Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	27th June 2023	**Level(s)**	Foundation, IST, Specialty
Type of visit	Re-visit (Virtual)	**Hospital**	Victoria Hospital
Specialty(s)	General Surgery	**Board**	NHS Fife

Visit panel	
Dr Marie Mathers	Visit Chair – Associate Postgraduate Dean (Quality)
Dr Susan McGeoch	Training Programme Director
Dr Gillian Roberts	Foundation Programme Director
Dr Hannah Jolly	Trainee Associate
Mr Ian McDonough	Lay Representative
Mrs Jennifer Duncan	Quality Improvement Manager
In attendance	
Mrs Gaynor Macfarlane	Quality Improvement Administrator

Specialty Group Information	
Specialty Group	Foundation
Lead Dean/Director	Professor Alan Denison
Quality Lead(s)	Dr Fiona Drimmie & Dr Marie Mathers
Quality Improvement Manager(s)	Mrs Jennifer Duncan
Unit/Site Information	
Trainers in attendance	5
Trainees in attendance	13 (F1 – 7, F2 - 3, IST - 0, ST - 3)

Feedback session: Managers in attendance	Chief Executive	0	DME	0	ADME	1	Medical Director	0	Other	12
Date report approved by Lead Visitor	Dr Marie Mathers 23rd August 2023 Professor Alan Denison									

1. Principal issues arising from pre-visit review:

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.

Following review and triangulation of available data, including the NES Scottish Trainee Survey, a Deanery re-visit is being arranged to General Surgery at Victoria Hospital. This visit was requested by the Foundation Quality Review Panel in September 2022.

Issues highlighted include:

<u>NTS Data</u>

F1 Surgery – Red Flags – Adequate experience, Induction, Overall satisfaction. Pink Flags – Clinical supervision, Educational Supervision, Facilities.

F2 Surgery – Red Flags – Educational governance, Overall satisfaction, Rota design, Workload. Pink Flags – Clinical supervision, Clinical supervision out of hours, Handover, Induction, Teamwork.

Core – All Grey Flags.

ST – Pink Flags – Clinical supervision out of hours. Lime Flags – Reporting systems.

<u>STS Data</u>

Foundation – All White Flags.

Core – All Grey Flags.

Specialty – All White Flags.

ST – All yellow.

At the pre-visit teleconference the visit panel agreed that the focus of the visit should be around the areas highlighted in the survey data and pre-visit questionnaire.

Due to only 1 F2 trainee being available to attend on the day of the visit the question set was sent via Questback to the remaining F2 and IST trainees. Responses were collated and are included in the main report.

Departmental Presentation:

The visit commenced with a presentation led by Mr Satheesh Yalamarthi, Clinical Director General Surgery. The presentation provided a useful overview of the structure of the department. It highlighted major achievements, recent changes, challenges faced by the department and service and finally plans for the future.

2.1 Induction (R1.13):

Trainers: Trainers reported a comprehensive induction day which included morning hospital induction, afternoon departmental induction and IT induction. Departmental induction includes information on how the department works, rota/workload, annual leave, sick leave, where to find lists, and a walk through of the department. They acknowledge the volume of information given over the course of the day however note this is supported in the induction handbook. Teams are approachable and happy to take questions at any time should trainees have any queries regarding any aspects of induction. Junior doctors are also asked to provide feedback on induction to allow improvements to be made for future sessions.

F1 Trainees: Trainees reported receiving induction however no catchup induction was provided for those who were unable to attend on the first day in post. They commented that the induction handbook was received however this focused on general surgery and requires some updating. Trainees would find it useful to have all surgical specialties that they will work in included especially trauma and orthopaedics with information such as a typical day, duties, roles, and responsibilities. They have found advanced nurse practitioners (ANPs) very helpful.

F2/IST Trainees: Trainees reported receiving hospital induction however found it difficult to watch online material during working time which meant this had to be watched in their own time. They found the in-person IT session useful. Departmental induction was shared with F1 trainees and was therefore heavy on the role of the F1 trainee. F2 trainees left feeling unsure of their roles and responsibilities and would welcome a more in-depth specific induction for F2 trainees from seniors and consultants regarding roles and responsibilities in all areas they will rotate through including what to do with urology patients and how AU2 interacts with the emergency department.

ST Trainees: Trainees reported receiving reasonable hospital and departmental induction and an induction handbook. They commented on good communication with the rota master.

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

Trainers: Trainers reported that IST and ST trainees should have no problems in attending all regional teaching sessions unless they are on-call, and that feedback received on attending teaching has been positive. National teaching is requested via study leave and included in the rota with on-call the only barrier to attending. Foundation teaching is delivered in the hospital and trainees are expected to attend handing bleeps to ANPs. Departmental teaching consists of open forums and an education department teaching session every Friday afternoon where feedback is sought. F1 trainees also take part in departmental teaching within the high dependency unit (HDU), trauma and orthopaedics, urology, and otolaryngology.

F1 Trainees: Trainees reported being able to attend around half of their regional teaching sessions. They commented that they feel a high pressure to complete tasks and discharges and feel by attending teaching they are neglecting other important tasks and risk delaying discharges. They stated that there is no protocol for handing over phones or bleeps to allow attendance at teaching. They are aware of Friday afternoon teaching and find it to be of good quality however find it difficult to attend. They commented that there is no surgical teaching specifically directed at F1 level. Otolaryngology provide adhoc teaching and occasionally an ST trainee will deliver teaching in trauma and orthopaedics however this is rare as they are busy.

F2/IST Trainees: Trainees reported no concerns in being able to attend teaching when in the hospital. They commented on an intense rota and not always being in the hospital when teaching is taking place however sessions are recorded, and they can catch up in their own time. They commented on being able to attend some Friday afternoon teaching sessions depending on what shift they are working. They find adhoc teaching at morning ward rounds extremely useful.

ST Trainees: Trainees confirmed attending regional teaching in Edinburgh with on-call the only barrier to attending. They have no concerns in attending departmental teaching unless they are attending regional teaching which also takes place on a Friday. Friday departmental teaching provides a good training opportunity however communications are sometimes poor and sessions cancelled at short notice.

2.3 Study Leave (R3.12)

Trainers: Trainers stated they do their best to accommodate all study leave requests.

F1 Trainees: Not asked.

F2/IST and ST Trainees: Trainees reported no issues in requesting study leave. Mr Bennett is very accommodating.

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

Trainers: Trainers stated that they have time within jobs plans and are well supported to undertake supervisory roles. They meet as a group regularly to discuss trainees, any issues and how these can be addressed in a supportive manner.

F1/F2/IST/ST Trainees: Trainees reported having allocated clinical and educational supervisors who they have meet and set learning objectives for the post.

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 stated they work in a team structure with trainees aware of who is in their team. There are morning and evening handovers daily. Rotas are also sent out monthly and guidance on routes for contacting seniors and accessing support are detailed clearly in the induction handbook. They commented that trainees should not feel they are left to cope with problems out with their competence as there is always a consultant available who is responsible for all patients. They noted previously receiving trainee feedback on the upper gastrointestinal (UGI) unit where trainees were unclear as to who is responsible for certain types of patients as they are come through the ward.

There is now a clear process which is embedded in the department and is also included within induction.

F1 Trainees: Trainees stated they often know who is providing clinical supervision during the day and out of hours however did note some difficulties in escalating to seniors for support. It can be unclear as to who is providing supervision, they do not have access to rotas to determine who is on and are often calling personal mobile phones for support and finding that person is at home. They have found the on-call registrar to be available however their willingness to help can be varied due to them not knowing about a patient. They find urology to have clear lines of supervision and escalation and find ANPs very knowledgeable regarding which consultant is looking after which patient. They stated that sometimes they have had to cope with problems beyond their competence especially when surgical patients have medical issues and require escalating to the medical team. They believe that they can take cases to a higher point than they are comfortable with before requesting ST trainee support especially in trauma and orthopaedics as they perceive that some are unwilling to assist. Finally, in general surgery there is often no middle grade as the F2 trainees are in theatre which leaves the F1 trainee to deal with issues until they come out of theatre.

F2/IST Trainees: Trainees advised being aware of who to contact for supervision during the day and OOH. They find supervision to be of good quality with approachable consultants. Generally, they do not feel they have to cope with problems out with their level of competence however noted that they can feel pressured by the emergency department into making decisions on whether to admit patients after review in the emergency department due to seniors being unavailable in theatre. There is also little guidance available on interactions with the emergency department and HDU within the induction handbook.

ST Trainees: Trainees reported knowing who to contact for supervision both during the day and OOH with accessible and approachable consultants. They confirmed that they have not had to deal with problems that are beyond their level of competence and commented on very supportive consultants who are willing to help with all patients.

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

Trainers: Trainers reported that the rota is discussed up on a weekly basis with trainees allocated to a range of different activities. This process has been audited and findings tabled at the specialty

training committee (STC). The focus for ST trainees is on operating time again this has been audited to ensure the correct balance to allow curriculum requirements to be meet. They recognise that F2 and IST trainees can be left out of operating time however they cover day surgery for elective operating in Queen Margaret Hospital as ST trainees do not rota there. Clinics can be difficult to manage however they are included within the rota and trainers believe F2 and IST trainees are happy with numbers. They also described reasonable exposure in the emergency setting with a good amount of operative work during the day. OOH the F2 and ST trainee work with a consultant. They acknowledge that ST trainees may feel they have less elective standard day operating time undertaking things like hernias and gall ballers as they are not on the rota for Queen Margaret hospital. They believe that endoscopy exposure has been better over the last year.

F1 Trainees: Trainees are confident they can achieve all competence and learning outcomes in post however most have not received assessments from a consultant. They believe that 95% of their time is spent undertaking tasks that are of little or no benefit to their education or training such as discharge letters and administrative tasks. They noted very little continuity with patient care, often they clerk in a patient, review, and set a management plan with no feedback provided and may never see that patient again to conduct any follow-up. They find ANPs invaluable especially at weekends and within ortho geriatrics.

F2/IST Trainees: Trainees reported no concerns in obtaining competence and intended learning outcomes for the post. They have had the opportunity to attend clinics and theatre sessions with senior support. Most believe around 25% of their time is spent undertaking tasks that are of little of no benefit to their education or training such as general administrative tasks, discharge letters, bloods, and cannulas.

ST Trainees: Trainees reported no concerns in achieving all learning outcomes required for the post however highlighted some difficulties in operative work due to the introduction of robots. They have no concerns with allocated clinic and theatre time. They believe all aspects of the job are relevant to their education and training.

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

Trainers: Trainers reported no concerns in any training grade achieving assessment requirements whilst in post. Consultants are friendly, approachable, and keen to train.

F1 Trainees: Trainees reported challenges in obtaining workplace-based assessments in post due to seniors being very busy and juniors not wishing to over burden them. They find that most consultants are not forthcoming with offers to complete assessments and most confirm receiving assessments from F2, IST and ST trainees.

F2/IST Trainees: Trainees confirmed having no difficulties in obtaining workplace-based assessments when in post with most assessments completed by ST trainees.

ST Trainees: Trainees reported no issues in obtaining workplace-based assessments in post. They believe exposure to endoscopy and colonoscopy could be improved however recognise efforts made to ensure reasonable numbers are achieved.

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

Trainers/F1/F2/IST/ST trainees: Not asked.

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

Trainers: Trainers reported all trainees are encouraged to take part in teaching based around audit or papers. There is also consultant overview with a list of projects kept and trainees regularly presenting at Friday meetings.

F1 Trainees: Trainees reported little opportunity to engage with quality improvement. They are being asked to take part in a project when in trauma and orthopaedics however do not have time to undertake this.

F2/IST/ST Trainees: Trainees reported good opportunities for involvement in quality improvement projects.

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: Trainers commented that they work in a team-based structure where all opportunities such as handover and ward rounds are used to continually train and teach. They provide ongoing on the job feedback to all with consultants going over procedures to maximise teaching opportunities.

F1 Trainees: Trainees reported receiving very little formal or informal feedback on clinical decisions during the day or out of hours. They believe this is due to moving around a lot and people not having time to get to know F1 trainees. Thoughts were that ST trainees would provide F1 trainees with more feedback if they were not so busy. They commented that they are structured into clear teams for 2 weeks however will rotate through different teams on night shift or on-call. This includes when on the ward in trauma and orthopaedics where there can be different on-call ST trainees and consultants every day.

F2/IST/ST Trainees: Most trainees reported receiving constructive and meaningful feedback on clinical decisions during the day and OOH.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: Trainers stated that trainees are given the opportunity to provide feedback to consultants within regular Friday education and teaching sessions. ST trainees can also provide standardised feedback via local STC meetings.

F1/F2/IST Trainees: Trainees reported little opportunity to provide feedback on the quality of their training to management other than through the national trainee surveys.

ST Trainees: Trainees reported being asked to provide informal feedback on the quality of their training, with formal feedback provided through this visit.

2.12 Culture & undermining (R3.3)

Trainers: Trainers stated that anonymised feedback is crucial to ensuring the training environment is free from bullying and undermining. The chief resident also plays an important role in ensuring a safe training environment. They work along with consultants to resolve any feedback received. The department also have a formal process detailed in the induction handbook. They are not aware of any current issues with trainees feeling unsupported or undermined.

F1 Trainees: Trainees commented on a supportive clinical team and seniors. They believe that on occasions that they have witnessed behaviours of a consultant undermining other trainees. They are unsure as to whether they would formally raise concerns regarding bullying or undermining behaviours.

F2/IST Trainees: Trainees commented on friendly and supportive seniors who they are comfortable contacting for support. They commented on occasionally feeling undermined regarding medical knowledge in the handover setting and of interactions with the emergency department regarding review when taking referrals.

ST Trainees: Trainees reported no concerns regarding bullying and undermining behaviours and commented on very supportive seniors. If they had any concerns, they would be comfortable raising these with any supervisor.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Trainers stated that the rota is discussed on a weekly basis and incorporates a range of activities such as operating time, endoscopy, and clinic sessions. They commented that rota gaps have varied over the training year. Gaps at F1 level have been filled by gateway doctors and at F2 level a clinical fellow has been appointed. At ST level there were additional trainees in post from August to February with these gaps then filled by locums from February. Trainers are not aware of any aspects of the rota that are compromising trainee wellbeing.

F1 Trainees: Trainees reported gaps in the rota which have been filled. They commented that the rota is heavy and tight with no flexibility if someone is off sick. Those on the rota often cover the

additional workload and on occasions trainees will be reshuffled that day with often the F1 trainee from HDU being moved. Workload over a weekend with short term absence is extremely difficult to manage. They believe the on-call rota is the biggest issue and can affect trainee wellbeing due to duration of shifts and frequent moves from 12 hour shifts to days to night and 7-day stretch with one day off.

F2/IST Trainees: Trainees reported no gaps in the rota apart from short-term sick leave. Should there be a gap due to sick leave a communication is sent requesting available cover; if no cover is available internally a locum request will be submitted. They believe the rota accommodates learning, clinic, and theatre sessions. Most commented on a difficult and intense rota which can impact their wellbeing due to heavy on-call, number of nights and duration of some shifts.

ST Trainees: Trainees reported no gaps in the ST rota. Sick leave is cross covered by the ST trainee cohort and occasionally locums. They believe the rota accommodates specific learning opportunities, clinics and theatre sessions and that there are no aspects compromising their health or wellbeing.

2.14 Handover (R1.14)

Trainers: Trainers are content that handovers provide learning opportunities to trainees. They described the emergency team having a sit-down morning handover in the admissions unit with the full team invited and all patients discussed including scan results, blood results and x-rays. Post on-call the team (consultant, ST trainee, F1 and F2 trainees) UGI and colorectal team go through their list of patients. There is also paper ward round handovers between 5pm-6pm and evening handover at 8pm.

F1 Trainees: Trainees do not believe handover is a learning opportunity. They commented on multiple handovers taking place at the same time for example the night and day trauma and orthopaedic handovers take place at the same time as ward handover. ANPs are also attending a nursing handover.

F2/IST Trainees: Trainees stated that morning handover generally provides good teaching opportunities however this can be consultant dependant with some keen to review scans, bloods, and x-rays.

ST Trainees: Trainees reported that some consultants are better than others at ensuring handovers are used as learning opportunities.

2.15 Educational Resources (R1.19)

Trainers: Trainers stated that there are surgical skills resources available in the admission unit trainees can use to practice on. There is also laparoscopy equipment available in Queen Margaret Hospital.

F1 Trainees: Trainees reported adequate facilities however they have no time to use these, and they are located some way from the department.

F2/IST/ST Trainees: Trainees reported good facilities and learning resources available to them.

ST Trainees: Trainees reported no hot food available overnight and no access to a formal library.

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

Trainers/FI/F2/IST/ST Trainees: Not asked. No concerns raised in pre-visit questionnaire.

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

Trainers/F1 Trainees: Not asked.

F2 Trainees: Trainees advised that should they have any concerns regarding the quality of training in post they would take these directly to educational supervisors or foundation programme director.

ST Trainees: Trainees advised that should they have any concerns regarding the quality of training in post they would take these directly to educational supervisors or the training programme director.

2.18 Raising concerns (R1.1, 2.7)

Trainers: Trainers reported that trainees are encouraged to raise concerns regarding patient safety or any aspects of their training with any member of the team. They believe working in a team structure helps build relationships and they have experience of trainees feeling comfortable in calling them to ask questions or raise concerns. There are also clear pathways for escalation detailed within the induction handbook.

F1/F2/IST/ST Trainees: Trainees stated that they have not had to raise concerns relating to the quality of training whilst in post however would be comfortable in doing so with supervisors.

2.19 Patient safety (R1.2)

Trainers: Trainers reported that the department have numerous systems to monitor patient safety such as safety huddles, resus huddles and handover huddles for overnight. There are also daily meetings with senior nurses.

F1 Trainees: Trainees are content that there are routine systems in place to monitor the safety of patients.
F2/IST Trainees: Trainees reported they would be comfortable if a friend or relative were to be admitted to the department. They commented that for a patient with concurrent medical problems it is perceived that there is a reluctance for the medical team to become involved and expectation problems should be managed by the surgical team. They are aware of nursing safety huddles taking place.

ST Trainees: Trainees commented they would have no concerns if a friend or relative were to be admitted to the department. They are not aware of any safety huddles but confirm lots of stops and check points.

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

Trainers: Trainers reported that adverse incidents are discussed at monthly M&M meetings which the full group are invited to attend. There are also opportunities within a forum that meets every second week and monthly trauma and orthopaedic M&M meetings. All trainee groups are invited to attend all meetings.

F1 Trainees: Trainees reported being aware of the datix system however have had no experience in the system and therefore were unable to comment on learning opportunities. They commented that M&M meetings take place within Friday teaching sessions however attendance is varied. There is also a rota for the HDU F1 trainees to present a case within these sessions.

F2/IST/ST Trainees: Trainees reported that adverse incidents are reported through the datix system and are discussed at M&M meetings.

2.21 Other

Overall Satisfaction Scores:

F1 – score taken from pre-visit questionnaire 1/10
F2/IST – average 6/10
ST – average 7.6/10

3. Summary

Is a revisit required?	**Yes**	**No**	**Dependent on outcome of action plan review**

The panel commended the engagement of the site, trainers, and medical education team in supporting the visit. The panel noted a good training environment for F2, IST and specialty trainees however some concerns were raised regarding F1 trainees. The key areas for improvement noted at the visit relate to induction, teaching, clinical supervision, assessment, feedback, and adverse incidents. The next steps will be to conduct a SMART Objectives meeting and Action Plan Review meeting.

Positive aspects of the visit:

- Good engagement from the department pre visit with an informative presentation delivered on the day.
- Positive training culture with an approachable consultant body who are keen to train.
- Team based structure has many positive benefits regarding continuity of care, continuity of training however this was not reflected by the F1 cohort who consider themselves to be ward based and not part of the team structure.
- Good training environment for ST trainees.
- Trainers reported having time within job plans for supervisory roles and being well supported in these.
- ANP support is working well with F1s commenting that they are worth their weight in gold.
- Friday afternoon education sessions well received by ST trainees.
- All training grades confirmed having allocated educational supervisors and set learning objectives for the post.
- Approachable and supportive clinical team and seniors.
- Good range of training opportunities for ST trainees.
- Good availability of quality improvement and audit projects within the department.
- Rota design at F2 level and above in accommodating learning opportunities with trainees paying particular thanks to Mr Bennett.

Less positive aspects of the visit:

- Difficulties with low trainee numbers in visit sessions for F2/Core and ST trainees.
- F1 training experience doesn’t reflect work underway to improve their training experience with frequent moves from base wards.
- No catch-up induction for those who are unable to attend due to nights etc.
- Induction handbook large with out-of-date information.
- F1s difficulties in attending bleep free teaching due to ward pressures and bleep cover.
- F1s not always clear on escalation policies and how to contact people. With contact being made to personal mobile phones.
- F1 rota is tight with little flexibility. They reported long stretches of nights to long days.

- Perception from F1s that most of their day is spent undertaking many tasks that are of little or no benefit to their education and training.
- Some instances of F1s believing they are working beyond their level of competence. Particularly around escalating medical issues on the ward.
- Only one F1 has received any workplace-based assessments from a recognised trainer.
- No formal feedback provided at foundation level.
- F1s mainly receive peer to peer handover not embedded within team handovers that take place with senior input.
- F1s report little opportunity for learning in ward rounds.
- All grades of trainees were unaware of any trainee committees or avenues to report concerns with the quality of their training.
- STs commented on the impact the introduction of robotic procedures has had on their training opportunities however recognise this is a short-term problem.
- STs reported a slight shortfall in endoscopy cases in terms of numbers for logbooks.
- All grades commented on little feedback and learning from adverse incidents.
- F1s are unaware of the chief resident role within the department/hospital.

4. Areas of Good Practice

Ref	Item	Action
N/A	N/A	N/A

5. Areas for Improvement

Areas for Improvement are not explicitly linked to GMC standards but are shared to encourage ongoing improvement and excellence within the training environment. The Deanery do not require any further information regarding these items.

Ref	Item	Action
5.1		F1s are unaware of the chief resident role within the department/hospital.
5.2		The rota structure is perceived to be too demanding because of a lack of down time between nights and long days and this must be addressed.

5.3		All grades of trainees were unaware of any trainee committees or avenues to report concerns with the quality of their training.
5.4		Perception from F1s that most of their day is spent undertaking many tasks that are of little or no benefit to their education and training.
5.5		F1s report little opportunity for learning in ward rounds.

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	A process must be put in place to ensure that any trainee who misses their induction session is identified and provided with an induction. The unit handbook must also be kept up to date to reflect changes to departmental processes.	Immediately	All
6.2	There must be active planning of attendance of F1 doctors at teaching events to ensure that workload does not prevent attendance. This includes bleep-free teaching attendance.	Immediately	F1
6.3	Review and clarify the Clinical Supervision arrangements to ensure a clear understanding of who is providing supervision and how the supervisor can be contacted ensuring clear and up to date escalation policies which are understood and followed by all involved.	Immediately	F1
6.4	The discontinuity of ward placements for Foundation trainees must be addressed as a matter of urgency as it is compromising quality of training, feedback, workload and the 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.	March 2024	F1
6.5	Doctors in training must not be expected to work beyond their competence particularly around escalating medical	March 2024	F1

	issues on the ward.		
6.6	There must be senior support, including from consultants/recognised trainers to enable doctors in training to complete sufficient WPBAs/SLEs to satisfy the needs of their curriculum	March 2024	F1
6.7	A process for providing feedback to Foundation doctors in training on their input to the management of acute cases must be established including regular consultant ward rounds which review trainee decisions, care plans, offers constructive feedback and teaching.	March 2024	F1
6.8	Handover processes must be improved to ensure there is a safe, robust handover of patient care with adequate documentation of patient issues, senior leadership and involvement of all trainee groups who would be managing each case.	March 2024	F1