Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	10th May 2021	**Level(s)**	FY/GP/ST
Type of visit	Revisit	**Hospital**	Queen Elizabeth University Hospital
Specialty(s)	Obstetrics & Gynaecology	**Board**	NHS Greater Glasgow & Clyde

Visit panel	
Prof. Alan Denison	Visit Chair - Postgraduate Dean
Dr Alastair Campbell	Associate Postgraduate Dean – Quality
Dr Caithlin Neil	Training Programme Director
Dr Jenny Hanslip	Training Programme Director
Dr Alan MacKenzie	Trainee Associate
Mr Les Scot	Lay Representative
Ms Fiona Conville	Quality Improvement Manager
In attendance	
Ms Patriche McGuire	Quality Improvement Administrator

Specialty Group Information	
Specialty Group	Obstetrics & Gynaecology and Paediatrics
Lead Dean/Director	Professor Alan Denison
Quality Lead(s)	Dr Peter MacDonald & Dr Alastair Campbell
Quality Improvement Manager(s)	Ms Fiona Conville

Unit/Site Information		
Non-medical staff in attendance	4	
Trainers in attendance	7	
Trainees in attendance	5 x FY2, 7 x GPST, 9 x ST1-7	

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

Date report approved by Lead Visitor	17/06/2021

1. Principal issues arising from pre-visit review:

This department was first visited in 2015 following the opening of the new hospital. This was a positive visit with 6 requirements being set, addressed and closed off by the Obstetrics, Gynaecology and Paediatrics Specialty Quality Management Group (OGP SQMG).

In 2018, survey data showed a significant deterioration and a triggered visit was undertaken on 3rd of May 2019. It was clear the department had taken steps to address some of the issues raised however, a number of concerns remained. The 2 main areas of concern related to culture within the department and potential patient safety. Planned revisits to the department for May 2020 and March 2021 were postponed due to the COVID-19 pandemic.

An action plan update meeting was held with the Director of Medical Education (DME) and local training leads in March 2021. The department highlighted new initiatives to address the requirements which suggested there had been progress against the requirements set in the May 2019 visit:

Requirements:

- Measures must be implemented to address the patient safety concerns associated with the lengthy delays between patients being discharged from the post-natal ward and completion of the immediate discharge letter.
- Initial meetings and development of learning agreements must occur within a month of starting in post
- Ensure that service needs do not prevent trainees from attending clinics and other scheduled learning opportunities
- Lack of access to clinics for Foundation trainees and for GP trainees must be addressed to improve the training opportunities for these cohorts.
- Trainees must not be expected or requested to seek consent for a procedure they are not competent to do and not undertaking.
- The department must have a clear escalation policy where there is a general medical concern about a patient, which is understood and followed by all involved.
- A regular programme of formal teaching should be introduced appropriate to the curriculum requirements for FY2 and GP trainees.

- All staff must behave with respect towards each other and conduct themselves in a manner befitting Good Medical Practice guidelines.
- Feedback to trainees on their input to the management of cases must be constructive and meaningful, not critical, particularly during handover.
- The department must ensure that there are clear systems in place to provide supervision, support and feedback to trainees working within the post-natal ward.
- Trainees must know who to contact for support at all times, especially within the post-natal ward
- There must be a process that ensures trainees understand, and are able to articulate, arrangements regarding Educational Governance at both site and board level.
- Trainees must receive feedback on incidents or concerns that they raise.

The visit commenced with Dr Vanessa Mackay delivering a detailed presentation to the panel which provided an update regarding progress against the previous visit requirements, along with the findings and action plan arising from a recent department survey.

2.1 Induction (R1.13):

Trainers: Trainers told us that all trainees receive induction to the site. We were told that trainees who could not attend the main induction were met separately and taken on a tour of the department. Prior to starting the role trainees are sent an induction pack which details their roles and responsibilities. Trainees are also encouraged to download the hospital app.

FY2: Trainees told us that they all received induction, except for those who had started on nights. We were told that follow up induction was not provided for trainees who could not attend. Trainees received an induction pack containing departmental information. We were told that this was received the night prior to starting in the unit. We were told that timely IT access and systems training was not provided to every trainee who had not worked within the health board previously. Trainees said a specific ward induction would be beneficial as the roles and responsibilities for each ward can vary.

GP: Almost all trainees told us they received a departmental induction, although none received a site induction. Trainees said the induction was comprehensive and included a tour of the department and

roles and responsibilities. Suggestions to further enhance the induction included providing more clinical content, such as common obstetric presentations.

ST: Trainees told us they received a virtual full day induction via MSTeams. This included a tour of the department and presentations from a range of department leads. Induction was comprehensive and trainees felt well prepared for their role.

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

Trainers: Trainers acknowledged the challenges of providing interruption-free training. The reasons included staff shortages on the junior rota. Teaching sessions take place at lunch time and are recorded using MS Teams which allows trainees to access the sessions at a more suitable time. At induction, trainees are encouraged to attend regional teaching sessions and asked to be proactive in contacting the rota coordinator to arrange. Trainers reported that they have reintroduced the daily 'What matters to me' discussion which allows them to facilitate trainee learning needs. They advised that they discuss trainee learning needs with each cohort and try to tailor the timetable accordingly. The panel were informed there are plans to provide a Greater Glasgow and Clyde local teaching program however, this is still at the planning stage.

FY: The trainees interviewed had been in post since 7th April 2021. They reported receiving on average 1 hour per week of locally delivered teaching which was not protected. Trainees said the delivery of teaching on MS Teams made social distancing challenging. A lack of IT infrastructure meant that multiple trainees had to share a single computer to join teaching, rather than being able to log in individually. They told us that it would be beneficial for future cohorts if certain teaching topics such as 'Maternity assessment unit – common presentations' were scheduled closer to the trainee start date.

GP: Trainees reported that there had been a recent change to the clinical teaching program and that after providing feedback, a weekly teaching session is now delivered at Tuesday lunchtimes. GP trainees can attend these sessions, although we heard that service pressures or rota allocations could limit attendance. We heard that teaching is of a good standard and that it was relevant to their curricula. The majority, of trainees were able to attend their regional teaching.

ST1-7: Trainees reported a historical lack of structured teaching which has now been addressed with the introduction of monthly trainee-led sessions. Teaching is scheduled on a Friday afternoon and is not protected. Attendance at the sessions has been variable. Trainees described service pressures and rota allocations as the main barrier to attending sessions. The teaching program is organised by trainees, who told us that it would benefit from consultant input. Other teaching opportunities are available such as:

- Cardiotocography (CTG)
- Journal club
- Early pregnancy
- Fetal medicine

To address the limited gynaecological operating exposure due to COVID, regular simulation teaching has been delivered and is scheduled into the ST1-2 trainees rota.

Trainees told us that regional teaching is now recorded via MS Teams, which has increased trainee accessibility for later viewing. This is delivered on a Friday afternoon live attendance can be difficult.

2.3 Study Leave (R3.12): Not covered. 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):

Trainers: We were told that prior to trainees starting in post a list is sent to all educational supervisors detailing their trainees for the block. Trainers are reminded they should have an initial, mid-point and end meeting. At induction trainees are asked to organise the initial meeting with their educational supervisor within 4-6 weeks of starting. College tutors check if this has been actioned via the E-portfolio for specialty trainees. The panel were advised of plans to split the pastoral care of GP and FY trainees.

All trainees: All trainees had been allocated educational supervisors. Almost all had met with them and agreed learning plans.

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 said that the escalation policy is detailed at induction and reiterated during the first educational supervisors meeting. There are plans to produce laminated forms detailing consultant leadership roles and responsibilities which will be displayed in the junior doctors room. Trainers reported they were not aware of any instances where a trainee had been left to cope with a situation beyond their competence. They said that the burden of weekend workload for trainees on the junior tier was an ongoing concern.

FY: Trainees said they knew who to contact for support both during the day and out of hours and told us they had not had to cope with situations beyond their competence.

GP: Trainees told us they always felt well supported by their senior colleagues and described them as friendly and approachable. They had not had to work beyond their level of competence and reported no instances when they were required to do so. Trainees described a lack of clarity around the escalation policy and told us it was sometimes unclear which consultant was on call, both at ward level and by hospital switchboard.

ST1-7: Trainees reported that they generally know who to contact for supervision both during the day and out of hours. None of the trainees told us they had to cope with a situation beyond their competence. ST2 trainees advised they were well supported when transitioning to the more senior on-call rota.

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

Trainers: Trainers confirmed that they are made aware of the various curricula requirements for specialty trainees via the RCOG. The department plans to split pastoral care of FY and GP trainees to help ensure a better understanding of the needs of these trainees.

Junior doctors have a clinic week scheduled into their rota providing them the opportunity to attend various clinics, theatres and specialist services that they find most useful to their learning. Trainers said that clinic weeks may be pulled to provide clinical care when there are shortages on the rota.

For specialty trainees, we were told that the department tries to tailor learning opportunities to grade of training. ST2 trainees are fully supported through the transition to the senior on call rota. Due to the pandemic, there has been limited operating exposure for trainees. To help address this, the department have a laparoscopic simulator which allows trainees to gain competencies. ST1-2 trainees have scheduled time in their rota to complete modules. Trainers described other competencies they thought trainees may struggle to achieve which included high risk obstetric cases.

Trainers told us trainees have access to a broad range of experiences within the department and have the opportunity, to further enhance learning opportunities through various departmental meetings and quality improvement projects.

FY2: The FY trainees interviewed noted that due to the timing of this post the majority, of competencies had already been achieved in preparation for their upcoming ARCPs. Trainees told us that while they have a scheduled clinic week on their rota, this would be the first activity to be pulled should there be staff shortages or an increase in clinical pressure. Trainees said they did not routinely participate in the management of acutely unwell patients as in most cases, the registrar is the first point of contact. They told us that this reflected the nature of the specialty. All described a lot of their time being spent on non-educational tasks such as completing IDLs and prescriptions, covering pre-op assessment clinics for gynaecology, and a 6am gynaecology phlebotomy round.

GP: Trainees told us they have a scheduled clinic week. However, the majority were unable to attend clinic sessions because of service pressures. Trainees estimated that around 95% of their work is carrying out tasks with little or no educational benefit. It was noted that when medical students are on site, trainees have limited opportunities and that educational priority is given to students. Trainees told us their senior colleagues are keen to train and will highlight opportunities for them where possible. At weekends, they told us that the workload is unmanageable.

ST1-7: Trainees described the impact of COVID on their learning opportunities including operating exposure. Priority has been given to more senior trainees who require competencies signed off at ARCPs. The burden of covering antenatal clinics and on-call arrangements significantly impacts the ability of trainees to attend other clinics. Trainees raised concern over a perceived disparity in allocation for those attending day surgery with some trainees attending 3 times per week compared to

others at once per month. The trainees told us that the junior rota does not support the acquisition of learning outcomes at ST1 level.

Trainees raised concerns with the limited learning opportunities whilst working in the antenatal clinics, which were described, as being consistently overbooked.

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

Trainers: Trainers reported that there are no problems for trainees completing their assessments.

FY: Trainees stated that in general they were able to complete Workplace Based Assessments (WPBAs) and have them signed off easily. The majority, of assessments were completed by ST trainees who were always supportive and keen to offer opportunities.

GP: GP trainees told us they are supported to complete their assessments by the ST trainees. On occasions, where the registrar is not senior enough to sign off the assessment, there was an agreement in place that allowed case discussion with a consultant for sign off.

ST1-7: Trainees reported that they have no issues completing their WPBAs.

2.8 Adequate Experience (multi-professional learning) (R1.17): Not covered, no concerns raised in pre-visit information

2.9 Adequate Experience (quality improvement) (R1.22): Not covered, no concerns raised in pre-visit information

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: We were told that the recent departmental survey suggested that trainees were not comfortable on receiving constructive criticism in open forums such as handover, ward rounds and staff meetings. Acknowledging the importance of providing feedback in a positive way, we heard that the department will be running Civility Saves Lives courses and are considering splitting the obstetrics

and gynaecology handovers which would allow a smaller forum for sensitive feedback delivery. The labour ward utilises a STAR system which allows staff to record when something has gone well. This is shared within the department.

FY: Trainees said they have had limited day to day feedback and reported the administrative burdens of their role can mean they do not see patients on a daily basis.

GP: Trainees reported that they do not routinely receive day to day feedback. Some trainees noted that if they requested feedback from their registrar this would be provided.

ST1-7: Trainees reported that they receive regular, informal feedback from more senior registrar trainees and midwifery/nursing staff. Consultant feedback was described as variable. Trainees reported that individual feedback can often be delivered in a group scenario such as handover. This could sometimes come across as intimidating and more negatively than intended. Trainees also stated that negative feedback has also been provided via group email. This was described as an unproductive way of addressing issues.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: Trainers said they receive feedback from trainees via internal surveys, the chief resident and by creating an open-door policy in which trainees may raise concerns verbally at any time.

FY: FY trainees told us they were asked to complete the departmental survey 2 days after starting in the post. Therefore, their ability to provide relevant information was limited. A new initiative to identify a learning objective for the shift has been introduced at morning and evening handovers and trainees are now asked ‘What matters to me’. Trainees advised this was in its early stages was a positive development and that more consultant input would be helpful.

GP: Trainees reported they had the opportunity to feedback concerns via the department survey which was ran by a registrar trainee.

ST1-7: Trainees advised that over the past few months trainers have actively sought feedback both informally and through the departmental survey.

2.12 Culture & undermining (R3.3)

Trainers: Trainers described known concerns regarding trainees having experienced undermining behaviour at handover, via email, during case discussions and instances of a trainee's conduct being openly discussed on the wards. To help address the issues the trainers reported that they have recently recommenced the Promoting Positive Culture group. There are also plans to remotely run the Civility Saves Lives awareness day in June 2021, with a follow up face to face workshop later in the year. At induction, trainees are informed how to report any bullying or undermining concerns and are encouraged to raise any issues with the bullying and undermining champions. Trainers operate an open-door policy which they hope would allow trainees to raise concerns with any member of staff. The department utilises the 'Greatix' and learning from excellence systems to help promote positive working environment.

FY: Trainees reported that they receive excellent support from the registrar trainees. They have limited interaction with the consultants but noted on the occasions they do work together the consultants are keen to teach if time permits. Trainees told us that they were informed at induction that there is a culture of undermining within the department. Trainees provided multiple examples of witnessing inappropriate conversations between midwifery and nursing staff regarding doctors in training. Trainees told us they would raise any concerns through their educational supervisor although noted some to be more approachable than others.

GP: Trainees said that when working alongside consultants, the support they receive is satisfactory and reported that some consultants are keen to improve their training. However, trainees also described a 'toxic' culture within the department, particularly on wards 48 & 49. Trainees reported instances where they have been threatened to be reported via 'Datix' should they not complete tasks as requested. The panel were advised that trainees had experienced and witnessed behaviour that had undermined their confidence, performance or self-esteem.

ST1-7: All trainees stated they worked in a generally supportive environment with approachable consultants. However, they described unproductive interactions at some handovers which had undermined and at times intimidated trainees. Trainees were aware they could raise concerns through the undermining and bullying champions or their educational supervisors. Despite

acknowledging a positive response to recent feedback, they told us that the current procedures in place were not robust enough to adequately ensure a trainee's anonymity when raising concerns.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Trainers confirmed that they try to tailor the rotas to enhance learning opportunities specific to the trainee's curriculum. Recent gaps on the junior rota were pro-actively managed, although a rota gap remains. In instances of covering short notice gaps, trainees will be asked to cover with the option of receiving additional pay or time in lieu.

Trainers described and acknowledged the circumstances of junior trainees regarding their workload at the weekends. They told us that this is currently under review.

FY2 & GP: Trainees were aware of gaps in their rota, some of which had been filled by locum trainees. They told us there was ambiguity around the cover of 'long' day shifts as this is not marked on the template rota. Trainees told us they do not receive the confirmed rota in a timely manner. All trainees were concerned that the high volume of workload at weekends was significantly affecting their wellbeing. Trainees had concerns regarding potential patient safety arising from the intensity and scale of weekend working. Trainees described weekend working as exhausting and unmanageable.

ST1-7: Trainees were aware of vacancies on their rota. They told us they were concerned over the consistency of their rota and reported that they do not receive confirmation of their day to day rota in advance. They appreciated the effort from trainers to provide training opportunities alongside a clinically demanding rota. Trainees described episodes of burnout and feeling overwhelmed by their workload.

2.14 Handover (R1.14):

Trainers: Trainers reported that during the pandemic the junior tier of doctors were not included in handover to allow adequate social distancing. This has now been rectified. We were told that handover takes place twice per day and provides safe continuity of care for all patients.

FY: Foundation trainees raised a concern that no junior doctors attend handover from downstream wards and they felt this could lead to a potential patient safety concern.

GP: Trainees stated that they now participate in the main handover which had been restricted at the beginning of their placement due to Covid restrictions.

ST1-7: Trainees reported that they found the joint handover of obstetrics and gynaecology challenging. They advised it would be beneficial to have these split and ensure that they remain multi-disciplinary. Trainees reported handover to be safe. Trainees stated that it was not always clear who the, consultant on call was.

2.15 Educational Resources (R1.19):

All Trainees: Each cohort of trainees reported a lack of educational resources available which included slow computers, not enough computers, and a lack of space to complete administrative tasks on wards.

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

All Trainees: Trainees said support was available for trainees who were struggling, and the panel were given several examples where reasonable adjustments were made for trainees. The panel were informed the site is very supportive of less than full time working (LTFT).

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

FY2: Trainees advised that previously raised concerns regarding the intensity of workload at the weekend and undermining throughout the unit had not been adequately addressed. Very few trainees were aware of the chief resident within the department.

GP: Trainees would raise concerns regarding the quality of their education through the chief resident or their educational supervisor.

ST1-7: Trainees reported multiple avenues to raise concerns over their education or training which included:

- Chief resident
- College tutor
- Consultant on call
- Educational Supervisor

2.18 Raising concerns (R1.1, 2.7):

Trainers: Trainers reported that they encourage trainees to raise patient safety concerns during their induction. If the concern is immediate, trainees are encouraged to follow the escalation policy and to complete a Datix form.

2.19 Patient safety (R1.2)

Trainers: Trainers said the department provides a safe environment for patients.

Trainees: Trainees told the panel that the department provided a safe environment for in-patients. However, trainees raised concerns over the overbooking of antenatal clinics, weekend workload for junior and a lack of consultant continuity on the gynaecology ward which could result in the changing of patient management plans.

2.20 Adverse incidents & Duty of Candour (R1.3 & R1.4) Not covered, no concerns raised in pre-visit information

2.21 Other

We noted that all trainee groups often used the term “SHO”. It appeared that this term is in common usage throughout the department. Trainees told us this term appeared on Ward notice boards.

Trainees were asked to rate their overall satisfaction experience of working within the department from a range of 0 (very poor) to 10 (excellent). The scores are listed below:

- Foundation – Range 4-6 Average 5
- General Practice – Range 2-7 Average 4.5
- ST1-7 – Range 4-9 Average 6.7

3. Summary

Is a revisit required?	Yes	No	Highly Likely	Highly unlikely

The visit panel noted the ongoing commitment of both the clinical lead and clinical director at the site in improving the educational environment for trainees. This included undertaking a survey in the weeks before the visit, describing in detail the results to us, acknowledging the challenges, and clearly presenting a plan to address issues. The visit team also noted the significant numbers of consultants and senior staff who attended and contributed to the visit.

The visit panel found serious concerns relating to workload and significant concerns regarding culture and post graduate teaching. The panel noted that the department has already identified these issues and constructed an internal action plan to address them.

We look forward to reviewing the formal action plan with a view to returning for a revisit in 9-12 months with an interim progress meeting with the DME team.

The positive aspects of the visit were:

- The department and DME team are very engaged in acknowledging and addressing the issues raised through a recent trainee survey and have a developed and begun to implement an action plan to address these areas of concern.
- Excellent turn out from the Consultant body, signalling a collective desire to improve the training environment.
- Creating good practice by committing to/providing Civility Saves Lives and Bystander training
- Considerable effort now being made to provide teaching to all grades of junior staff
- Undergraduate teaching and learning is strongly valued and well received

- Excellent and consistent support to junior staff from registrars and consultants. Senior staff are always accessible when needed.
- Clinical supervision is effective across trainee groups.
- Good support of trainees with needs for reasonable adjustment including LTFT
- Laparoscopic simulation training is incorporated into the rota for ST1-2 trainees

The less positive aspects of the visit were:

Culture

- Examples of non-medical staff treating trainees inappropriately including using disparaging comments and using Datix reporting as a threat.
- Handover is sometimes conducted in a way which is not conducive to learning and a healthy workplace culture
- Persistent reference to the SHO grade by all groups of trainees

Workload

- The weekend workload is exceptionally intense for junior tier trainees, with an adverse impact on their health and wellbeing, and a risk for patient safety
- Rota concerns – Examples of trainees receiving their weekly rota late.
- Trainees were not always clear who the consultant on call was
- The quality and timeliness of delivery of induction was variable
- Antenatal clinics are very busy, impacting on their suitability as a training environment

Teaching

- The IT teaching infrastructure is unsuitable which makes social distancing challenging
- The balance between service and training is challenging for the trainees
- Feedback is effective from peers but inconsistent from senior staff

Review of previous requirements from 2019:

Ref	Visit requirement from 2019	Progress in 2021 visit
7.1	Measures must be implemented to address the patient safety concerns associated with the lengthy delays between patients being	Addressed

	discharged from the post-natal ward and completion of the immediate discharge letter.	
7.2	Initial meetings and development of learning agreements must occur within a month of starting in post	Addressed
7.3	Ensure that service needs do not prevent trainees from attending clinics and other scheduled learning opportunities	Partially met see 6.2
7.4	Lack of access to clinics for Foundation trainees and for GP trainees must be addressed to improve the training opportunities for these cohorts.	Partially met see 6.3
7.5	Trainees must not be expected or requested to seek consent for a procedure they are not competent to do and not undertaking.	Addressed
7.6	The department must have a clear escalation policy where there is a general medical concern about a patient, which is understood and followed by all involved.	Addressed
7.7	A regular programme of formal teaching should be introduced appropriate to the curriculum requirements for FY2 and GP trainees.	Partially met see new requirement 6.5
7.8	All staff must behave with respect towards each other and conduct themselves in a manner befitting Good Medical Practice guidelines.	Ongoing see 6.6
7.9	Feedback to trainees on their input to the management of cases must be constructive and meaningful, not critical, particularly during handover.	Ongoing see 6.7
7.10	The department must ensure that there are clear systems in place to provide supervision,	Partially met see 6.8

	support and feedback to trainees working within the post-natal ward.	
7.11	Trainees must know who to contact for support at all times, especially within the post-natal ward	Partially met see requirement 6.4
7.12	There must be a process that ensures trainees understand, and are able to articulate, arrangements regarding Educational Governance at both site and board level.	Addressed
7.13	Trainees must receive feedback on incidents or concerns that they raise.	Addressed

4. Areas of Good Practice

Ref	Item	Action
4.1	The use of MS Teams to record training sessions which can be accessed later by trainees.	
4.2	Laparoscopic simulation training has been scheduled into the ST1-2 trainees rota.	
4.3	Reintroduction of the Promoting Positive Culture work group.	

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	Workload	The antenatal clinic staffing and workload should be reviewed.
5.2	Trainee Engagement	The department should publicise the identity and function of the chief resident to all grades of trainees
5.3	Adequate Experience	Consideration should be given to ensure learning opportunities for FY and GP doctors are not compromised when hosting medical students.
5.4	Adverse Incidents	Trainees should not be threatened with the use of Datix as a performance management tool.

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	Weekend trainee medical staffing must be reviewed to ensure doctors in training have a reasonable and manageable workload and that patient safety is safeguarded	3 months	All
6.2	The department should ensure that service needs do not routinely prevent trainees from attending clinics and other scheduled service-based clinical learning opportunities	6 months	All
6.3	Access to clinics for Foundation and GP trainees must be reviewed to optimise the training opportunities for these cohorts.	6 months	FY/GP
6.4	The department should ensure that the on-call consultant can be clearly identified by trainees	6 months	All
6.5	Arrangements for on call teaching programmes should be reviewed and monitored to maximise attendance by/accessibility to trainees.	6 months	All

6.6	The Board must ensure that staff (including non-medical staff) behave with dignity, respect, care and compassion towards each other	6 months	All
6.7	Feedback to trainees on their management of cases must be constructive, timely, objective, and meaningful, and delivered in an appropriate environment, particularly during handover.	6 months	All
6.8	The department must ensure that there are clear systems in place to provide supervision, support and feedback to trainees working within the post-natal ward.	6 months	FY/GP
6.9	A process must be put in place to ensure that any trainee who misses their induction session (hospital or departmental) is identified and provided with an induction.	6 months	All
6.10	The department must ensure that references to “SHOs” and “SHO Rotas” cease.	6 months	All
6.11	The Board must review the IT provision available to doctors in training such that they can access appropriate core teaching and learning materials.	6 months	All
6.12	The Department must ensure that Rotas are issued to trainees in a timely manner, usually 6 weeks in advance.	6 months	All