Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	22nd January 2020	**Level(s)**	FY/GPST/CMT/IMT/ST
Type of visit	Triggered	**Hospital**	Beatson West of Scotland Cancer Centre
Specialty(s)	Clinical Oncology	**Board**	NHS Greater Glasgow and Clyde

Visit panel	
Dr Reem Al-Soufi	Visit Chair
Dr Stephen Glen	Associate Post Graduate Dean for Quality
Fiona Stewart	Lay Representative
Dr Izhar Khan	Foundation Programme Director
Dr Catriona Ingram	Trainee Associate
Alex McCulloch	Quality Improvement Manager
In attendance	
Patriche McGuire	Quality Improvement Administrator

Specialty Group Information	
Specialty Group	Medicine
Lead Dean/Director	Professor Alastair McLellan
Quality Lead(s)	Dr Alan McKenzie Dr Stephen Glen Dr Reem Al-Soufi
Quality Improvement Manager(s)	Alex McCulloch and Heather Stronach
Unit/Site Information	
Non-medical staff in attendance	9
Trainers in attendance	8

Trainees in attendance	FY2 x 2	GPST x 1	Core/IMT x 5	ST x 15

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

Date report approved by Lead Visitor	20th February 2020 Dr Reem Al-Soufi

1. Principal issues arising from pre-visit review:

The Beatson West of Scotland Cancer Centre was formally under the GMC Enhanced Monitoring process from 2015 – January 2018. Following the last deanery visit in January 2018, the site was de-escalated from the Enhanced Monitoring process. Following review and triangulation of the available data in relation to the site at the Medicine Quality Review Panels in September 2019, concerns were raised in relation to a significant decline in National Training Survey results, most notably for FY2 trainees and Core Medicine Trainees. A visit was triggered to further investigate these issues. The data that raised the concerns is detailed below.

Foundation Trainees (FY2) in Clinical Oncology:

7 NTS red flags for Adequate Experience (triple red 2017-2019), Overall Satisfaction, Study Leave, Supportive Environment, Workload, Curriculum Coverage, Rota Design (double red flag 2018-2019).

4 pink flags for Clinical Supervision, Educational Supervision, Teamwork and Educational Governance.

Core Medicine Trainees in Clinical Oncology:

2 NTS red flags for Clinical Supervision and Regional Teaching
2 NTS pink flags for Overall Satisfaction and Local Teaching
1 STS red flag for Educational Environment

Specialty Trainees in Clinical Oncology:

2 NTS red flags for Feedback and Local Teaching

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.

Site presentation: The visiting panel was grateful for the helpful update that was provided by the local service manager and the clinical lead at the start of the visit day. The update allowed the panel to appreciate the challenges faced by the oncology department at the Beatson and the on-going efforts to resolve outstanding issues which include:

- Small numbers of trainees (FY2/CMT/IMT/GPST) make it difficult to interpret survey results.
- Significant numbers of staff on sick leave over the past 6-week period leading to rota gaps.
- Despite on-going work to improve the training environment several of the longstanding issues remain difficult to resolve (such as a lack of any FY1 trainees on site).
- The ward environment at the Beatson could be very different from the more traditional medical ward, this could often make FY2/CMT/IMT/GPST trainees feel uncomfortable. However, with time they become more familiar with the set up at the Beatson.
- Acknowledgement that service demands do affect training and that the clinical team and management are continually working to address these issues.
- Reduction in GPST training numbers reduced the number of doctors available.
- The challenge of producing rotas compliant with the maximum of 7-working days resulting in zero days that could challenge accessibility to training opportunities available on these zero days.

2.1 Induction (R1.13):

Trainers: Trainers advised that a full day of induction was provided for trainees, with separate catch ups for trainees who couldn't attend the initial main induction. Induction packs were saved on the local shared drive, where trainees could access them, and they were sent to them ahead of starting their post. Included in the packs was the Beatson's escalation policy for sick patients and at this year's induction, trainers had covered what trainees could expect to encounter at the Beatson (as a non-traditional medicine/hospital environment).

Foundation and General Practice Trainees: Trainees described Induction as a full day, which provided them with most of the information they required to start working in the Beatson. Some IT issues were identified in regard to being able to access shared ward e-mail inboxes and some of the trainees had not received usernames and password for them and had been unable to access them until quite recently.

Core and Internal Medicine Trainees: Trainees could attend Induction and received protected time to attend for the full day. No concerns were raised by them in relation to induction.

Specialty Trainees: The specialty trainees highlighted that a very good induction was provided for them. Some of the trainees commented that it was the best induction they had received. Induction was inclusive of supporting documentation and usernames and passwords for all relevant IT systems.

Nursing and Non-Medical Staff: Nursing and Non-Medical Staff felt that trainees received an adequate induction that was effective in preparing them to work during the day and out of hours.

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

Trainers: Local teaching was provided for FY2/GPST/CMT/IMT trainees on Wednesday at lunchtime, on a weekly basis. Trainees could also attend Beatson wide generic teaching sessions, which were generally consultant led and were based around tumour groups and took place every Friday.
Once every 6 weeks a junior doctors forum takes place. Morbidity and Mortality (M&M) meetings took place every 6 weeks, but FY/GPST/CMT/IMT trainees would often not attend. For the Wednesday teaching sessions, trainees were invited to give their pagers to the local administrator, so they would not be interrupted but many chose not to do this and would take their pagers into the teaching sessions with them. Trainees could also attend their regional (programme) teaching and trainers were unaware of any circumstances where a trainee had not been able to attend a session.
Trainees were also able to attend a palliative medicine teaching day, which was a full day of training open to all cohorts of trainee.

Foundation and General Practice Trainees: Trainees were aware of local teaching taking place on a Wednesday at lunchtime but did not think that it took place on a weekly basis and thought it took place monthly. They also found it difficult to get to because of workload. Trainees also described a sarcoma multi-disciplinary meeting taking place at the same time as Wednesday sessions, which made it more difficult for some of them to attend. Trainees were not aware that the teaching was bleep-free and so they would take their pagers into the teaching session with them, which meant they could be interrupted.

Core Medicine and Internal Medicine Trainees: Trainees advised that local teaching took place on a Wednesday lunchtime but did not think that it took place every week. Trainees present had been to the 1st national IMT training day and boot- camp (3 day residential simulation course) but the Core Medicine trainees hadn't been to regional teaching yet, this was due with them being replaced by national training days, which would take place later in the year.

Specialty Trainees: Teaching for the higher trainees took place on a Friday afternoon. The sessions were organised by the trainees themselves and were generally consultant led. All could attend the available sessions. Trainees confirmed that they were also able to attend their regional teaching sessions and were involved in the delivery of the Wednesday teaching sessions for the junior (FY/GPST/CMT/IMT) trainees.

Nursing and Non-medical staff: Nursing and non-medical staff supported trainees to attend the available teaching by providing ward cover for them to allow them to attend. The generic teaching sessions that were delivered on a Friday were multi-disciplinary sessions and anyone could attend them.

2.3 Study Leave (R3.12)

Trainers: Trainers felt that trainees could access study leave without any difficulties and were not aware of any instances where trainees study leave requests had been turned down.

All trainee cohorts: No concerns were raised by any trainee cohort in relation to study leave.

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

Trainers: Trainers were allocated educational and clinical supervisors before they started in their posts and confirmation was sent to them along with their induction documentation. Trainers felt they rarely received information about trainees with known concerns before they started and often found out by reviewing their e-portfolio. Trainers maintained responsibility for the same cohort of trainee each year, which helped build familiarity with their curriculum. Trainers met regularly with the training programme director at the specialty training committee to discuss training issues. All trainers felt they were appropriately trained and had attended the required Train the Trainer courses to become a trainer. The trainers present felt they had enough time in their job plans to conduct their roles.

Foundation and General Practice Trainees: Trainees present had been allocated educational supervisors and had met with them and put learning plans in place.

Core Medicine and Internal Medicine Trainees: Of the trainees' present, all had been allocated educational supervisors. 2 of the trainees' present had met with their educational supervisor and had learning plans in place but 1 trainee had not yet met with their supervisor, despite starting their post in December. They had made attempts to contact their supervisor but were yet to have a response.

Specialty Trainees: Trainees present had been allocated educational supervisors and met with them regularly.

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 advised that they were working on the implementation of a coloured badge system to ensure that staff can differentiate between different grades of trainee, their experience and level of competence. Trainers felt that the clarity around who trainees should contact for advice both during the day and out of hours could be improved and made more formalised. Trainers were unaware of instances of trainees working beyond their competence, They did feel there was some potential for a situation to arise if an FY2 was working on nights and a seriously ill patient was requiring an emergency transfer to the Queen Elizabeth University Hospital for ITU/HDU support, they would have to call the on-call Anaesthetist (located at a local hotel). This could pose a concern for them if it happened with multiple patients at the same time, due to their being only one Anaesthetist available (because the Beatson is located on a hospital campus that has no ITU/HDU department).

All Trainee Cohorts: Trainees were aware of who to contact for supervision both during the day and out of hours and of the trainees' present, none had concerns of working beyond their competence. They felt their senior consultant colleagues were accessible and approachable.

Nursing and Non-Medical staff: Nursing and non-medical staff were aware of the work going on to implement a coloured badge system. At the moment staff would introduce themselves to trainees and would support them on an informal basis to help them obtain their training requirements.

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

Trainers: Trainers were aware of the trainee's various curricula by maintaining responsibility for the same cohort of trainees each year. Core/IMT/Specialty Trainees were allocated clinic weeks, which were pre-planned into their rotas, Foundation and GPST trainees were allocated 3 days of clinics. Competences could be difficult for trainees to obtain, included central line and lumbar puncture training.

Foundation and General Practice Trainees: Trainees felt there could be more Palliative Care experience provided to them, they had attended a palliative care training day but felt the job itself could include more experience. FY2 trainees could get to around 3 clinics per block and GPSTs estimated they got to around 10 days of clinics over 3 months. Trainees felt that between 50 – 80% of their day was spent completing tasks that they considered to be of little educational value to them such as Immediate Discharge Letters and taking blood samples.

Core and Internal Medicine Trainees: Trainees felt they had little contact with consultants in their posts, which made it difficult for them to complete workplace-based assessments and get them signed off. They highlighted their clinic experience as very good but estimated they spent most of their time completing tasks which they considered to be of no educational value to them.

Specialty Trainees: Trainees felt they could achieve all their training requirements from their post, if they were pro-active.

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

Trainers: Trainers were aware of the assessments that trainees need to complete, through familiarity with the curriculum and discussion with the trainees when creating a learning plan. Trainers felt that opportunities were available for trainees to complete workplace-based assessments, although Acute Care Assessment Tools (ACATs) could be difficult for trainees to complete.

Foundation and General Practice Trainees: Trainees advised it could often be difficult for them to complete Workplace Based Assessments (WPBA), they were often working in wards on their own and felt that as much of their workload consisted of what they considered to be non-educational tasks, they often did not have the evidence required to complete WPBA. The frequent movement of trainees around wards and the infrequency of contact with consultants, made it difficult for trainees to get WPBA signed off. On the occasions where they had completed assessments and had them signed off, they felt they were assessed fairly and consistently.

Core and Internal Medicine Trainees: Trainees present had not had the opportunity to complete workplace-based assessments to date in their posts.

Specialty Trainees: Trainees reported no difficulties in completing WPBA and felt they were assessed fairly and consistently.

Nursing and non-medical staff: Nursing and non-medical staff supported trainees with their WPBA by responding to tickets sent to them, by trainees through e-portfolio.

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

Trainers: Not covered.

All Trainees Cohorts: Trainees confirmed that lots of opportunities for multi-professional learning took place regularly on the wards. The Friday Beatson-wide teaching sessions were also open to all multi-disciplinary staff. However, workload could often affect trainees' ability to attend.

Nursing and non-medical staff: Nursing staff confirmed lots of regular opportunities for multi-professional learning and highlighted the Friday Beatson wide teaching sessions as an example of this.

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

Trainers: Trainers felt that lots of opportunities were available for trainees to become involved in audit and quality improvement projects. Often quality improvement projects were discussed at initial meetings with educational supervisors. Supervisors would "buddy up" FY2 trainees with specialty trainees to support them with projects.

All Trainee Cohorts: Trainees confirmed lots of opportunities to become involved in audit and quality improvement projects.

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: Trainers described opportunities for trainees to receive feedback at morning handover and during ward rounds from consultants. Feedback was also provided to trainees following clinics. Trainers acknowledged that more feedback could possibly be provided to FY/GPST/Core/IMT trainees but as they were often moved around the wards more frequently, it could be more difficult to provide them with feedback**.**

Foundation and General Practice Trainees: Trainees felt that feedback was more readily available in the mornings post night shift, than during the day. A lack of ward continuity made it difficult for trainees to become familiar with consultants in order to receive feedback on their work. Trainees also described overlapping ward rounds taking place, where several consultants and registrars would attend the ward to see patients, this arrangement made it difficult for the trainees to attend ward rounds and so limited opportunity to receive regular feedback on their care for patients.

Core and Internal Medicine Trainees: Trainees felt they got very little feedback from consultants on their clinical decision making during the day and at night. They felt they had to be persistent with questions and approaches to consultants to get any feedback.

Specialty Trainees: The trainees present advised they received lots of feedback on their clinical decisions on a regular basis and felt the feedback they received was constructive and meaningful.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: Not covered.

All Trainee Cohorts: Trainees highlighted the trainee forum as where they could provide feedback on the quality of the training they were receiving.

2.12 Culture & undermining (R3.3)

Trainers: Trainers felt there had been an improvement in the culture in the Beatson over the past few years and the support they received from hospital management had improved significantly. One possible undermining incident had been raised by a trainee with their educational supervisor, this had subsequently been reported to the clinical lead and the training programme director, who were investigating it.

All Trainee Cohorts: Trainee did not report any undermining or bullying behaviours or incidents. If they did witness any or were subjected to any, they would raise any such concerns with their educational supervisor or other consultant colleagues.

Nursing and Non-Medical Staff: Staff felt a good team culture was in place at the Beatson and were unaware of undermining or bullying incidents taking place. They felt a good escalation policy was in place and that both nursing and senior medical staff were open and approachable to trainees. Staff described a Greatex system was in place to support and celebrate good practice and also the recent creation of a Beatson football team.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Trainers felt the rota worked well for trainees, if they had a full complement with no gaps. Difficulties arose when short term cover was required for sick leave/annual leave etc. The issues related to cross cover for gaps were known to the trainers and management, with alternative arrangements being put in place, such as the employment of clinical development fellows and advanced nurse practitioners. Trainers acknowledged that cover arrangements affected the ward continuity of the Foundation/GP/Core/IMT trainees. Trainers confirmed that a consultant organised the rota including annual leave and clinic days where 1 week of clinics is allocated for Core/IMT/Specialty and 3 days for FY2.

Foundation and General Practice Trainees: Trainees confirmed they had clinic days pre-planned into their rotas. Trainees had concerns around the continuity of ward cover, as they were moved frequently and at short notice to cover short term service gaps. This meant they found it difficult to build up a rapport with the team they were working with, which in turn made it difficult to complete workplace-based assessments.

Core and Internal Medicine Trainees: Trainees felt management of short term and long-term rota gaps could be improved and that it had the potential to affect patient safety. They advised recently there had been a lot of short-term gaps created by sick leave and they felt these could have been managed more effectively. Trainees acknowledged that work was ongoing to address the issue of how rota gaps were filled and hoped that the situation would improve when a full complement of staff is achieved.

Specialty Trainees: Trainees were not aware of any gaps in their current rota. The rota was organised by one of the trainees themselves they felt it worked well. Trainees also appreciated the learning opportunities that were planned into their rota.

Nursing and Non-Medical Staff: Staff described the continuity of the rota for Foundation trainees as very difficult. They were often moved around wards without much notice and this was highlighted as particularly challenging over the Festive period.

2.14 Handover (R1.14)

Trainers: Trainers felt handover was structured and effective in ensuring that information about sick patients is passed to the next team. Whether handover could be used as a learning opportunity or not, varied depending on who was leading it.

All Trainee Cohorts: Trainees confirmed that handover took place daily at 9.00 am, 5.00 pm and 8.30 pm with morning handover being more formalised and consultant led. Handover during the week was conducted verbally with some written documentation and Trakcare was used at weekends. Foundation and General Practice trainees described an issue with regard to a lack of Haematology input to handover, this was problematic for trainees as they provided cover for Haematology in the out of hours period as well as for ward B7 (teenage cancers), yet they reported inconsistent handover for

those two areas that frequently fell below the standards of Oncology handover. Trainees felt that handover could be used as a learning opportunity although time constraints limited its use for educational purposes.

Nursing and Non-Medical Staff: Staff felt handover worked well and was effective in ensuring information about sick patients was passed on to the next team.

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)

Trainers: Trainers advised they would contact a trainee's supervisor if they had concerns about a struggling trainee. They felt that as a multi-disciplinary team they worked closely together and that everyone was approachable. Support was provided for less than full time trainees and trainees returning from maternity leave such as making reasonable adjustments to accommodate their needs.

All Trainee Cohorts: Trainees felt support would be available to them if they were struggling with their job due to health or other issues. Most trainees felt that the Beatson would accommodate reasonable adjustments for trainees with needs, although a trainee did mention that the support they received when they returned from maternity leave wasn't as good as they had expected but they added that this was probably an exception to the normal procedures due to vacancies and workload pressures.

Nursing and Non-medical Staff: Staff confirmed they would raise any concerns that had in relation to a trainee's performance with their Educational Supervisor or other consultant colleagues.

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: Not covered.

All Trainee Cohorts: Trainees were unaware of who their director of medical education was and what they were responsible for. Trainees highlighted the trainee forum as where they would raise any concern they had in relation to the quality of training they were receiving.

2.18 Raising concerns (R1.1, 2.7)

Trainers: Trainers described Datix as the reporting took for trainees to raise any concerns about patient safety. They could also raise any concerns they had about their own training at the junior doctor forum.

All trainee cohorts: Trainees described Datix as the main reporting tool for raising concerns about patient safety. Workload was highlighted as overwhelming for Foundation/General Practice/Core and Internal Medicine trainees but felt that the escalation procedures in place where known to them and they could access support if they required it.

Nursing and Non-Medical Staff: Staff highlighted Datix as the main reporting tool for raising concerns about patient safety.

2.19 Patient safety (R1.2)

Trainers: Trainers felt the environment at the Beatson was safe for both patients and trainees. The last 6 weeks of the winter period were described as very busy and difficult for all staff and particularly for more junior trainees (FY/GPST/CMT/IMT). The main challenge was that the Beatson have no HDU/ITU on the hospital campus and so critically ill patients require transfer to the Queen Elizabeth University Hospital with Anaesthetics support, provided by an on-call Anaesthetist who covers the Beatson on locum basis.

All Trainee Cohorts: Trainees present confirmed they would not have any concerns about the quality or safety of care that a friend or relative would receive if they were admitted to the Beatson. The boarding of patients was thought to be a rare occurrence and when boarding did take place, patients were generally reviewed by consultants on daily basis.

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

Trainers: Trainers described Morbidity and Mortality meetings (M&M) as forums for discussing adverse incidents and the learning gained from them. As the M&M meetings were multi-disciplinary, they were often learning events that all staff contributed to and learned from. As the Beatson was a consultant led hospital, they would lead any discussions when something went wrong with a patient's care and would include the trainee in the discussions with the patient.

All Trainee Cohorts: Trainees felt if they were involved in an adverse incident, they would be supported by their educational supervisor. They highlighted the Datix system as the reporting system for adverse incidents. FY2/GPST/IMT trainees present had not been involved in any adverse incidents and appeared to be unaware of the M&M meetings that took place. Some of the specialty trainees present had been involved in adverse events and had been well supported throughout the process and were able to attend M&M meetings.

Nursing and Non-Medical Staff: Not covered.

3. Summary

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

The visit panel found differing experiences of training in this visit, with the Specialty Trainees receiving a very positive experience while the Foundation, General Practice, Core and Internal Medicine trainees having a much less positive experience than their senior colleagues. This is reflected in the variation in the overall satisfaction scores that were given by trainees below. Serious concerns are raised in relation to the junior trainee's ability to meet their curriculum requirements based on the current training experience they are receiving. These concerns have been drafted into DME requirements in the action plan attached to this report.

Overall Satisfaction scores:

Foundation and General Practice Trainees - scored between 4 – 5 out of 10.
Core and Internal Medicine Trainees -scored between 4 – 5 out of 10 with an average score of 4.75
Specialty Trainees – scored between 7 – 9 out 10 with an average of score of 8.2

Positive aspects of the visit:

- Approachable and supportive consultants who are committed to high quality patient care
- Comprehensive Induction with a period of shadowing for the specialty trainees, inclusive of PDF documents for the junior tier that is emailed to doctors prior to commencing in post.
- Clinic allocation on rota was positively received; Clinic weeks for CMT & IMT trainees and 3 days of clinics for FY2 & GPST.
- The appointment of Advanced Nurse Practitioners and Clinical Development Fellows to support the trainees with their workload.
- Well-structured and well-attended handover for oncology wards.
- Quality Improvement and audit opportunities are readily available to all trainees.
- Good access to study leave
- Trainees forum meets regularly and is well attended by trainees. The forum's link allows trainees to raise concerns, which management then try and actively resolve.
- Specialty Trainees have a very positive training experience and are very satisfied with their training environment, overall satisfaction score = 8-9/10
- Culture of the Beatson is very supportive and the multi-disciplinary team work harmoniously across all levels

Less positive aspects of the visit:

- Trainees at FY/GPST/CMT/IMT level felt unsatisfied with their training experience and would not recommend the post to a colleague, overall satisfaction score was 4-5/10
- Trainees at FY/GPST/CMT/IMT level felt that frequent changes to ward cover and inability to attend ward rounds reduced their exposure to clinical supervision by consultants and as a result found it difficult to obtain WPBAs.
- Trainees at FY/GPST/CMT/IMT reported the timing of ward rounds was unpredictable and subsequent documentation in notes was sometimes lacking, better coordination of the ward rounds was desired as simultaneously-occurring rounds were challenging to attend, particularly when a single doctor covered the whole ward.
- Paucity of feedback on clinical performance provided to FY/GPST/CMT/IMT trainees during the day. However, trainees reported better access to feedback following night shifts.
- FY/GPST/CMT/IMT trainees felt they spent between 50 – 80% of their time completing tasks of little educational value to their training level such as IDLs, phlebotomy and ECGs.
- Workload intensity was heightened by short term rota gaps and trainees cross-covering other wards resulted in lack of continuity in patients' care and clinical supervision.
- Variable awareness of teaching happening amongst FY/GPST/CMT/IMT trainees, particularly Wednesday teaching and Morbidity and Mortality meetings (M&M).
- The generic e-mail had not been accessible by a number of trainees who only received access last week, despite being in post since December.
- Handover: FY/GPST/CMT/IMT provide out-of-hours cover for patients in Haematology and B7 (teenage cancers), yet they reported inconsistent handover for those two areas that frequently fell below the standards of Oncology handover.

4. Areas of Good Practice

Ref	Item	Action
4.1		

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	Access to generic ward e-mail inboxes in order for trainees to access relevant patient information must be improved.	

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	Staffing levels in wards must be reviewed to ensure that workload is appropriate and does not prevent access to learning opportunities including outpatient clinics.	7th October 2020.	FY/GPST/CMT/IMT
6.2	Tasks that do not support educational and professional development and that compromise access to formal learning opportunities for all cohorts of doctors should be reduced.	7th October 2020.	FY/GPST/CMT/IMT
6.3	The discontinuity of ward placements for Foundation, GPST and IMT/CMTs 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.	7th October 2020.	FY/GPST/CMT/IMT
6.4	Rota/ timetabling management must be addressed to eliminate frequent, short notice, movement of trainees away from their base ward.	7th October 2020.	FY/GPST/CMT/IMT
6.5	Trainees must be made aware of when ward rounds in downstream wards are taking place, avoiding simultaneous ward rounds. Trainees should be included in ward rounds and receive feedback on their management of medical inpatients.	7th October 2020.	FY/GPST/CMT/IMT

6.6	A process for providing feedback to doctors in training on their input to the management of acute cases must be established. This should also support provision of WPBAs.	7th October 2020.	FY/GPST/CMT/IMT
6.7	There must be active planning of attendance of doctors in training at teaching events (Wednesday teaching and M&M meetings) to ensure that workload does not prevent attendance. This includes bleep-free teaching attendance.	7th October 2020.	FY/GPST/CMT/IMT
6.8	Handover of care of (Haematology patients and ward B7 teenage cancer patients) must be more formalised to support safe continuity of care and to ensure unwell patients are identified and prioritised.	7th October 2019	FY/GPST/CMT/IMT
6.9	Initial meetings and development of learning agreements with Educational Supervisors must occur in a timely manner (before the end of the 1st month in post).	Immediately	FY/GPST/CMT/IMT