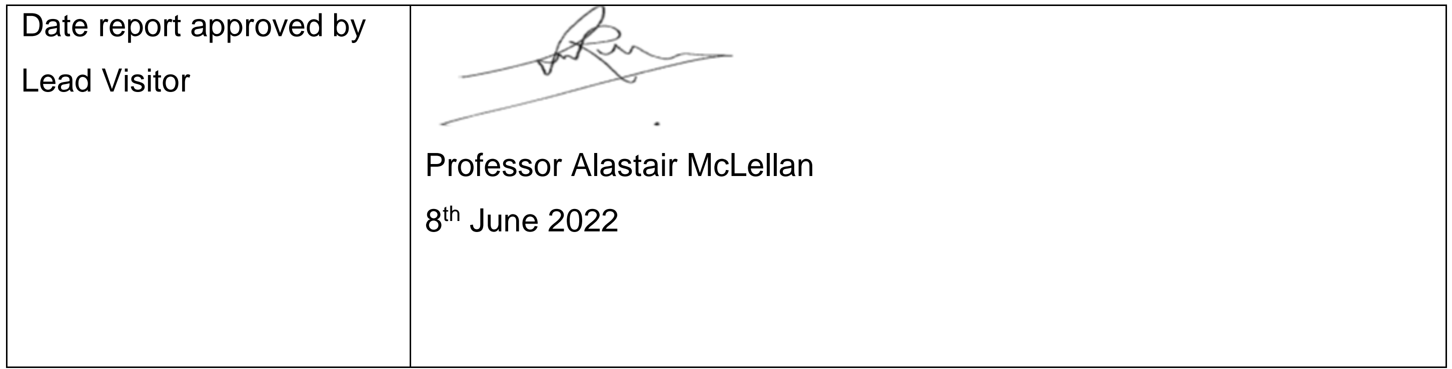
Scotland Deanery
Quality Management Visit Report

Date of visit	26th May 2022	**Level(s)**	FY/GPST/IMT/ST
Type of visit	Enhanced Monitoring	**Hospital**	University Hospital Crosshouse
Specialty(s)	General Internal Medicine	**Board**	NHS Ayrshire and Arran

Visit panel	
Professor Alastair McLellan	Visit Chair - Postgraduate Dean
Kate Bowden	Principal Education QA Programme Manager
Dr Marie Cerinus	Lay Representative
Dr Greg Jones	Associate Postgraduate Dean – Quality
Dr Jane Dymott	Foundation Programme Director Representative
Dr Corrine Coles	General Practice Representative
Dr Sonul Gajree	Trainee Associate
Alex McCulloch	Quality Improvement Manager
In attendance	
Claire Rolfe	Quality Improvement Administrator

Specialty Group Information	
Specialty Group	Medicine
Lead Dean/Director	Professor Alastair McLellan
Quality Lead(s)	Dr Alan McKenzie Dr Greg Jones Dr Fiona Drimmie
Quality Improvement Manager(s)	Alex McCulloch
Unit/Site Information	
Non-medical staff in attendance	N/A

Trainers in attendance	17									
Trainees in attendance	FY1 – 9	FY2 – 2	GPST – 1	BBT – 1	IMT - 9	ST - 4				
Feedback session: Managers in attendance	Chief Executive		DME	✓	ADME	✓	Medical Director	✓	Other	Assistant Medical Director, General Managers and Clinical Directors

Date report approved by Lead Visitor	 Professor Alastair McLellan 8th June 2022

1. Principal issues arising from pre-visit review:

University Hospital has been on a re-visit cycle with the deanery since 2015, it was escalated to the GMC Enhanced Monitoring process in September 2021 following the last deanery re-visit in June 2021. The GMC had concerns in relation to the site not meeting training requirements for the following GMC standards/requirements:

S1.1 - The learning environment is safe for patients and supportive for learners and educators. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers, and families.

R1.8 - Organisations must make sure that learners have an appropriate level of clinical supervision at all times by an experienced and competent supervisor, who can advise or attend as needed. The level of supervision must fit the individual learner's competence, confidence, and experience.

R1.12 - Organisations must design rotas to provide learning opportunities that allow doctors in training to meet the requirements of their curriculum and training programme.

R1.15 Organisations must make sure that work undertaken by doctors in training provides learning opportunities and feedback on performance and gives an appropriate breadth of clinical experience.

At the June 2021 visit, 13 requirements were identified and included in the visit report. Some of these requirements were also identified in the 2019 deanery visit.

- Those providing clinical supervision must be supportive of trainees who seek their help and must never leave trainees dealing with issues beyond their competence or 'comfort zone'.
- Staffing levels must be reviewed to ensure that workload is appropriate for safe quality care and does not prevent access to learning opportunities including outpatient clinics, in order for trainees to meet the requirements of their curriculum.
- Measures must be implemented to address the perceived patient safety concerns described in this report in relation to COTE & CAU.

- There must be robust arrangements in place to ensure the tracking of all boarded patients. In addition, for boarded patients, there needs to be clarity which Consultant and clinical care team are responsible, how often patients are reviewed and what the escalation policy is.
- Handover of care of patients transferred from CAU to downstream wards including to boarding wards must be introduced to support safe continuity of care and to ensure unwell patients are identified and prioritised.
- Measures must be implemented to address the patient safety concerns associated with the lengthy delays between arrival and definitive assessment of GP referrals as soon as possible. [Requirement 7 from 2019 visit report]
- Departmental induction must be provided for all departments including the CAU which ensures all trainees are aware of all of their roles and responsibilities and feel able to provide safe patient care. [Requirement 9 from 2019 visit report]
- All trainees must have timely access to IT passwords and system training through their induction programme. [Requirement 8 from 2019 visit report]
- The burden of tasks for all cohorts of doctors in training that do not support educational or professional development and that compromise access to formal learning opportunities must be significantly reduced.
- A process for providing feedback to doctors in training on their input to the management of acute cases must be established. [Requirement 5 from 2019 visit report, note slight re-wording]
- There must be a clear escalation policy which is understood and followed by all involved for trainees managing patients referred via pager no 3850. [Requirement 4 from 2019 visit report]
- FY1 trainees in medical specialties must have opportunities to clerk and assess acutely unwell patients during ward rounds and to receive constructive feedback on their contributions to add learning to their experience.
- The department must increase relevant training opportunities for GP trainees.

The visit team reviewed progress against the previous visit requirements and also took the opportunity to gain a broader picture of how training is carried out within the department visited to identify any points of good practice for sharing more widely. The visit team would like to thank Dr Phil

Hodkinson for the informative presentation he provided, giving an insight into progress against previous visit requirements that he delivered in the management session.

2.1 Induction (R1.13):

Trainers: Not covered.

All Trainee Cohorts: Most trainees had received site induction, although 2 or 3 trainees who had started out of synch with their colleagues on night shifts didn't receive site induction. Most trainees had received departmental induction and felt it was thorough. The trainees again highlighted difficulties in receiving their usernames and passwords for IT systems and a few commented it took a few days to get this resolved, although this was an issue for some trainees it was less of a problem than in the 2021 visit.Trainees appeared unaware of what role cards were.

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

Trainers: Trainers advised that some teaching was planned into the trainee's rota, such as the IMT bootcamps. If trainees could provide adequate notice of regional/programme teaching these sessions could also be planned into the rota in advance. The local hospital teaching programme has been in abeyance so far this training year due to COVID related service pressures, but plans were underway to re-instate the programme. Various departmental teaching programmes were highlighted including Acute Internal Medicine which took place weekly on a Thursday and was recorded for trainees to watch it they couldn't attend in person. Some teaching was now taking place again in person, but most sessions were still being conducted virtually through MS Teams.

Foundation Trainees: FY1 trainees said they got to around 1 hour of teaching per week and protected time was provided for them to attend. Access for FY2 trainees was more limited and they noted difficulties with getting to teaching due to workload on the wards. FY2s had raised concern about not being able to attend FY2 programme teaching and were given days 2.5 days of study leave back to watch the recorded sessions.

General Practice Trainees/Broad-Based Trainees/Internal Medicine Trainees: Trainees described their ability to get to teaching as minimal with no-one achieving even one hour per week.

Provision was variable with some departmental teaching available in Acute Medicine, Renal, Cardiology, Infectious Diseases and Care of the Elderly. Teaching sessions were typically organised by clinical teaching fellows – some teaching provision lacked senior support and input. Access was limited because of workload and staffing. There was no hospital-wide teaching.

IMTs advised there was variation in who got to attend the IMT national teaching programme with some trainees being able to access through study leave via the rota coordinator while others were not. GPSTs reported being able to attend their monthly regional teaching sessions. BBTs were able to access regional/national teaching sessions.

Specialty Trainees: Trainees reported they could access local teaching for around 1 hour per week in Acute Medicine and Cardiology and noted the Respiratory Medicine teaching programme had been re-instated in the past week after a pause due to COVID pressures. Teaching had been delivered on MS Teams and some sessions had just started to be delivered in person again. Attendance at regional programme teaching ranged from <50% to ~75% of sessions.

2.3 Study Leave (R3.12) – Not asked.

2.4 Formal Supervision (R1.21, 2.15, 2.20, 4.1, 4.2, 4.3, 4.4, 4.6) – Not asked.

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 trainees should be able to get support from consultants who were in charge of their wards and it was clear on the rota who they were, this was the same for on-call support for trainees whilst working out of hours. Handover in the High Dependency Unit (HDU) which was flagged in previous visits, was now led by the HDU consultant to bring structure and clarity to it. The trainers told us the rotas were now available to view online on Rota Watch and were regularly monitored to ensure senior cover was provided at all times.

Foundation Trainees: Trainees said they could get senior support both during the day and in the out of hours period. FY1 trainees were more supported than their FY2 colleagues and trainees highlighted concern with regard to senior support in ward 5D, which left them as the only doctor on

the ward on occasions. The trainees confirmed that this had been raised with hospital managements, who were actively involved in trying to resolve the trainee concerns.

General Practice/BBT/IMT trainees: Trainees were aware who to contact for support both during the day and when working out of hours. Staffing challenges occasionally presented difficulties with accessing ‘registrars’ . The on-call medical consultant was on-site until 8:00 PM and IMT3s would stay beyond their shifts to help out at times. Only rarely had there been difficulty accessing a consultant out of hours. In general, consultants were noted to be very approachable and accessible.

Specialty Trainees: Trainees said they were aware of who to contact for support both during the day and whilst working out of hours and raised no concerns in regard to Clinical Supervision. Trainees felt their consultant colleagues were very supportive.

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

Trainers: Trainers advised they had recently started collecting data around trainee attendance at clinics using dictation software and so far, had collected around 4 months of data but data collection had been suspended because of COVID. In some specialties such as Gastroenterology clinics were planned into the rota and efforts were made to allow trainees to attend. Trainers said they recognised the importance of clinics (particularly for IMTs) and hoped that with services less affected now by COVID that it would increase clinic opportunities for trainees. Trainers felt that the challenges posed by COVID had reduced training opportunities due to the need for social distancing but again highlighted the efforts being made to re-instate them.

Foundation Trainees: Trainees did not feel there were any particular learning opportunities that were difficult to get. For the most part they had not been to any clinics. Trainees said they majority of their day was spent completing tasks that they considered to be non-educational for around 75 – 90% of their working week. Although trainees felt their rotations were sufficiently long overall, they reported they were frequently moved from their base wards and around other wards. As an illustration one reported they had rotated round 3 different specialty wards in one week; another estimated they had only spent around 1.5 weeks in their base ward so far in their current rotation.

Opportunities for FY1s to clerk acute medical patients had been introduced to provide more exposure to acutely unwell patients. These trainees had managed to get onto post-receiving wardrounds in the morning to receive feedback on their input.

General Practice Trainees/BBT Trainees/IMT Trainees: Trainees had very little access to clinics and described them as being very difficult to get to with further reduction in opportunities because of the COVID pandemic. Trainees estimated that since the start of their posts in August they had been to between 0-8 clinics. One trainee starting in April had managed to attend one clinic, while the rest had not been too any clinics. The renal department and the IM ICU post offered greatest potential to access clinics. GPSTs had not managed to attend clinics or equivalent opportunities.
Trainees were unaware of plans to record clinic attendance.

Trainees felt they had good exposure to acutely unwell patients but also highlighted that a significant proportion of their time (50 – 60% of their working week) was spent carrying out what they considered to be non-educational tasks. Trainees highlighted manual blood forms as taking up a significant amount of time to fill out and estimated they could spend around 1.5 hours a day completing them. Trainees reported discontinuity of their ward work and that were often not in wards long enough to form relationships with trainers causing problems with getting assessments done, as they often didn't meet with a consultant in the wards they were moved to; one trainee estimated they had only worked in their base ward for 9 or 10 days since starting their rotation.

There is a GP (training) champion who advocates for training relevant to GPSTs on behalf of this cohort.

Specialty Trainees: Trainees described variable access to clinics, with some able to access limited numbers of available clinics. Trainees felt they spent a significant amount of time completing non-educational tasks.

They noted that opportunities to progress internal medicine learning were limited through lack of access to consultant presence for feedback, noting that their internal medicine experience was largely unsupervised. By contrast though, by providing senior cover to the back of the hospital that included cover to the HDU there were more opportunities to get feedback from consultants in that setting. On

the general wards they tended to do ward rounds independently of consultants with limited opportunities to feedback to inform their learning.
The posts did offer Group1 specialty trainees the opportunity to progress some specialty training for example Respiratory Medicine trainees had access to a bronchoscopy session each week, Acute Medicine trainees had protected time for training in point of care ultrasound and the ability to access some cardiology clinics, Cardiology trainees had access to two days per month in the catheter lab and cardiac pacing sessions and one day per month in echocardiography.

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

Trainers: Trainers felt trainees could get workplace-based assessments completed and signed off, although they acknowledged some such as Acute Care Assessment Tools (ACATs) could be difficult.

All Trainee Cohorts: Trainees said access to Workplace Based Assessments could be an issue, made more difficult because of the discontinuity of the wards in which they were working.

2.8 Adequate Experience (multi-professional learning) (R1.17) – Not asked

2.9 Adequate Experience (quality improvement) (R1.22) – Not asked

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: Trainers felt improving feedback opportunities for trainees had been difficult to implement, attempts had been following previous visit to engage with the trainee cohorts and opportunities were created in post night shift ward rounds for trainees to receive feedback. Trainers said engagement by trainees had been variable and they had tried various methods to encourage attendance with limited success so far, some trainers had been to other units in Scotland to see how they provide feedback to try and improve opportunities for trainees.

All Trainee Cohorts: Most trainees felt feedback on their clinical decisions was variable and was better in some ward areas such as in Renal and the Stroke Units than in others. FY1s did manage to get some feedback on their clerk-ins on the morning post-receiving ward rounds. Access to feedback on the clinical management of acutely unwell patients the post-Foundation trainees had managed

overnight was difficult. Some reported their perception that this wasn't the right time for them to be receptive to feedback (after heavy overnight shifts), others reported being turned away because they weren't on the right ward round in the right zone. The acute medicine consultants had made efforts to work on delivery of feedback with some success. Access to feedback on the downstream words was also difficult because of discontinuity and because of the need to do ward rounds independently of consultants.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: Trainers highlighted the local Chief Resident as very active in organising a trainee forum, although attendance amongst the trainee cohorts had been very limited. Trainers advised they had 2 Chief Residents up until February and the 1 remaining Chief Resident liaised with trainees over their concerns and would bring them back to trainers and senior medicine management to discuss, the main concerns that trainees had raise recently were in relation to staffing.

Foundation Trainees: Trainees were unaware there was a trainee forum and were also unaware of who their Chief Resident was. They did mention that it may have been covered in induction but were now unsure of who the were.

General Practice Trainees/BBT Trainees/IMT Trainees: Trainees were aware there was a local trainee forum but felt they couldn’t get to it because of workload. Trainees were also aware of who their local Chief Resident was. Some exprerssed doubts about the effectiveness of responses to feedback.

Specialty Trainees: Trainees were aware of the local trainee forum and some had raised concerns through it, the were also aware of who their local Chief Resident was. Trainees again advised they struggled to attend the trainee forum due to workload.

2.12 Culture & undermining (R3.3)

Trainers: Trainers were unaware of any recent undermining incidents and felt they were open and approachable to trainees.

All Trainee Cohorts: Trainees said their consultant colleagues were all very approachable and supportive. Foundation trainees reported that middle grades were very supportive. There had previously been concerns highlighted with regard to culture in the CAU, but this had been the theme of QI work and this was perceived to have brought significant improvement and to be going in the right direction. Trainees would raise any concerns in relation to undermining with their Educational or Clinical Supervisors.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Trainers felt that staffing was a significant issue, recently a considerable number of Clinical Development Fellows (CDFs) had left their posts, which left them with around 15 gaps on their rota. Trainers advised their Rota Co-ordinator had been working hard to arrange cover for these gaps, but it was becoming very difficult to fill them.

Foundation Trainees: Trainees did not feel that staffing levels were appropriate for their workload. Trainees advised they had on occasions had to manage around 40 patients by themselves. FY2 trainees also felt they could be working beyond their competence whilst working out of hours and of being expected to work at a registrar level on occasion. They did however confirm they could access support from an on-call consultant. Out of hours Foundation trainees felt they were axting in a more senior role – but there was access to a registrar and ANPs for support.

Trainees highlighted that although minimum staffing levels were supposed to mean there were 3 doctors per ward, there was often 2 or just 1 doctor on the wards. Trainees highlighted the main gaps were in the CDF cohort and said significant numbers of them (9 – 12 CDFs) had left their posts. Trainees felt the rota was affecting their health and wellbeing as they were often asked to cover additional shifts and worked regularly over their rostered hours. Trainees felt the rota was heavily reliant on junior trainees to cover rota gaps.

General Practice Trainees/BBT Trainees/IMT Trainees: Trainees did not feel that staffing numbers were appropriate for workload due to vacancies. Trainees felt the rota made it difficult for them to get annual leave, even with the appropriate 6-week notice period. Trainees described back shifts from 4.00pm – 11.00 pm (which were created to make the rota compliant) as being an additional challenge

to well-being as many of the shifts had been taken on by the trainees. Some estimated that about 50% of their work was out of hours noting this had a further adverse impact on training opportunities. The premature departure of a large number of clinical teaching fellows had been very detrimental to the rotas adding further to the difficulties.

Specialty Trainees: Trainees felt ward staffing was variable but generally acceptable out of hours – although the rota was challenged by gaps, especially following the departure of many CTFs. Trainees felt they were doing a lot more medicine shifts and spending less time in their specialty; they also felt that although the number of backshifts they worked had a beneficial affect on their wellbeing, they did comprise their access to learning opportunities.

2.14 Handover (R1.14)

Trainers: Trainers said handover worked reasonably well and all tasks were recorded on an electronic system during the week. For out of hours handover, they were considering extending the use of the electronic system. Trainers confirmed handover took place daily at 9.00am, 4.00pm, 8.00pm and 11.00pm, with 9.00am and 4.00pm having consultant presence.

All Trainee Cohorts: Trainees felt that handover was generally fine and all ward teams were represented at handover with supervision of the handover by an HDU consultant.

2.15 Educational Resources (R1.19) – Not asked.

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 said trainees had unlimited access to staff wellbeing services, with regular reflective sessions offered to trainees in groups. Wellbeing areas were provided throughout the hospital that give trainees rest areas and free access to tea and coffee. Trainers said they were working hard to give trainees access to hot food whilst the were working out of hours, the funding in place to support this had ran out in April but work was being done to re-instate it.

All Trainee Cohorts: Not asked.

2.17 Educational governance (R1.6, 1.19, 2.1, 2.2, 2.4, 2.6, 2.10, 2.11, 2.12, 3.1) – Not asked.

2.18 Raising concerns (R1.1, 2.7)

Trainers: Trainers said trainees could raise any serious concerns through the Datix system and should receive feedback on the concerns they were involved in. Trainers advised that informal concerns could be raised with either their Educational or Clinical Supervisors.

All Trainee Cohorts: Trainees were aware of how to raise concerns and would do so through the Datix system. Trainees confirmed they would raise informal concerns through their Educational or Clinical Supervisors, some commented they had done so and reached resolution to some of their concerns.

2.19 Patient safety (R1.2)

Trainers: Trainers said a robust system was in place for monitoring boarded patients. A business intelligence list was produced on a daily basis with nominated consultants responsible for cohorted areas of patients.

Foundation Trainees: Trainees highlighted patient safety concerns with regard to wards 5A (General Medical overspill ward) and 5D (Care of the Elderly ward) which were mainly to do with a lack of staffing and wards being overflowing with patients. Trainees in particular had concerns around the A&E department and the CAU which they said were both over-full with patients on most days.

General Practice Trainees/BBT Trainees/IMT Trainees: Trainees did not raise specific concerns about patient safety but described long waits for patients for scans and tests. Trainees were aware of the boarding system and of the arrangement to ‘cohort’ boarded patients in specific ward areas with nominated consultants. Trainees felt that the numbers of boarded patients on a ward were not taken into consideration when staff were allocated to them and there was often an imbalance of patients and staffing across the wards.

Specialty Trainees: Trainees did not have specific concerns with regard to patient safety but felt it was a risk that patients were waiting so long to be seen in A&E, with some suggesting patients had

waited 24 hours on occasion to be seen. Trainees reported that the current arrangements for boarders (cohorting boarded patients in designated ward areas and with nominated consultants for these areas) was a better system that ensured identification and tracking and consultant responsibility for patients who were boarded. Most trainee cohorts had access to the daily 'boarders list' that was usually accurate - with patients rarely being missed off the list.

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

Trainers: Trainers felt that adverse incidents were always followed up by a report which was circulated to trainees. The main Medicine Morbidity and Mortality (M&M) meeting had been postponed due to the COVID 19 pandemic but had been re-instated in the last month. Departmental M&M had continued, and trainees were able to attend them.

All Trainee Cohorts: Trainees confirmed they would submit Datix reports to report adverse incidents. Some trainees had submitted Datix and received feedback on them, but others had not. Trainees' attendance at M&M was also variable and appeared to be ward dependent in the absence of the main General Medicine M&M.

2.21 Other

Overall Satisfaction scores:
Foundation trainees: Scored between 5 -7 out of 10 with an average score of 6 out of 10.
General Practice Trainees/BBT Trainees/IMT Trainees: Scored between 4 – 7 out of 10 with an average score of 5.8 out of 10.
Specialty Trainees: Scored between 3 – 9 out of 10 with an average score of 6.5 out of 10.

3. Summary

Is a revisit required?	Yes	No	Highly Likely	Highly unlikely

The visit panel found trainees were receiving an improved training experience since the last deanery visit in 2021. Some visit requirements have been resolved, whilst some others remain open. The visit

panel would like to acknowledge the engagement of the local trainers to address local training issues, despite local staffing and workload concerns caused by the continuing impact of COVID 19. Following the issue of this visit report, discussions will take place between the deanery and the GMC to assess the sites progress against the 4 GMC standards/requirements highlighted by the 2021 visit:

S1.1 - The learning environment is safe for patients and supportive for learners and educators. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers, and families.

R1.8 - Organisations must make sure that learners have an appropriate level of clinical supervision at all times by an experienced and competent supervisor, who can advise or attend as needed. The level of supervision must fit the individual learner's competence, confidence, and experience.

R1.12 - Organisations must design rotas to provide learning opportunities that allow doctors in training to meet the requirements of their curriculum and training programme.

R1.15 Organisations must make sure that work undertaken by doctors in training provides learning opportunities and feedback on performance and gives an appropriate breadth of clinical experience.

Positive aspects of the visit:

- The commitment to improvement and the continuing trajectory of improvement despite the ongoing service and staffing pressures from COVID
- Very supportive and accessible cohort of trainers
- Acute Medicine training environment is very positive with support, good training and feedback provided to trainees
- Clinic participation tracking system (although paused because of COVID until recently)
- Departmental induction is working well for most trainees

Less positive aspects of the visit:

- Staffing for workload (acknowledging this has been exacerbated by the recent resignations of many within the CDF cohort)

- Discontinuity of ward placements with frequent movement of FY & GPSTs resulting in the disruption of training
- Residual COVID effect on trainees' ability to access clinics (noting that there remains in place a derogation around the target numbers for IMT trainees)
- The provision of departmental teaching has been impacted by COVID, but as these teaching sessions resume the trainees' ability to access them is prevented by workload
- Trainees working overnight on-call shifts on first day in post missed out on induction
- IT usernames and passwords - some trainees didn't get these by the time they started their clinical duties and could only access the systems using colleagues' logins and passwords
- Feedback on trainees' clinical decision making on their acute medical cases (noting the challenges around this for trainees and for trainers)
- The need to improve the training opportunities for GPSTs (noting they can access GP regional teaching)

The 13 visit requirements from the 2021 visit have been categorised below into address, progress noted, and little progress noted:

Requirement	Theme	Commentary
6.1	Those providing clinical supervision must be supportive of trainees who seek their help and must never leave trainees dealing with issues beyond their competence or 'comfort zone'.	Addressed.
6.2	Staffing levels must be reviewed to ensure that workload is appropriate for safe quality care and does not prevent access to learning opportunities including outpatient clinics, in order for trainees to meet the requirements of their curriculum.	Little progress noted.
6.3	Measures must be implemented to address the perceived patient safety concerns described in this report in relation to COTE & CAU.	Addressed for CAU; in process of being addressed in COTE
6.4	There must be robust arrangements in place to ensure the tracking of all boarded patients. In	Addressed.

	addition, for boarded patients, there needs to be clarity which Consultant and clinical care team are responsible, how often patients are reviewed and what the escalation policy is.	
6.5	Handover of care of patients transferred from CAU to downstream wards including to boarding wards must be introduced to support safe continuity of care and to ensure unwell patients are identified and prioritised.	Addressed.
6.6	Measures must be implemented to address the patient safety concerns associated with the lengthy delays between arrival and definitive assessment of GP referrals as soon as possible. **[Requirement 7 from 2019 visit report]**	Progress noted.
6.7	Departmental induction must be provided for all departments including the CAU which ensures all trainees are aware of all of their roles and responsibilities and feel able to provide safe patient care. **[Requirement 9 from 2019 visit report]**	Addressed.
6.8	All trainees must have timely access to IT passwords and system training through their induction programme. **[Requirement 8 from 2019 visit report]**	Progress noted. Some instances still arose in induction this year.
6.9	The burden of tasks for all cohorts of doctors in training that do not support educational or professional development and that compromise access to formal learning opportunities must be significantly reduced.	Little progress noted. Although we acknowledge the significant staffing issues faced.
6.10	A process for providing feedback to doctors in training on their input to the management of acute cases must be established. **[Requirement 5 from 2019 visit report, note slight re-wording]**	Some progress. We acknowledge the effort trainers have put into

		resolving this issue, thus far without resolution.
6.11	There must be a clear escalation policy which is understood and followed by all involved for trainees managing patients referred via pager no 3850. [Requirement 4 from 2019 visit report]	Addressed.
6.12	FY1 trainees in medical specialties must have opportunities to clerk and assess acutely unwell patients during ward rounds and to receive constructive feedback on their contributions to add learning to their experience.	Addressed.
6.13	The department must increase relevant training opportunities for GP trainees.	Progress noted.

Good Practice Items:

Ref	Item	Action
4.1	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 in regard to these items.

Ref	Item	Action
5.1	Local teaching provision	There should be senior input into locally delivered teaching sessions, including from consultants.
5.2	Chief Resident & Junior Doctor Forum	There should also be advocacy around the needs of Foundation trainees by the Chief Resident and at the Junior Doctor Forum.

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	Staffing levels must be reviewed to ensure that workload is appropriate to ensure access to learning opportunities including outpatient clinics and local formal teaching sessions in order for trainees to meet the requirements of their curriculum.		FY/GPST/BBT/IMT/ST
6.2	Measures must continue to be implemented to address the patient safety concerns associated with the lengthy delays between arrival and definitive assessment of GP referrals.		FY/GPST/BBT/IMT/ST
6.3	All trainees must have access to IT passwords and system training through their induction programme by the time they start clinical duties.		FY/GPST/BBT/IMT/ST
6.4	The burden of tasks for all cohorts of doctors in training that do not support educational or professional development and that compromise access to formal learning opportunities must be significantly reduced (including the significant amount of time spent competing blood test request forms).		FY/GPST/BBT/IMT/ST
6.5	Feedback to all levels of trainees on their management of acute receiving cases must be provided to inform their learning and training (aiming for this in at least 40% of opportunities).		FY/GPST/IMT/ST
6.6	The discontinuity of ward placements for Foundation, GPST and IMTs must be addressed as a matter of urgency as it is compromising quality of training, feedback, workload, and the		FY/GPST/IMT

	safety of the care that doctors in training can provide. The duration of ward attachments of Foundation doctor must be increased to be for at least 4 weeks.		
6.7	The department must increase relevant training opportunities for GPSTs.		GPST
6.8	The issue reportred by trainees regarding the supervision arrangements within the Care of the Elderly Dept must be fully addressed.		