Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	10th November 2022	**Level(s)**	FY1, FY2, GPST, IMT, ST
Type of visit	Enhanced Monitoring Revisit	**Hospital**	Inverclyde Royal Hospital
Specialty(s)	General Internal Medicine and Geriatric Medicine	**Board**	Greater Glasgow & Clyde

Visit Panel	
Professor Alastair McLellan	Visit Chair – Postgraduate Dean for Medicine, Lead Dean Director for Quality, Medicine
Dr Clive Goddard	Associate Postgraduate Dean for Medicine, South-East Scotland
Dr Corinne Coles	General Practice Representative
Dr Marie Mathers	Associate Postgraduate Dean, Quality – Foundation
Dr Jane Rimer	Training Programme Director Representative
Dr Duduzile Musa	College Representative
Dr Joshua Newmark	Trainee Associate
Robin Benstead	GMC Representative
Gayle Kennedy	Lay Representative
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 Reem AlSoufi, Dr Greg Jones, Dr Alan McKenzie
Quality Improvement Manager(s)	Alex McCulloch and Gillian Carter

Unit/Site Information											
Non-medical staff in attendance	N/A										
Trainers in attendance	15										
Trainees in attendance	FY1 x 8		FY2 x 3		GPST x 3		IMT x 3		ST x 2		
Feedback session: Managers in attendance	Chief Executive		DME	✓	ADME	✓	Medical Director	✓	Other		

Date report approved by Lead Visitor	21st November 2022

1. Principal issues arising from pre-visit review:

Inverclyde Royal Hospital has been on Enhanced Monitoring for Medicine and Geriatric Medicine since 2019.

The Deanery last visited Medicine and Geriatric Medicine at Inverclyde Royal Hospital (IRH) in November 2021. At that time, it was noted that there was a clear sense of significant ongoing improvement, which is particularly evident over the past 2 years.

The specific requirements that resulted from that visit were:

1. Staffing levels, in particular at middle-grade level, must be sufficient for the workload and to ensure access to learning and training opportunities.
2. 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'.
3. Work must be undertaken to ensure that IMTs, ST3s and GPSTs are supported to attend sufficient numbers of clinics without compromise because of service needs.
4. Feedback to all levels of trainees on their management of acute receiving cases must be provided to inform their learning and training (aiming for feedback on ~40% of cases that trainees manage during a session of acute medical receiving).
5. The department should ensure that service needs do not prevent trainees from attending scheduled formal local and regional learning opportunities.
6. The learning environment must support the provision of the WPBAs required to support training progression.
7. All staff must behave with respect towards each other and conduct themselves in a manner befitting Good Medical Practice guidelines.

On review of survey data at the Medicine Quality Review Panels in 2022, significant progress was noted across the Medicine specialties at IRH with an overall reduction in red flag outliers and some positive green flags recorded in IMT.

This revisit is being undertaken to review progress against previous visit requirements, identify good practice and to identify any current trainee concerns**.** 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 panel would like to thank Drs Abigail Gunn & Janice Murtagh (Lead Trainers) who delivered a very detailed and informative presentation to the panel, which provided an update regarding progress against the previous visit's requirements, along with supporting evidence/documentation.

2.1 Induction (R1.13):

Trainers: Not covered

FY1: All trainees present had received hospital and departmental induction, which included a ward induction to the J North section of the hospital. Induction was supported by an e-mail with attachments which was sent to trainees from Dr Gunn, although 2 of the trainees didn't appear to have received the e-mail. Trainees who were not from the University of Glasgow and hadn't participated in Preparation for Practice would have appreciated more information in induction, of what clinical skills would be expected of them as FY1s.

FY2/GPST: All trainees present had received induction and felt it to be of a good standard. In particular the Care of the Elderly departmental induction was highlighted as very thorough.

IMT/ST: All trainees present appeared to have received induction and had been sent the induction pack through e-mail, 1 trainee (who started their post on night shift) did not receive the appropriate IT username and passwords to access the clinical systems and had to use a colleague's login for their first couple of shifts, but they were provision of induction content by email in advance. Some trainees also felt referral pathways were not covered in induction.

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

Trainers: Trainers described the teaching that was provided for trainees, which included a Wednesday session after grand rounds. A mix of grade level opportunities was provided, and consultant led with some of its curriculum relevant for FY and IMTs. Additional GPST sessions were

delivered which had been developed with input from local Training Programme Director (Dr Brian Scott) to ensure they were curriculum relevant.

FY1: Trainees confirmed a variety of teaching sessions available to them, these included grand rounds, Morbidity and Mortality meetings (M&M), multi-disciplinary meetings and mini informal teaching sessions after ward rounds. Trainees highlighted mini teaching sessions led by Dr Gunn in the Larkfield unit as particularly good. Trainees said that handover in the medical receiving Unit (J North) overlapped with the Wednesday lunch time teaching sessions and some trainees had missed up to 6 teaching sessions because of the overlap. Trainees had raised this with Dr Gunn, who was taking it forward to try and come to a solution. Trainees also highlighted other barriers to teaching, which all centred around what they considered to be a lack of staffing on J North, which often made it difficult to get to teaching, including Foundation regional teaching. Trainees in other ward areas commented that it was easier to attend teaching than those working in J North.

FY2/GP: Both FY2 and GPSTs estimated they got to around 1 hour of teaching each on a weekly basis, trainees confirmed this was mostly uninterrupted but occasionally ward workload could affect their ability to get to it. Trainees confirmed that some teaching sessions were recorded, and they could access the recordings if they were unable to attend in person. FY2s & GPSTs trainees could access regional teaching sessions and were able to take study leave in advance for longer sessions that required it. The content of both local and regional teaching is relevant to their curricula.

IMT/ST: Trainees confirmed that teaching was provided to them on a weekly basis locally on a Wednesday following the GG&C Grand Round. Trainees again highlighted the issue of lunchtime handover in J North clashing with the local teaching sessions which impacted on trainees' ability to attend. Both IMT and the STs said they could access their regional teaching, with catch up time provided if they were unable to attend the original sessions in person.

2.3 Study Leave (R3.12)

Trainers: Not asked.

All Trainee Cohorts: Not asked.

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

Trainers: Trainers confirmed they had undertaken Recognition of Trainers and that new supervisors were also expected to do this before taking on their role, with a current supervisor currently working their way through this process.

FY1: All trainees had been allocated Educational Supervisors, although a trainee present had some difficulties arranging an initial meeting with their supervisor as they were not based at IRH. Once they did set up an initial meeting, it was a 15- minute session that was shared with another trainee, which was also their last meeting.

FY2/GP & IMT/ST: All trainees present had been allocated Educational Supervisors, had met with them, and could access them when required.

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 felt that although trainees would see things that were out with their level of competence, the service was consultant-led and there should always be a consultant on hand to support them. The trainers confirmed that a skills matrix was used which provided the level and competence of each trainee, in order that an individual based approach could be provided for their training needs. The skills matrix was sent to each trainee in their first week and they were asked to complete it and return it.

FY1: Trainees reported they were able to access support when they required it most occasions, during the day. Whilst working out of hours trainees found it more challenging to get support when they required it and this was felt to be due to a lack of staffing in some departments, such as the High Dependency Unit (HDU). Trainees felt that staffing in HDU was quite junior, and highlighted occasions were there were minimal numbers of FY2s to support them, although the trainees confirmed they could get support from consultants if they escalated their concerns.

FY2/GP & IMT/ST: Trainees confirmed they knew who to contact for support both during the day and whilst working out of hours (including in IRH Medicine and in the Larkfield Unit Geriatric Medicine).

They reported no instances of having to work beyond their competence. Trainees said their consultant colleagues were supportive and approachable when contacted for support and also felt their clinical supervision ensured safe patient care.

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

Trainers: Trainers felt they were familiar with the various trainee cohorts and efforts were made to cohort trainees by grade, so the supervisors became familiar with the relevant curriculum curricular requirements. Update training was provided when it was required, trainers gave the recent example of training sessions on changes to the Foundation curriculum being delivered by the local Associate Post Graduate Dean for Foundation (Dr Caroline Whitton). Trainers advised a monthly clinic rota was in operation. When asked if anyone was tracking the clinic numbers vs curriculum needs, some of the trainers were able to provide the number of clinics trainees had undertaken recently. High numbers of clinics had been attended in Endocrinology and Diabetes with each trainee in the department having undertaken 8 clinics in 3 months and Rheumatology trainees could expect to attend around 3 clinics per week.

FY1: Trainees felt although overwhelming at the start of their training, they felt well supported and were provided with lots of opportunities to be involved in the management of acutely ill patients. Trainees said they spent up to 90% of their time completing administrative tasks that were not of benefit to their training.

FY2/GP: FY2 trainees felt there were limited practical procedures available to them due to the nature of IRH being a small site, however they felt out of hours provided excellent opportunities if they planned well ahead with consultants. FY2s had not had access to clinic opportunities. GPSTs said they got to scheduled clinics around 1 per month, and some had been to 2 or 3 since starting their post. Trainees appeared aware of a clinic rota which they could find on Teams. Trainees felt their posts provided them with enough experience of managing the care of acutely unwell patients. FY2s said around 75% of their time was spent completing what they considered to be non-educational tasks, the GPSTs felt this was slightly less for them at 30 – 40%.

IMT/ST: Trainees said some IMT procedures could be difficult for them to get, which was made for difficult due to a lack of ST4 level trainees in IRH, trainees did highlight they had escalated this to the

trainers who worked to support them to get procedures; reference was made to the 'skills matrix'. IMT trainees reported their clinic access was variable and they often struggled to leave the wards to attend clinics due to a lack of staffing to provide cover; other IMTs could get to more clinics but commented that it was not enough to meet their curriculum requirements (although there remains a derogation to the curricular requirements, nationally, in place). IMTs estimated they had attended between 5 – 12 clinics so far this year – which is adequate in the current circumstances (if not meeting the pre-derogation curricular targets). The ST experience of clinics was similar, with access challenging due to ward workload and staffing. All trainees felt their posts gave them enough experience of managing acutely unwell patients. IMTs estimated around 60% of their time was spent completing what they considered to be non-educational tasks, for STs this was slightly less at 50%.

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

Trainers: Trainers felt there was a significant consultant presence on the wards in most departments who were available and able to sign off Workplace Based Assessments. They had received feedback from some trainees that Workplace Based Assessments could be challenging due to the low numbers of higher trainees in Medicine (above ST4), who could also sign them off. Despite these challenges, trainers were unaware of any occasion where trainees had been unable to meet their curriculum requirements for Workplace Based Assessments.

All Trainee Cohorts: All trainees confirmed they were able to complete Workplace Based Assessments and could have them signed off without much difficulty. Time to complete them could be a challenge for IMTs.

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

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

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: Trainers felt that feedback was offered to trainees on a regular basis due to the consultant presence on the wards up until 8pm. Feedback was delivered regularly, after-ward rounds. What had

been highlighted in the past is how feedback is received and a result trainers attended an I- Teach course.

All Trainee Cohorts: Most trainees felt they received feedback fairly regularly, although in Geriatric Medicine some felt they had to be more pro-active in their approach by asking for it. Trainees estimated they got feedback on around 40 – 90% of the acute medical cases they had seen during the day and between 40 – 80% of the cases they had seen at night. Trainees felt the feedback they received was constructive and meaningful and informative to their learning.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: Trainers confirmed a trainee forum was in place, which was organised and led by 2 local Chief Residents. Trainees could bring issues to the forum, which would then be discussed by management. Trainers gave an example of a ward debrief being implanted to address trainee concerns around a lack of feedback which was raised through the forum.

All Trainee Cohorts: Most trainees were aware of who their local Chief Residents were and said attempts had been made to set up trainee forum meetings but there had been difficulty with room availability and the meeting didn't go ahead. Trainees felt they could approach their Chief Residents to pass on feedback, or to go to Dr Gunn or Dr Murtagh directly. GPSTs did not appear to be aware of a trainee forum or who their Chief Resident colleagues were.

2.12 Culture & undermining (R3.3)

Trainers: Trainers highlighted they had all been through Civility Saves Life Training and Active Bystander Training. They felt they worked hard to set examples of good behaviour and by ensuring trainees had different pathways at different levels to report concerns around culture and undermining. Trainers were aware of 1 incident recently which had been escalated by trainees, investigated, and addressed.

All Trainee Cohorts: Overall trainees said their consultant colleagues were very supportive and approachable. However, specific 2 examples of perceived recurrent undermining behaviours were

described by trainees. Further information in regard to these incidents was provided to the local Director of Medical Education and Medical Director following the visit.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Trainers described a mix up in regard to an FY1 training day in which the local units weren't notified and which clashed with an FY2 training day. Cover for this event had to provided by GPSTs and some trainees were unable to attend it. They were provided with time of in lieu to watch the recorded session. Trainers also said their rota co-ordinator was currently on long term sick leave, which created difficulties in the organisation of and management of the rotas.

FY1: Trainees said staffing had been adequate at the beginning of the training year but staffing numbers had gone down recently, trainees attributed this to combination of trainees taking annual leave and attending teaching events. A trainee highlighted a few days when HDU only had x1 FY1 and they perceive this staffing level to be inadequate, they were aware of who to call for support if they required it.

FY2 & GPST: Trainees felt staffing had been generally adequate, however some occasions were highlighted when they couldn't attend learning events due to a lack of cover on the wards.

IMT & ST: Trainees described their rota as variable and in a state of flux. They described a lack of FY2 colleagues on the wards, which could make it difficult for them leave to attend learning events or clinics as they were uncomfortable with leaving FY1s unsupported on the wards. Trainees highlighted the support they received from their Advanced Nurse Practitioner (ANP) colleagues, which they described as excellent.

2.14 Handover (R1.14)

Trainers: Trainers felt that handover arrangements were robust and provided safe care for patients. Morning handover was described as the most robust handover of the day. The felt handover arrangements were clear to trainees. Trainees had highlighted a lack of formal handover from the night team to downstream wards, solutions were currently being explored by the HAN (Hospital at Night), trainers felt this would make their current processes even more robust.

FY1: Trainees were not part of some the handover processes – such as of medical patients in the morning who are handed over at the J North huddle, and handovers of unwell patients in HDU involve seniors to the consultant on call and don't include the FY1s – leaving the out of the loop. Also the ANPs who are on overnight have an informal handover of patients they have seen overnight.

FY2 & GPST: JN has a morning handover of night team to day team at 9:00 am. This handover includes all grades and follows a structure with a checklist that included all hospital events including deaths, cardiac arrests, unwell patients around the hospital, new sick patients including those in HDU and all patients admitted that hadn't been seen yet by a consultant. It also identifies learning opportunities as well as opportunities for feedback. Trainees felt it was useful as a learning opportunity. Trainees said downstream ward morning handover was more of a ward huddle and a 'rapid rundown review' than a handover, and a charge nurse will advise if a patient has been seen by Hospital at Night. In the Larkfield Unit - there is a structured handover with a rapid run through of patients.

IMT & ST: Trainees felt handover was robust and raised no concerns with regard to it.

2.15 Educational Resources (R1.19) – Not covered

2.16 Support (R2.16, 2.17, 3.2, 3.4, 3.5, 3.10, 3.11, 3.13, 3.16, 5.12) – Not covered

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 covered

2.18 Raising concerns (R1.1, 2.7)

Trainers: Trainers highlighted that an IMT2 had been appointed as the local M&M lead, who undertook Datix reviews, and coordinated M&Ms. Trainers also highlighted that IRH had an 'In the spotlight' newsletter that Dr Gunn used to highlighted immediate concerns that have been raised recently. Trainers felt all trainees could go to M&M if they were on shift. Daily ward huddles also highlighted any real-time issues.

FY1: Trainees had no concerns but felt they could raise any concerns regarding patient safety with a senior colleague, such as a nurse colleague or a consultant colleague.

FY2/GP: Trainees were aware of how to raise concerns; they would do so through a consultant colleague. There was confidence that concerns that were raised would be addressed. Trainees could also attend effective and useful M&M meetings and had received the spotlight newsletter from Dr Gunn that was a distillate of learning points shared with staff including the doctors in training.

IMT/ST: Trainees were aware of how to raise concerns and who to contact to do so. Trainees felt most of their consultant colleagues were approachable and supportive and that a culture of listening and trying to make improvements was in place.

2.19 Patient safety (R1.2)

Trainers: Trainers felt the environment in Medicine at IRH was safe for patients. They described it as busy but no more so that anywhere else in Medicine. Trainers felt they had strong dialogue with the management team around boarding, but said boarding arrangements were functional and they had done their best to mitigate risks around boarding of patients.

FY1: Trainees felt the environment was safe for patients in Medicine with the exception of boarded patients. Trainees said there were a lot of boarded patients, up to 50 in the last week alone. They described the boarders team as difficult to reach and said there were instances of patient reviews being missed. As FY1s they were unsure of what their role was in the management of boarders.

FY2/GP: Trainees felt that the Larkfield Unit was safe for patients in Geriatric Medicine. Trainees felt in general that the environment in medicine was also safe for patients, they did however describe long waits for patients admitted to A&E and then waiting for a bed in a Medicine ward, they described pressure to make beds available. Trainees were aware of the boarding process and of who to contact but felt the boarded patients weren't seen as often by consultants as patients in the Medicine wards. Trainees described a patient safety incident where a patient was prematurely transferred to a General Medicine ward and became immediately unwell. The trainee said an FY1 supposed to go through a "Safe to Go" checklist but often they are put under pressure by bed managers and nursing staff to do this quickly to free up bed space, which resulted in transfers of patients who were not fit for transfer.

IMT/ST: Trainees again highlighted concern around medical boarders, noting there were 40-50 around boarders in the last week. Concern was also raised around safety in J North due to the junior

nature of trainees based there (usually FY1 & 2). Trainees also had concern around what they perceived as the unsafe use of the Safe to go process, which although they felt was a good idea, in reality was often not implemented properly. Trainees described pressure being applied by nursing and bed management staff, to complete Safe to Go checklists constantly and them not having appropriate time to complete the process properly.

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

Trainers: Trainers described ward huddles, safety bulletins and the M&M meetings as the main sources of learning from adverse incidents.

All Trainee Cohorts: Trainees could attend M&M meetings and also highlighted the safety bulletins from Dr Gunn as sources of learning from adverse incidents.

3. Summary:

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

Progress against 2021 visit requirements:

Ref	Issue	Trainee cohorts in scope	Requirement met?
6.1	Staffing levels, in particular at middle-grade level, must be sufficient for the workload and to ensure access to learning and training opportunities.		Partially
6.2	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'.		Met

6.3	Work must be undertaken to ensure that IMTs, ST3s and GPSTs are supported to attend sufficient numbers of clinics without compromise because of service needs.		Met
6.4	Feedback to all levels of trainees on their management of acute receiving cases must be provided to inform their learning and training (aiming for feedback on ~40% of cases that trainees manage during a session of acute medical receiving).		Met
6.5	The department should ensure that service needs do not prevent trainees from attending scheduled formal local and regional learning opportunities.		Met
6.6	The learning environment must support the provision of the WPBAs required to support training progression.		Met
6.7	All staff must behave with respect towards each other and conduct themselves in a manner befitting Good Medical Practice guidelines.		Partially

There is a clear sense of significant ongoing improvement at this site. This is highlighted in the significant progress that has been made against the 7 visit requirements that were highlighted in the 2021 visit report, with either resolution or significant progress being made against almost all. Discussions will now take place with the GMC around whether or not the site has reached the threshold for removal of its Enhanced Monitoring status. Despite the site's progress, some concerns remain around the management of boarded patients and also around some of the highlighted undermining concerns described by trainees. These incidents were noted to be isolated however and the general culture in the Medicine department was felt to be a supportive one with an engaged group of trainers.

Positive Aspects of the Visit:

- Consultant workforce well engaged in supporting the improvements in the quality of training. Dr Gunn's noteworthy leadership of the improvement journey supported by her colleagues.
- The processes that are in place that enable doctors in training to raise concerns around quality of training and safety of care.
- The sharing and dissemination of learning from adverse incidents is working well.
- Support for clinic attendance, as well as the tracking and reporting of trainees' clinic attendances. All trainees, including IMTs and GPSTs, were getting to reasonable numbers of clinics.
- Commitment to ensuring provision of a range of formal local learning opportunities; most trainees can access sufficient local learning opportunities but noted some service pressures in certain ward areas such as (J North) affecting attendance.
- Provision of feedback on acute medical cases is excellent, reaching, and exceeding targets that were agreed for most trainees.
- Creative support for fostering teaching and learning through initiatives such as iTeach.
- The information pack provided by the site in advance of this visit was an exemplar.
- Roll out of FRAPPs to IRH, providing additional external support for FY trainees.

Less Positive Aspects of the Visit:

- Despite the measures undertaken to support a positive culture, a couple of issues in relation to culture will be discussed with the DME and MD.
- Boarding – the trainees' perception is that the management of boarded patients presents potential risks to safety of care. It is unclear if the issue is that numbers of boarded patients are exceeding the capacity of the boarding system or whether the system itself isn't working.
- Safe to go process – while the process itself is potentially an exemplar, its use in practice is compromised because there is undue pressure upon FY1 trainees to complete the safe to go form to enable patient transfer when proper assessment and application of the process might suggest otherwise.
- Appropriate induction including provision of IT passwords must be provided for trainees starting on nights.

4. Areas of Good Practice

Ref	Item
4.1	Tracking and reporting of trainee's clinic attendance
4.2	Provision of feedback on acute medical cases
4.3	Creative support for fostering teaching and learning through initiatives such as iTeach.
4.4	The compilation of a skills matrix summarising what training has been attained by trainees but also highlighting trainees' remaining training needs.

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	A review of the application of the "Safe to go" process should be conducted	Trainees feel under pressure from Nursing and bed management staff to complete Safe to go checklists and felt in-accurate checklists had potentially contributed to unsafe transfers of patients. Safe to go forms should be used to ensure patients are safe for transfer – not as was reported as, at times, a perfunctory process.
5.2	Provision of passwords for those starting on nights	While induction processes were generally satisfactory trainees starting on nights should be provided with passwords to enable their access to the various IT systems.
5.3	Educational supervision	In general education supervision arrangements worked well, but an arrangement for provision of educational supervision by a consultant rotating to the IRH struggled to provide time for fruitful 1:1.
5.4	Attendance at Wednesday lunchtime local teaching	The timing of handover on J North compromises trainees' attendance at the Wednesday weekly local teaching and should be revised.

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	All staff must behave with respect towards each other and conduct themselves in a manner befitting Good Medical Practice guidelines.	August 2023	FY2/GPST/IMT/ST
6.2	The Board must make sure there are enough staff members who are suitably qualified to manage the additional workload associated with the selection and assessment of medical boarders.	August 2023	FY2/GPST/IMT/ST