Scotland Deanery
Quality Management Visit Report

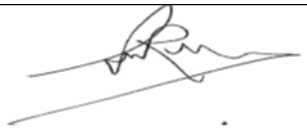
NHS Education for Scotland

Date of visit	8th & 9th April 2021	**Level(s)**	FY/GPST/IMT/ST
Type of visit	Enhanced Monitoring re-visit	**Hospital**	University Hospital Ayr
Specialty(s)	General Internal Medicine	**Board**	NHS Ayrshire and Arran

Visit panel	
Professor Alastair McLellan	Visit Chair - Postgraduate Dean
Dr Alan McKenzie	Associate Postgraduate Dean – Quality
Robin Benstead	Principal Education QA Programme Manager (Devolved nations)
Dr Jim Hall	General Medical Council Representative
Dr Carol Blair	Training Programme Director Representative
Archie Glen	Lay Representative
Alex McCulloch	Quality Improvement Manager
In attendance	
Patriche McGuire	Quality Improvement Administrator

Specialty Group Information		
Specialty Group	Medicine	
Lead Dean/Director	Professor Alastair McLellan	
Quality Lead(s)	Dr Alan McKenzie Dr Reem Al-Soufi Dr Greg Jones	
Quality Improvement Manager(s)	Alex McCulloch and Hazel Stewart	
Unit/Site Information		
Non-medical staff in attendance	3	
Trainers in attendance	9	

Trainees in attendance	FY1 x 6	FY2 x 1		GPST x 2		IMT x 7		ST x 2		
Feedback session: Managers in attendance	Chief Executive		DME	✓	ADME	✓	Medical Director	✓	Other	Acute Services Director, General Manager for Medicine, Post Graduate Administrator,

Date report approved by Lead Visitor	 Professor Alastair McLellan 26th May 2021

1. Principal issues arising from pre-visit review:

University Hospital Ayr has been under the GMC Enhanced Monitoring process since November 2016, conditions set by the GMC were added to the case in August 2018 following a further deterioration in the training environment. Since the November 2018 visit, 2 of the 4 conditions have been addressed and removed. There are 2 remaining conditions attached the UHA Enhanced Monitoring case:

- NHS Ayrshire & Arran must ensure that core medical trainees are provided with appropriate learning opportunities and feedback.
- NHS Ayrshire & Arran must ensure that learners are not subject to behaviour that undermines their professional confidence, performance or self-esteem.

The last Enhanced Monitoring re-visit took place in November 2019, which identified 5 requirements for the site to address:

- Concerning behaviours at the Radiology – Medicine interface must be addressed.
- The potential risks associated with a) patients being boarded out directly from Combined Assessment Unit (CAU, and b) the additional risks from consequent delays in consultant assessment, must both be addressed.
- OOH medical staffing must be reviewed to ensure doctors in training have a reasonable and manageable workload.
- Measures must be implemented to address the potential patient safety concerns associated with the lengthy delays between arrival and definitive assessment of patients within the Emergency Department (ED) and CAU departments, (more usually 4-6hours but reported to be up to 10 hours at times).
- A process for providing feedback to Foundation Year Trainees (FY), Core Medicine Trainees (CMTs) and General Practice Specialty Trainees (GPSTs) on their input to the management of acute cases must be established.

A scheduled enhanced monitoring re-visit was due to take place on the 8th & 9th of December 2020 but was cancelled at the request of NHS Ayrshire & Arran due to COVID-19-related service pressures. As the December visit was cancelled, an action plan review meeting between the Deanery and NHS Ayrshire and Arran's medical director (MD), director of medical education (DME) and assistant director of medical education (ADME) took place on 29th January 2021 and agreed actions were taken from the meeting for the site, the Deanery and the GMC to address.

As well as a review of the highlighted items above, the visit team took the opportunity to gain a broader picture of how training is carried out within the department visited and to identify any points of good practice for sharing more widely. 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.

The Deanery would like to thank Dr Hugh Neill (DME) and Dr Derek McLaughlin (ADME) for the helpful and informative presentation which gave a detailed overview of work being done to address the 2019 visit requirements, which was delivered to the visit panel during the management session. The Deanery QM visit panel acknowledged the great work done by staff in University Hospital Ayr (UHA) -Medicine during the COVID pandemic both in terms of patient care and in sustaining the delivery of training, even in these more challenging circumstances.

2.1 Induction (R1.13):

Trainers: Trainers reported a regular hospital induction programme was provided to trainees that was repeated at regular intervals for those who missed the initial sessions. Catch up sessions were provided by Dr Sword, along with the rota co-ordinator and one of the senior nurses.

All Trainees Cohorts: All trainees present had attended hospital induction and thought it was to prepare them for working in their posts. All received IT passwords & training. Trainees' experience of departmental induction was more variable; with some having thorough departmental induction providing clarity around roles and responsibilities, some reported little by way of departmental induction beyond the provision of handbook. Those receiving little by way of departmental induction

highlighted the need for greater clarity around roles and responsibilities in relation to the acute medical receiving system and expectations on wards.

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

Trainers: Trainers advised that trainees were provided with at least 2 hours of teaching per week, with trainees involved the development and delivery of sessions through the trainee forums. Sessions took place on Tuesdays and Fridays and Trainers maintained the delivery of teaching during the 2nd COVID wave. Teaching was interruption free for FY1 and efforts were made to avoid paging other groups of trainees out of sessions. As teaching sessions were now delivered virtually, trainees could attend whilst on shift and at home. Teaching attendance records were kept by the local post graduate administrator.

Foundation Trainees: Trainees advised they could attend teaching whilst working on the wards, attending was more difficult for trainees when they are working on-call shifts in the CAU. Trainees confirmed the FY1 specific teaching that took place on Wednesdays to be protected and interruption free. The Tuesday and Friday sessions were less protected, but trainees could attend most sessions without being paged out.

General Practice Trainees: Trainees could attend the twice weekly 1-hour sessions of teaching provided on Tuesdays and Fridays, if they were working in the wards but couldn't attend if working a period of on-call shifts; in practice, their actual attendance was minimal. Trainees could also attend their GP programme specific teaching, which took place one day per month. Trainees confirmed they had appropriate IT equipment as well as suitable space to join the virtual sessions.

Internal Medicine Trainees: Trainees were able to attend most teaching sessions and estimated they could attend around 50 – 75% of the available teaching sessions provided. They also confirmed they had access to appropriate IT equipment to enable them to join sessions.

Specialty Trainees: Trainees could attend the Tuesday and Friday teaching sessions but advised it was more difficult whilst working a run of on-call shifts. Chief residents were involved in the creation and delivery of the Tuesday sessions and Friday sessions were by consultants. Trainees advised that all their teaching was delivered through MS Teams.

2.3 Study Leave (R3.12)

Not asked. No concerns raised in pre-visit information.

2.4 Formal Supervision (R1.21, 2.15, 2.20, 4.1, 4.2, 4.3, 4.4, 4.6) Not asked. No concerns raised in the pre-visit information.

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

Trainers: Trainers confirmed that most worked closely with the trainees they supervised on the wards. During the 2nd COVID wave between March and May, trainers worked night shifts to provide support to trainees. Trainers were unaware of any instances were trainees had to work beyond their competence.

Foundation Trainees: Trainees were aware of who to contact for support both whilst working during the day and out of hours and did not raise concerns in relation to the Clinical Supervision they were receiving.

General Practice Trainees: Trainees could access support both during the day and whilst working out of hours. Trainees did not report any instances where they had to work beyond their competence. Trainees reported a shortage of consultant staffing in some of the wards which presented challenges. This was highlighted to be a particular problem in station 14 (an endocrinology and diabetes ward), where trainees struggled to access specialist senior input, for example, to get advice on issues such as insulin dosage to use.

Internal Medicine Trainees: Trainees reported no concerns with being able to access senior support during the day. IMT2 trainees felt more exposed as the 'medical registrar' on-call when working out of hours, due to the requirement for them to act up as a registrar and be the 2nd on-call contact for junior trainees. Due to lack of specialty trainees in UHA, their next line of escalation was to consultants, where trainees felt they got variable responses depending on which consultant was on shift. Back-up for procedures was available from anaesthetics.

Specialty Trainees: Trainees could access support from senior colleagues both during the day and out of hours and felt them to be approachable. The trainees described examples of the trainee forum being used to escalate trainee concerns around confusion in regard to referral pathways for some specialties. This resulted in some training sessions on referral pathways being delivered to trainees.

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

Trainers: Clinics were taking place again and being scheduled into trainee rotas (although not as frequently as pre COVID) and the provision of supervised learning events (SLEs) for trainees had also continued. Trainers confirmed that trainees had access to a procedures list, for which trainees could put their names forward to gain experience of procedures (such as endoscopy and central line insertion). In addition, trainers highlighted echocardiogram simulation experience and various clinic opportunities in different departments (such as injection clinics ran in rheumatology). Advanced nurse practitioners (ANPs) were available on the wards during the week to assist trainees with some of the non-medical tasks they were required to undertake.

Foundation Trainees: Trainees reported they could achieve their learning outcomes and reported plenty of opportunities, including in managing acutely unwell patients. Trainees seemed unaware of a procedure list but described their senior colleagues as approachable and amenable to going through procedures with them. Trainees were aware that the local rota co-ordinator scheduled clinics into the trainee rotas (potentially of relevance to FY2s); one had attended a clinic. Availability of clinics was more limited because of COVID, and most opportunities were allocated to trainees where clinics were a requirement of their curriculum.

Trainees' time spent on tasks considered to be non-educational was variable and estimated to be between 50 – 60 % of their time, although this was higher whilst working on-call in CAU (around 75%) of the time. On-call, evening and night shifts provided more access to learning opportunities.

General Practice Trainees: GPSTs were positive about their learning opportunities. There were plenty of opportunities to develop skills and competencies in managing acutely unwell medical patients. They commended the role of the rota co-ordinator in scheduling trainees to attend clinics; all had been to 2 clinics so far, since starting their posts in February. Trainees noted that clinic opportunities were particularly limited because of the COVID pandemic. There were some

opportunities for practical procedures; they reported that they hear of opportunities to do procedures by word of mouth, and that the use of a 'procedures' page' had been discontinued. They reported that a large part of their role on the ward was dedicated to non-educational, administrative tasks.

Internal Medicine Trainees: There was plenty of access to acute medical presentations. Trainees felt they would meet their curriculum requirements for skills and procedures. Trainees described the IMT bootcamp and their intensive care blocks were very good for learning and helped them gain a lot of their required competences. Trainees were aware of the process by which opportunities to do procedures were shared through a trainees' Whats App group. They were also aware of local provision of SIM-based training. Trainees confirmed they were rota'd into available clinics by the rota co-ordinator. However, because of COVID, the numbers of clinics available were greatly reduced. They were not unduly burdened by having to do non-educational tasks.

Specialty Trainees: Trainees felt they received lots of experience managing acutely unwell patients. They described good relationships between the Intensive care unit (ITU) and medicine and when they assess patients there, they can receive feedback on their input. Trainees described their access to procedures as excellent and had access to the procedures list through Whats App and valued the echocardiogram simulation experience they received. Trainees highlighted the efforts of the rota co-ordinator in what they described as the fair allocation of clinics to their rota.

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

Trainers: Trainers felt that trainees were able to complete workplace-based assessments and encouraged them to send tickets to them from e-portfolio to sign them off.

All Trainee Cohorts: Most trainees reported no concerns in regard to being able to complete workplace-based assessments and have them signed off; some observed that a very small group of consultants tend to engage with these assessments. GPSTs described some difficulties with a lack of trainer familiarity and engagement with the new general practice e-portfolio, which caused them some difficulties obtaining sign off for some of their assessments.

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

Not asked. Not identified in pre-visit information as a concern.

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

Not asked. Not identified in pre-visit information as a concern.

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: Trainers felt they provided formal feedback through workplace-based assessments; informal feedback was more likely to be given to trainees when they had made an error as opposed to recognising good practice. They felt this could be an area they could improve on collectively, although they advised that trainees were now prompting them more frequently for feedback.

Foundation Trainees: Trainees reported that feedback was not routinely provided on their management of patients, and on their clerk-ins and management of patients on their out of hours shifts. They have little direct communication with consultants in the morning following a night shift. Trainees could receive feedback if they pro-actively asked for it and they felt their senior colleagues were very approachable.

General Practice Trainees: Trainees described feedback on their contributions was variable, and seldom routinely given. Feedback on their overnight admissions was rarely on more than one or two of their patients; some consultants wouldn't give feedback. If they seek out feedback, they can get it.

Internal Medicine Trainees: Trainees felt they did not receive feedback often and would have to seek it out; this was particularly the case during post take ward rounds, following night shifts. Trainees felt there wasn't a sufficient structure in place to facilitate feedback to them, which was exacerbated by the limited number of consultants willing and able to provide it.

Specialty Trainees: Trainees felt they received feedback regularly during ward rounds and felt the feedback they received was both constructive and meaningful. Feedback on their input to managing acutely unwell patients was less frequent.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: Trainers had opportunities to feedback to their senior colleagues in regard to the quality of their training through the junior doctor forum and their chief resident colleagues. Trainers advised that issues from the trainee forum would be collated into an e-mail and circulated around the medical education team. Trainee feedback was also brought to Monday morning management meetings by chief residents to discuss.

All Trainee Cohorts: Trainees reported their perception that there is a culture of listening to the voice of trainees, of all grades. Trainees described forms inviting feedback following formal teaching sessions. Trainees highlighted the efforts of their chief resident colleagues, who would take forward concerns from them to the weekly management meetings. They described the trainee forum as a further route for providing feedback to trainers and management on the quality of their training. There was recognition that not every concern was amenable to change. GPSTs felt they hadn't been in their post long enough to provide feedback on their quality of training yet, as they had started their posts in February.

2.12 Culture & undermining (R3.3)

Trainers: Trainers felt they created a team environment by ensuring they are part of a ward team for 4 months and efforts were made to keep trainees team based. Trainees would also generally be supervised by a trainer they worked with daily. Trainers and trainees would regularly take lunch breaks together, which helped create an informal atmosphere.

All trainee cohorts: Most of the trainees' present felt their consultant colleagues were supportive and approachable and most had not been subjected to or witnessed any bullying or undermining behaviours. Trainees described confidence in raising concerns of this nature and were sure action would be taken.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Trainers described increased trainee support being provided over the past year. Although the rota was felt to be tight, red and green escalation pathways were in place to support trainees. The

rota co-ordinator would allocate clinics into trainee rotas. FY trainees were allocated 2 days every few months which they could use for learning opportunities.

Foundation Trainees: Trainees were unaware of any current gaps in their rota and felt they were well staffed even during the 1st and 2nd waves of the COVID pandemic. Trainees confirmed they were allocated 2 learning days per block, to use as they wish to experience different opportunities. Trainees were aware that the rota co-ordinator would schedule clinic opportunities into their rota where possible but the opportunities to attend clinics were sparse.

Trainees appreciated the local wellbeing centres that has been set up during the 1st and 2nd waves of the pandemic and felt they were a helpful and supportive resource to have; they felt it was a shame they had now been disbanded.

General Practice Trainees: Trainees had received their rota around 2/3 weeks before starting their posts and were made aware at this point there were 2 gaps in their rota, which would remain unfilled in the rotation. This was covered by shortening the break between their block of on-call shifts from 9 weeks to 7 weeks. Trainees did not have concerns in regard to their rota affecting patient safety or their own wellbeing.

Internal Medicine Trainees: Trainees highlighted 1 gap on their current rota, which was currently being advertised for a locum appointment. Trainees described a large number of beds/wards being opened during the COVID pandemic, these were supported by the recruitment of locum staff and the re-deployment of trainees from other Medicine specialties and sites. Trainees were unaware of any patient safety concerns created by their rota and did not feel it affected their well-being. Trainees were aware that the rota coordinator allocated clinics in their rota but described the number of clinics as sparse.

Specialty Trainees: Trainees were unaware of any gaps on their rota and had reported no concerns in regard to their rota affecting patient safety or their wellbeing.

2.14 Handover (R1.14)

Trainers: Trainers described handover as taking place 3 times daily at 9.00am, 5.00 pm and 9.00pm. Trainers felt handover provided safe care for both new admissions and for the patients in the downstream wards.

All trainee Cohorts: Trainees felt handover was safe and reported no issues that had affected patient safety. Most trainees confirmed that morning handover had consultant presence, although some felt their presence in morning handover to be variable.

2.15 Educational Resources (R1.19)

Not asked, no concerns raised in pre-visit information.

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

Trainers: Not asked, no concerns raised in pre-visit information.

All Trainee Cohorts: Trainees described UHA as a supportive environment. All trainees were aware of the wellbeing centres that had been set up during the 1st and 2nd waves of the COVID pandemic and those that had used them, spoke highly of them. The opportunities to engage with the wider multi-disciplinary team and ancillary staff such as porters was particularly valued.

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

Trainers: some trainers were aware of the local medical training improvement group, but none had attended it. Local Clinical Director (Victor Chong) provided updates to the trainers on what had been discussed at the group, at local management meetings.

All Trainee Cohorts: Trainees were aware of the local trainee forum and highlighted the work of their chief resident colleagues to raise any concerns they had with their training with local hospital management.

2.18 Raising concerns (R1.1, 2.7)

Trainers: Not asked. Not raised in pre-visit information.

All Trainee Cohorts: Trainees were aware of how to raise concerns and advised they would do so through their educational/clinical Supervisor, or more formal concerns through the Datix system. Feedback on concerns raised through Datix was variable.

2.19 Patient safety (R1.2)

Trainers: Trainers advised they were chronically understaffed at a substantive consultant level and this meant they were spread thinly across medicine. Despite this they felt they minimised patient safety issues as much as possible, often by cancelling out-patient workload to support in-patient work. Trainers felt a safe system was in place to manage boarded patients, when patients are being boarded the on-call team was involved to ensure they are appropriately boarded. The bed managers would then inform the second on-call contact, as to who is being boarded, who then had the ability to change the boarding plan, if they felt it was in-appropriate. Trainers felt that patients admitted to the CAU, would not wait extended periods of time to be assessed by a consultant, there was consultant presence on CAU from 8.00 am – 8.00 pm, any patients who were admitted after this time would be assessed the following morning during the morning ward round by a consultant. On rare occasions patients boarded out from CAU could possibly wait longer for assessment, but trainers were unaware of any occasions when this had happened recently.

All Trainee Cohorts: Trainees reported some concerns in regard to patients being moved from CAU to the wards before being reviewed by a consultant and of patients being left off the ‘boarders’ lists’ (with subsequent delays in review by consultants). This was highlighted to be an ‘occasional occurrence’.

Many trainees highlighted their concerns with regard to a lack of substantive consultant staffing in the hospital; this situation has been exacerbated by a recent additional consultant vacancy in Station 14.

Another potential concern was raised by several around a specific aspect of patient care that was discussed with the MD & DME following the visit.

Improvements had been made to the flow between the ED and CAU and instances of patients waiting long periods of time for assessment was now considered less of an issue than in previous visits. Some concerns were expressed about the appropriateness of boarding of patients at times.

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

Trainers: Trainers highlighted morbidity and mortality (M&M) meetings and advised that trainees would present cases for discussion at them. Learning from Datix incidents was discussed at M&M and learning from them would be collated into an e-mail and sent round the teams within Medicine.

All Trainee Cohorts: Trainees confirmed that M&M meetings took place every 2 – 3 months, although FY trainees appeared less aware than the other cohorts of when then took place. Most trainees could attend without difficulty and trainees were involved in presenting cases for discussion. Learning points from M&M were collated and distributed to everyone involved via e-mail. Trainees also confirmed that Datix was the method of reporting adverse incidents, although feedback to trainees involved in a Datix incident could be more variable, with some receiving feedback and others not receiving it. Trainees also highlighted ward safety huddles as a regular method of discussing any concerns.

2. Summary

Is a revisit required? (please highlight the appropriate statement on the right)	**Yes**	**No**	**Highly Likely**	**Highly unlikely**

The visit panel noted significant progress in some areas and that trainees were being provided with a mostly positive training experience. There remains ongoing challenges and discussion will take place between the Deanery and the GMC around enhanced monitoring status & conditions, following final

approval of this report. A further action plan update meeting will be co-ordinated to take place in October 2021.

Overall satisfaction scores were given by trainees:

Foundation Trainees: Scored between 4 – 8 (out of 10) with an average score of 6.5.

General Practice Trainees: Scored 7 out of 10.

Internal Medicine Trainees: Scored between 4 – 6 (out of 10) with an average score of 5.6

Specialty Trainees: Scored 9 out of 10.

Progress had been made against some of the previous visit requirements, although more work is required to address others. The visit panel has categorised previous visit requirements into addressed, progress noted, or little progress noted:

Req	Theme	Commentary
7.1	Concerning behaviours at the Radiology – Medicine interface must be addressed.	Addressed
7.2	The potential risks associated with a) patients being boarded out directly from CAU, and b) the additional risks from consequent delays in consultant assessment, must both be addressed	Progress noted. Visit panel heard from trainees that this was now less of a concern that previously highlighted but on occasion did still occur
7.3	OOH medical staffing must be reviewed to ensure doctors in training have a reasonable and manageable workload	Progress noted
7.4	A process for providing feedback to FY, CMT and GPSTs on their input to the management of acute cases must be established.	Little progress noted
7.5	Measures must be implemented to address the potential patient safety concerns associated with the lengthy delays between arrival and definitive assessment of patients within the ED and CAU departments, (more usually 4-6hours but reported to be up to 10 hours at times).	Addressed

Positive aspects of the visit:

- Culture of listening to the voice of doctors in training:
    - There is recognition that not everything is easy to fix, but there is active attention to resolve issues
    - Elements of this include the chief residents and the junior doctor forum
    - The recently introduced medical training Improvement group provides a more robust framework for addressing issues raised
- Access to learning opportunities:
    - The breadth of acute medical presentations
    - The provision of valued formal local learning opportunities, despite COVID.
    - The availability of local simulation training and opportunities to support development of procedural skills (formerly supported through a ‘procedures list’, now supported via the trainees’ WhatsApp group)
    - The scheduling of access to clinic opportunities by the Rota Co-ordinator, Janet Stephenson, albeit the numbers of clinics have been greatly reduced because of COVID
    - The availability of rooms and IT to access learning opportunities
- Provision of wellbeing centres during COVID to provide support to all staff including doctors in training
- Supportive substantive consultants
- Overall satisfaction scores high for most cohorts of doctors in training

Less positive aspects of the visit:

- The small number of substantive consultants, who are generally very supportive, are perceived to be spread very thinly; this raises potential concerns around the fragility of this training and patient care environment.
- The lack of feedback to doctors in training on their management of acute medical patients, which is a recurring issue
- Departmental induction providing greater clarity around roles, responsibilities and how things work could be enhanced by having a face to face component to add value to what is provided in the handbook
- A specific concern was discussed separately with the medical director and colleagues

4. Areas of Good Practice

Ref	Item	Action
4.1	Medical Training Improvement Group	N/A
4.2	The scheduling of access to clinic opportunities by the Rota Co-ordinator, Janet Stephenson, albeit the numbers of clinics have been greatly reduced because of COVID	N/A
4.3	Local simulation training and opportunities to support development of procedural skills (formerly supported through a ‘procedures list’, now supported via the trainees’ WhatsApp group)	N/A

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 regarding these items.

Ref	Item	Action

N/A

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	A process for providing feedback to FY, IMT and GPSTs on their input to the management of acute cases must be established.	24th September 2021	FY/GPST/IMT
6.2	There must be sufficient substantive consultant staff in 'medicine' to provide appropriate supervision and feedback to trainees and to support the safe care for patients.	24th September 2021	Trainers
6.3	Departmental induction must be provided to all trainees which ensures they are aware of all of their roles and responsibilities and feel able to provide safe patient care. Handbooks or online equivalent may be useful in aiding this process but are not sufficient in isolation	24th September 2021	FY/GPST/IMT/ST
6.4	The potential risks associated with a) patients being boarded out directly from CAU, and b) the additional risks from consequent delays in consultant assessment, must both be addressed	24th September 2021	FY/GPST/IMT/ST
6.5	An update on the progress of the agreed plan to follow through on the specific concern raised with the MD and colleagues must be provided.	24th September 2021	FY/GPST/IMT/ST