmental structure with no hierarchy who provide support to the trainees and encourage them to talk about any concerns.

Foundation Trainees: Trainees reported one very busy chaotic day after which the consultants were very supportive and asked how things could be improved. This was also used as a teaching event at grand rounds.

Specialty Trainees: Trainees advised they would contact their educational supervisor or consultant if they had any patient safety concerns.

Non-Medical Staff: Although the team have not raised any concerns in relation to patient safety they would speak to a consultant if they had any concerns.

2.19 Patient safety (R1.2)

Trainers: The trainers reported having worked hard trying to improve boarding. Since the introduction of daily dynamic discharge this has brought boarding numbers down from 31% in May to 9% in October. There has been a locum doctor appointed to ward 13 therefore trainees do not see any patients boarded to this ward. There are criteria to relating to safe boarding which is adhered to as much as possible. The department are continually trying to improve to reduce boarding.

Foundation Trainees: Trainees advised that they generally have no patient safety concerns however at peak activity there are some concerns that they cannot see everyone in a timely manner. Patients boarded to other wards do not always receive the same standard of care as those on base wards as they are not included in the ward round and therefore their care can be delayed. Examples were given of patients who by the recommendation of the boarding criteria should not be boarded but due to bed pressures the patient still being boarded. The daily dynamic discharge (DDD) has improved boarding and the locum junior doctor on ward 13 is very helpful. Trainees raised concerns that they are still responsible for all care of boarded patients and spend much time away from their base ward doing this. They also advised they do not have access to the boarding list at the start of the day and are worried that it is not always up to date.

General Practice/Core Trainees/Specialty Trainees: Trainees reported concerns regarding patients whose condition meant that they should not be boarded according to the boarding criteria but due to bed pressures they still have to be boarded. The trainees reported being responsible for the boarded patients unless they are on ward 13 however there is no clear medical handover process to ward 13. Trainees stated they would not have any concerns if a friend or relative had been admitted however there were some concerns if they were boarded or were admitted at the weekend for example a Friday, as AU1 is extremely busy and they would not been seen till Saturday and there would be no information or prioritisation on the generated list. The recent meeting to banish boarders was highlighted as a way the hospital is trying to address the issue. Trainees are anxious that those who are discharged quickly may end up readmitted.

Non-Medical Staff: The team reported that the rapid run down and DDD have been an important improvement in the department. There is still a high level of boarders daily however the department are working hard to make improvements and within gastrointestinal unit (GI) the numbers have decreased since the introduced of DDD. The night co-ordinator sends out boarding lists by email every morning to the charge nurses. The team attend daily hospital safety huddles which includes multi-professional staff (this huddle does not include trainee doctors who have their own handovers).

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

Foundation Trainees: Trainees stated that any adverse incidents are raised through the datix system. Trainees advised that they have not raised any concerns relating to boarding through datix.

Specialty Trainees: Trainees reported using datix and if an adverse incident had occurred it would be discussed at a significant events analysis.

Non-Medical Staff: The team advised that the datix system is used to report incidents. There are M&M meetings in the department, and significant adverse event meetings which are used as a learning opportunity for all staff.

2.21 Other

Specialty Trainees: Trainees stated their training would improve if the previous ward structure was put back into place which would ensure all trainees start at the same time.

Overall satisfaction scores:

Foundation trainees average score 7/10.
Core/IMT/GP trainees average score 6/10.
Specialty trainees: average score 6/10.

3. Summary

The visit panel found a department that has been focused on making improvements since the previous visit. There has been progress with some requirements from the previous visit and there is focus on continuing these. The key areas of concern remain those related to workload and available staff. The continued pressures relating to boarded patients affect the efficiency of work and the overall workload is affecting the educational environment for GPST, CT and ST trainees. The IT systems for handover currently in place still do not meet the needs of trainees or permanent staff in managing their workload and we are pleased to hear that an electronic solution will soon be identified. There is a willingness to improve and an enthusiasm to teach. The visit panel plan to revisit to ensure that progress is achieved in a reasonable timescale.

What is working well:

- Approachable senior staff.
- Comprehensive and well-balanced induction.
- Chief registrar role is visible amongst all grades of trainees.
- Newly appointed rota co-ordinator is a positive move but still in the development stage.
- Daily dynamic discharge is being recognised and is having a positive impact.
- Addition of medical staff in Ward 13 is a noted improvement.
- Recognised support put in place to reduce the service jobs for trainees. For example, clinical support workers and phlebotomists.

What is working less well:

- Although work has been done to improve handover, trainee's expressed anxiety about the weekend and early evening handovers and the prioritisation of patients.
- Lack of visibility of the patient boarding list.
- Concern from IMT trainees that the required number of curriculum competencies may not be met.
- The variable start time of trainees was identified as an issue for higher trainees.
- The rota does not currently support access to clinic's for GP, core and specialty trainees.
- Whilst trainees receive authorisation for study leave there is often no cover put in place unless the trainee can find someone to cover.
- Annual leave is only allocated during floating week.
- Constant use of SHO terminology by all groups of trainees, particularly in reference to the middle grade rota.

Is a revisit required?	**Yes**	**No**	**Highly Likely**	**Highly unlikely**

4. Areas of Good Practice

Ref	**Item**
4.1	Chief registrars are visible and accessible to all trainees.
4.2	Introduced of daily dynamic discharge is a positive step for improvement.

5. Areas for Improvement

Ref	Item	Action
5.1	Annual leave fixed on senior ST rota.	
5.2	The variable start time of trainees was identified as an issue for higher trainees.	

6. Requirements - Issues to be Addressed

Ref	**Issue**	**By when**	**Trainee cohorts in scope**
6.1	The site must continue to develop the boarding policy, tracking and manging boarded patients and ensuring appropriate clinical ownership and oversight of patient care.	August 2020	All grades
6.2	Weekend and evening handover processes must be improved to ensure there is a safe, documented, robust handover of patient care with senior leadership and involvement of all trainee groups.	August 2020	All grades
6.3	Educational supervisors must understand curriculum and portfolio requirements for their trainee group.	August 2020	CT/IMT
6.4	Appropriate outpatient clinic training opportunities must be provided for General Practice, Core Medical and Specialty trainees.	August 2020	GP/CT/IMT/ST
6.5	Speciality trainees must have regular opportunity for work of educational value suitable for their grade and not be routinely used for work more suitable for a junior trainee.	August 2020	ST
6.6	All trainees must be able to access Study Leave with a system put in place to allow for cover when trainees are away and must not be dependent on trainees arranging their own service cover.	August 2020	All grades

6.7	Higher trainees must similarly receive feedback on their out of hours work	August 2020	ST
6.8	All references to “SHOs” and “SHO Rotas” must cease.	August 2020	All grades