Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	28th & 30th May 2025	**Level(s)**	FY, GPST, IMT, ST
Type of visit	Enhanced Monitoring	**Hospital**	Queen Elizabeth University Hospital
Specialty(s)	General (Internal) Medicine	**Board**	NHS Greater Glasgow and Clyde

Visit panel	
Professor Adam Hill	Postgraduate Dean – Visit Chair
Dr Jane Rimer	Associate Postgraduate Dean – Medicine
Ms Kate Bowden	GMC representative
Dr Izhar Khan	Foundation Programme Director
Dr Ken Lee	Associate Postgraduate Dean for Quality/GP Representative
Dr Duduzile Musa	College representative
Dr Aye Doris	Trainee Associate
Mr Bill Rogerson	Lay representative
Ms Gillian Carter	Quality Improvement Manager
In attendance	
Ms Ashley Bairstow-Gay	Quality Improvement Administrator

Specialty Group Information	
Specialty Group	Medicine, Surgery, Anaesthetics, Intensive Care Medicine, Emergency Medicine, ACCS and Occupational Medicine
Lead Dean/Director	Professor Adam Hill
Deputy Lead Dean/Director	Mr Alastair Murray
Quality Lead(s)	Dr Reem Al Soufi, Dr Alan McKenzie, Mr Phil Walmsley, Dr Kerry Haddow, Dr Fiona Drimmie
Quality Improvement Manager(s)	Ms Jennifer Duncan, Ms Vhari Macdonald

Unit/Site Information					
Trainers in attendance	14				
Resident Doctors in Training (RDITs) in attendance	FY1: 16	FY2: 4	GPST: 5	IMT: 5	ST: 6

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

Date report approved by Lead Visitor	17th June 2025

1. Principal issues arising from pre-visit review:

General Internal Medicine (GIM) at the Queen Elizabeth University Hospital (QEUH), Glasgow, has been under the GMC enhanced monitoring process since 2016.

The last visit to QEUH took place on 13th and 14th March 2024. At this visit the panel commended the ongoing engagement of service leads and trainers in supporting RDITs and seeking evidence-based improvements in the department whilst noting the persisting concerns across all cohorts of RDITs relating to patient safety, access to educational opportunities and alleged Dignity at Work concerns.

The visit identified 3 requirements which were:

- Handover arrangements must be reviewed, particularly for patients moved under the GlasFLOW system and handover from the front door to downstream wards.

- Work must continue to ensure sufficient staffing, including medical staffing, is available for the workload and to ensure RDITs have access to quality training; this includes ensuring FY1s, FY2s, GPSTs and IMTs are supported to attend an average of around 2 hours per week of local teaching opportunities, and ensuring GPSTs and IMTs are supported to attend sufficient clinics without compromise because of service needs.

- All staff must behave with respect towards each other and conduct themselves in a manner befitting Good Medical Practice guidelines.

There are currently 3 requirements attached to the enhanced monitoring case which are:

- R1.7 – All RDITs reported that when they were able to access supervision they felt well supported. However, due to workload at the site FYs and GPSTs reported that supervision could be hard to find, specifically out of hours. As work still needs to be undertaken in this area this requirement remains part of the enhanced monitoring case.

- R1.14 – There was evidence of improvement to some handover arrangements, specifically post-receiving handovers which have been used as an educational tool. However, RDITs reported several areas where the lack of robust handovers affected quality and safety of care. In addition, new concerns were raised regarding handover of patients transferred

as part of the GlasFLOW model. As work still needs to be undertaken in this area this requirement remains part of the enhanced monitoring case.

- R5.9 – FYs, GPSTs and IMTs reported that service needs often prevented them from accessing educational opportunities such as attending teaching and clinics. As work still needs to be undertaken in this area this requirement remains part of the enhanced monitoring case.

This visit aimed to review progress against the previous visit requirements as well as to review progress towards the GMC's outstanding requirements for enhanced monitoring. The areas explored during the visit were reflective of these aims. The visit also aimed to take the opportunity to gain a broader picture of how training is carried out within the department visited and to identify any points of good practice for sharing more widely.

The panel thanked Dr Neil Ritchie and Dr Neil McGuchan, Clinical Directors, for the detailed and informative presentation shared at the start of the visit.

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.

2.1 Induction (R1.13): Not covered.

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

Trainers: Trainers described the methods by which they enable RDITs to attend regional teaching and reported that it was unusual to struggle to accommodate regional teaching attendance. Some regional teaching, such as IMT teaching, is recorded and RDITs are given time off in lieu to watch recordings if they cannot attend live. Trainers also confirmed that the regional teaching programme for FYs was bleep-free. In terms of local teaching, some departments described regular bleep-free teaching, for example in Infectious Diseases where departmental teaching was also recorded. Trainers in Acute Internal Medicine noted challenges in providing a local teaching programme due to low RDIT engagement which stemmed from workload, burnout and lack of suitable facilities in the

department. They felt that protected space within the area where care is provided was essential for provision of local teaching when there are rota pressures. An example of this working well was found in Gastroenterology where a waiting room has been changed into a seminar room using endowment funding to allow departmental teaching to take place within the department.

FY1: FY1s reported that they could usually only attend their 1 hour of regional teaching per week and could not attend any local teaching due to workload. They sometimes also struggled to attend regional teaching due to workload. As the teaching was online they were able to catch up in their own time.

FY2: FY2s reported that they had attended 1-2 hours of local teaching in total since starting the post and generally could not attend due to workload. They suggested that it could be better if there was GIM-wide teaching rather than just departmental teaching as this could improve the culture surrounding attendance. It was also suggested that more consultant-led teaching would be beneficial as most local teaching was peer-led which was more beneficial to the teacher than the learner. RDITs in several cohorts mentioned that teaching in Diabetes and Endocrinology was all peer-led and they would appreciate some consultant-led teaching. RDITs in several cohorts also mentioned that no local teaching was available in Cardiology. FY2s had not been able to get study leave to attend regional teaching however they had been given time off in lieu to watch recordings of the sessions.

GPST: GPSTs reported that they could attend 0.5-1 hour of local teaching per week and sometimes struggled to attend due to workload, staffing or when in medical receiving. GPSTs reported that they could access study leave to attend regional teaching if they were working a normal day, but would not be able to attend if on a long day.

IMT: IMTs reported that they could attend 0.5 hours per week of local teaching which was RDIT-led. Like trainers, they noted that space to deliver teaching in the Acute Medicine department was insufficient. They reported that it could be difficult to attend teaching due to workload and staffing and when they did manage to attend they were often interrupted. Nonetheless, they were able to access time off in lieu to watch recordings of their regional teaching if they had been unable to attend live.

ST: Most STs reported that they and their peers were responsible for organising teaching in their departments, although noted that there was consultant-led teaching in Respiratory Medicine.

Obstacles to attending teaching included being off-site at clinics or lack of appropriate space, especially in Acute Internal Medicine. STs felt that the main obstacle to teaching in Acute Internal Medicine was not workload but rather space and the culture towards prioritising teaching. In terms of regional teaching, accessibility varied by department with some having to watch recordings as they could not be released to attend live. Whilst RDITs found this arrangement adequate, they felt it would be better for them to attend teaching live to be able to interact with the content.

2.3 Study Leave (R3.12): Not covered

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

Trainers: Trainers reported that supervisors are allocated by nominated consultants within each department based upon the lists of RDITs sent to departments and the availability of Supporting Professional Activities (SPA) time for each trainer. Some trainers have preferences regarding the grade of RDIT they wish to supervise which are usually honoured. They felt well supported by the Training Programme Directors (TPDs) based within the site and the TPDs in turn were well-supported by the Associate Postgraduate Deans (APGDs). Trainers noted that they need more time to arrange supervision for RDITs with specific needs and, whilst they can accommodate this well within such a large site, it would be useful to receive this information at the earliest opportunity. Most trainers advised that they receive 0.25 sessions of SPA time per RDIT that they supervise, however it was recognised that some trainers have no SPA time for their role. This can be a point of contention at appraisal as adequate SPA time is a requirement for the Recognition of Trainers credential. Supervision roles are also not covered when a trainer is on leave, for example on maternity leave, so the work needs to be absorbed by other trainers.

RDITs: Not asked.

2.5 Clinical supervision (day to day) (R1.7, 1.8, 1.9, 1.10, 1.11, 1.12, 2.14, 4.1, 4.6)

Trainers: Trainers reported that RDITs wear coloured badges to identify their grade. The term ‘SHO’ is no longer used except sometimes in self-identification by RDITs or locums. Trainers reported daily consultant presence on the wards and a constant presence on the ground floor. Role cards are available for each area which outline escalation processes and these are also highlighted within

departments, for example at handover. Generally they did not think RDITs needed to work outside their competence or experience. Trainers were not aware of any issues in terms of RDITs being asked to consent for procedures and noted no issues had arisen at morbidity and mortality governance reviews. It was felt to be a strength of the site that so many consultants and senior RDITs were available to support procedures.

FY1: FY1s confirmed that they knew who to contact for supervision both during the day and out of hours and they understood the escalation routes. They reported that they sometimes had to work beyond their competence due to workload, particularly out of hours or overnight, for example doing ward rounds and patient reviews on their own. FY1s reported that there was variability in terms of the approachability of senior colleagues.

FY2: FY2s reported that they did ward rounds on their own but then could speak briefly to consultants for help afterwards. Nonetheless, they knew who to contact for support if required and found most of their senior colleagues to be approachable. FY2s felt confident in the types of patients they had to manage, but felt the workload left them sometimes working beyond their competence or experience. They noted that they rarely had to make decisions without senior support available, but support could sometimes be delayed due to registrar vacancies, clinics or lack of phone signal.

GPST: GPSTs reported that they knew who was providing their supervision most of the time. They felt their supervisors were approachable and if there was not someone available in person they could telephone a consultant for help. They did not feel they needed to work outside their competence or experience as there was sufficient support available.

IMT: IMTs were confident regarding who was providing their supervision and felt their senior colleagues were usually approachable and accessible. They felt that they were treated with respect by supervisors and were never made to feel like they had asked a ‘silly question’. IMTs reported that they sometimes felt they needed to work outside their competence or experience in emergency situations or when patients were referred to Acute Internal Medicine inappropriately but otherwise were able to access support.

ST: STs found it fairly easy to access support when needed and felt their senior colleagues were accessible and supportive. They never had to work beyond their competence or experience. The only

concern raised was regarding consultant cover in the same day urgent care centre as there was no formal cover for this area until after 2pm however other consultants were generally happy to help if needed.

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

Trainers: Trainers reported that they kept up-to-date with curriculum requirements by using guides and by speaking with the TPDs and APGDs at the site. Trainers acknowledged challenges in terms of clinic attendance due to understaffing and lots of clinics being off-site. They noted that it was harder for IMTs to meet their clinic requirements compared with other sites, although the High Dependency Unit (HDU) block helped with attainment as they were able to go to clinics at Gartnaval General Hospital, Glasgow, in the afternoons. Some departments have clinic rotas, for example Infectious Diseases. Trainers felt that service was generally more prevalent than learning opportunities due to the staffing being too low for the workload. They reported that Advanced Nurse Practitioners (ANPs) have helped support the workload, however many have left as they were unsatisfied with their working conditions. Trainers noted that a full phlebotomy service would help to reduce the workload for RDITs as they have to do a lot of bloods and handbacks, however the current service is limited, for example there is no phlebotomy service at the weekend. A trial was completed last winter whereby medical students were employed to take bloods and this was found to give RDITs more time for educational activities, however funding has not been allocated to allow this to continue.

FY1: FY1s found it easy to obtain most competencies as there was usually a mid-tier RDIT on the wards, although in General (Internal) Medicine they found it too busy during the day to be observed for supervised learning events (SLEs). They reported that they had to complete most of their portfolio at home as it was too busy to do this at work. They found it most difficult to gain their competencies in delivering teaching and working on quality improvement projects as they felt there was a lack of time and support for these. FY1s felt the emphasis in this post was on service provision and estimated that 95% of their work was non-educational. They reported spending most of the day doing administrative tasks like referrals and discharge letters and did not do a lot of clinical decision-making.

FY2: FY2s reported that they found it easy to obtain case-based discussions, but struggled with other workplace-based assessments as the workload was too high for senior colleagues to observe them. This has been raised as an issue, but there has not yet been any solution found. They found it easier

to complete mini-Clinical Evaluation Exercises (mini-CEXs) when working in acute receiving. Like FY1s, they reported that they do not have any time during the day to work on their portfolios and noted that they receive little feedback. FY2 felt that mid-tier doctors were expected not to change management plans and to maintain the status quo until the next consultant review. FY2s also echoed the comments regarding an insufficient phlebotomy service which meant they got a lot of handbacks and had to do all cannulation themselves.

GPST: GPSTs reported that it could be difficult to complete assessments which needed to be observed as it could be difficult to find an appropriate ST4+ colleague to observe them in such a busy environment. They found it was easier to complete assessments in the acute receiving unit. GPSTs felt most of their work on the wards was non-educational and their role was similar to that of an FY1 with a lot of bloods, cannulas and discharge letters to complete.

IMT: IMTs felt they would have struggled to achieve pleural procedures in this post had they not already done these in a previous post. They also had to attend a different hospital to do direct current cardioversion. In terms of clinics, IMTs reported that some departments were good at offering opportunities to attend clinics on- and off-site, including Renal Medicine and Cardiology. Otherwise they got all of their clinic experience during their HDU block where they could attend clinics at Gartnaval General Hospital. They noted that the success of this model was dependent upon the timing of the HDU block as some RDITs had been scheduled this experience over Christmas and there were no clinics running. IMTs also reported that they did not get much clinic experience while working in Acute Internal Medicine. Whilst they had access to ambulatory care, most of the work here was done by ANPs. RDITs felt that most of their work was educational, however this was variable according to staffing levels and on occasion they were asked to do phlebotomy rounds due to lack of suitable staff to do these.

ST: STs reported that challenges for them were obtaining their ultrasound competencies in Acute Internal Medicine and attending General (Internal) Medicine clinics as they did not have protected time for these activities. STs found it was sometimes difficult to obtain competencies when on-site as they often do not have a senior colleague working with them due to clinics being off-site. STs reported that work could be non-educational overnight or when working in the Initial Assessment Unit (IAU) during the day as these shifts were more similar to tier 2 middle grade reviews or clerking shifts. STs

noted that 3 locums had recently been appointed to support the IAU which allowed them to have a more appropriate registrar role, however these posts were temporary.

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

Trainers: Trainers reported that there was a wide range of experience available within the site and consultants are proactive in encouraging RDITs to use cases for assessments. The 'SpR of the Week' model allows STs to obtain assessments more easily whilst working in Acute Internal Medicine, particularly Acute Care Assessment Tools (ACATS). The only procedure noted as hard to achieve was direct current cardioversion as it needs to be performed in a laboratory setting.

FY, GPST: Not asked.

IMTs: IMTs reported it was generally easy to obtain assessments if RDITs are proactive in asking for them to be done. They noted that rotations sometimes mean that they do not spend long enough in a department to get to know consultants well enough to ask them to complete assessments, however this becomes easier in IMT3 when they move to 6-month placements.

STs: STs reported that it was very easy to obtain assessments in Acute Medicine, but there could be challenges in other areas. The challenge was generally a lack of direct working with consultants, for example less-than-full-time RDITs reported that they spent less time with consultants as they do more long days than weekends. STs felt it was difficult to build relationships with consultants in General (Internal) Medicine or other specialties outside their own so this limits the consultants to whom they can send assessments. They also noted that consultants in the IAU and medical HDU did not tend to engage with them when starting a shift so they do not have an opportunity to ask for assessments.

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): Not covered

2.11 Feedback from trainees (R1.5, 2.3): Not covered

2.12 Culture & undermining (R3.3)

Trainers: Not asked.

FY1: FY1s reported that they had not experienced any regular bullying or under-mining on medicine wards, however they had experienced hostility from other specialties when referring patients from Acute Internal Medicine. Some other individual incidents were described including being shouted at by a nurse and undermined by a consultant. FY1s did not always feel comfortable raising their concerns when these incidents happened as they worried about the repercussions or felt it would be described as a ‘personality issue’.

FY2: FY2s reported some patterns of undermining including female staff being undermined by older male consultants and GPSTs being undermined in relation to their training programme. FY2s felt that raising issues regarding culture and undermining whilst still in post would make these problems worse.

GPST: GPSTs had not experienced bullying or under-mining in this department.

IMT: IMTs had not experienced bullying or under-mining in this department, but had some experience of other departments being uncooperative. If they needed to raise concerns they would bring these to their supervisor and, if not resolved, to their TPD.

ST: STs had not experienced bullying or under-mining in this department. If they did experience this, they would speak to their supervisor or the on-call consultant. They noted that consultants had an ‘open door’ policy.

2.13 Workload/Rota (1.7, 1.12, 2.19): Not covered

2.14 Handover (R1.14)

Trainers: Trainers reported that handover arrangements have been reviewed and there is now a better process for unwell patients, smaller ground floor handovers and a pro forma for structured handover which incorporates learning opportunities. The ground floor handover now takes place in smaller groups with a larger resus handover afterwards which trainers felt made it more effective and improved the cultural issues reported at the last visit. Anecdotally they had heard that this format was preferred by RDITs and they felt safer speaking up during handover. The new structured handover process includes an opportunity to share interesting cases so this can be used as a learning opportunity. The structured handover is RDIT-led but should also have consultants in attendance.

FY1: FY1s had no concerns about the structured handover process and were aware that the new guidelines for handover included an opportunity to discuss interesting cases for learning although had not seen this done in practice yet. FY1s did have concerns regarding the process of handover from acute receiving to the wards as they reported there was no formal handover for these patients and things could be missed as a result.

FY2: FY2s agreed that the verbal structured handover was good. They found it more practical than educational although they described some consultants introducing discussions of interesting cases. Like FY1s, FY2s had concerns regarding the lack of handover of patients from acute receiving to the wards and noted that these patients often came without any notes.

GPST: Similarly, GPSTs found the structured handovers good, although they did not find them educational. They had similar concerns regarding the handover of patients transferred to the wards due to the variable quality of the handover, particularly when patients were accommodated in a corridor on arrival without a doctor being informed.

IMT: Like other cohorts, IMTs found the structured handovers good and noted that a pro forma was in use which encouraged discussion of interesting cases although this was often skipped after night shifts when RDITs were tired and keen to go home. They also reported similar concerns regarding a lack of handover of patients moved under the GlasFLOW model including patients being moved while test results were awaited, difficulties completing investigations in corridors and patients being moved to inappropriate settings without input from a doctor.

ST: STs were aware that the large ground floor handover which happened previously was re-structured due to cultural issues, however they had concerns regarding the efficacy of the replacement. STs reported that shift start times were staggered such that the consultant started while the overnight registrar was still clerking and the daytime registrar had not yet started work. Whilst the daytime registrar did receive a handover from the overnight registrar, the bleep was passed to someone else. This was leading to RDITs walking around pods asking for information as handover was not working effectively. There was also no longer daily engagement with the rota team who used to attend the previous handover. STs suggested that it could be better if the overnight registrar joined the consultant and FY1 on a ward round to discuss patients. They also suggested that it would be good to check in with RDITs before they left to ensure they were OK and safe to drive. STs also noted that the medical boarders team do not attend weekend handover which makes it difficult to raise issues regarding unwell boarded patients. Nonetheless, STs felt handover was safe although not a good learning opportunity. Whilst there was a pro forma including discussions of interesting cases, STs did not feel this worked as intended as RDITs were too tired to discuss cases after night shift.

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: Not asked.

FY1: FY1s did not have experience of raising patient safety concerns but would know what to do if they needed to raise a concern.

FY2: FY2s provided answers more relevant to section 2.19 so their answers have been included below.

GPST: GPSTs reported that they would raise immediate concerns with nursing staff and would discuss any adverse events with consultants. They noted that they had been asked for feedback by the DME and had told them about their concerns relating to GlasFLOW in terms of lack of handover and the use of unsuitable patient placement.

IMT, ST: Not asked.

2.19 Patient safety (R1.2)

Trainers: Trainers noted that the standardised mortality rate for the hospital is the best in the Health Board and felt that the hard work of nurses and RDITs made the department as safe as it could be, however there were ongoing challenges with demand capacity and patients being accommodated in non-ward areas which some trainers felt compromised patient safety. Trainers noted that the aim of GlasFLOW was to spread risk however there was still a high level of risk in Acute Internal Medicine alongside risks in the wards. Risk in the downstream wards was due to patients being cared for in corridors or other areas without necessary equipment such as in seminar rooms or in the endoscopy suite. Trainers noted that patients without beds were not factored into the staffing matrix so staffing levels were insufficient for the numbers being accommodated in the hospital.

FY1: FY1s were concerned about patient safety due to staffing levels in terms of both RDITs and nurses. They also had concerns about boarding in terms of unsuitable patients being boarded and the capacity of the boarding team. FY1s reported that in some cases bed managers were making decisions regarding which patients should be boarded and unwell patients had been boarded inappropriately. FY1s described the boarding team as including 1 consultant, 1 ANP and some locum mid-tier doctors who were over-whelmed by the workload. They reported that boarder ward rounds could continue until 8:30pm and plans were not always handed over due to the high workload.

FY2: FY2s expressed several concerns regarding patient safety including; detained patients absconding due to low staffing; RDITs reviewing unsafe numbers of patients alone; patients being accommodated in corridors; lack of handover of patients being moved under the GlasFLOW model; feeling rushed to discharge patients who are not ready to be discharged; patients waiting a long time after ringing for nursing assistance due to workload. In terms of boarding, FY2s reported that there

was a dedicated boarders team and boarding decisions were generally made by consultants although there could be pressure upon RDITs to make boarding decisions.

GPST: Like other cohorts, GPSTs had concerns relating to low staffing and handover of patients from acute receiving to the wards. GPSTs reported that the staffing levels led to pressure on staff and mistakes being made. They also had concerns relating to boarding in terms of being asked to identify patients for boarding and needing to provide care for boarders about whom they lacked information. GPSTs noted that there was a boarding team responsible for the boarders, however tasks would be passed onto the doctors on the ward who did not know the patients. They described being asked to write referrals and discharge letters for boarders whom they had never met.

IMT: IMTs also had concerns relating to handover of patients as described above and boarding. Like other cohorts, they described mid-tier RDITs including FY2s being asked to make boarding decisions, boarding of inappropriate patients and boarding directly from the front door.

ST: STs had concerns relating to the first 12-24 hours for patients arriving via IAU as there was over-crowding and long waits to be triaged and seen by a doctor. They noted that the IAU staffing at QEUH compared to Glasgow Royal Infirmary was lower. STs also had concerns about boarding. They confirmed that the policy is that boarders should be expected to be discharged in 24-48 hours, however if there were no such patients available they would be asked to choose other patients to board to create space and allow the progress of GlasFLOW. They felt that the boarders team was effective during the day and currently Acute Internal Medicine was functioning well during the day due to the presence of temporary locums, however after 5pm it could become very busy as many GP referrals arrived after this time. They noted that even with sufficient staffing it was a very busy hospital and demand may still exceed capacity at times.

2.20 Adverse incidents & Duty of Candour (R1.3 & R1.4): Not covered

2.21 Other:

FY1: FY1s mentioned that they found their workload exhausting and their rota very demanding which affected their wellbeing. They reported that even if had better access to learning opportunities they would not feel able to take these up as they are too tired. They noted that they sometimes only get 1

day between day shifts and night shifts so do not have time to rest as they need to prepare for the next set of shifts. FY1s reported that they were not allowed to take any Taster weeks due to the workload.

GPSTs: GPSTs also had concerns relating to their rota as they felt the centralised rota team did not appreciate the pressure on the wards. They also reported long waits to hear back about leave requests or queries.

IMTs: IMTs also found their rota challenging and reported that every block they have 1 or 2 periods where they work 7 consecutive days including 5 long days with 1 zero day afterwards before returning to work. This rota pattern comprises over 70 hours of work within 1 week which they found hectic.

3. Summary

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

Overall, the panel found improvement from the previous visit and noted the efforts of the leadership and management team in continuing to engage with RDITs to improve the training experience. Whilst some concerns remained in terms of access to educational opportunities and handover of GlasFLOW patients, the cultural issues reported at the previous visit were not heard and there was a high level of confidence about accessing clinical supervision across all grades.

Strengths:

- A significant improvement was noted in culture since the previous visit, particularly in terms of the ground floor.
- There is a committed and engaged leadership team who meet regularly with RDITs and make changes in light of feedback.
- Clinical supervision arrangements are clear and visible with RDITs confident in where to seek help when needed.
- The panel commended the ongoing use of the GIM app including the Right Decision service.
- The number of datix reports relating to GlasFLOW has reduced since the last visit.

Weaknesses:

- There are ongoing patient safety concerns in relation to the GlasFLOW model, specifically patient selection and patients being accommodated in non-ward areas.
- RDITs were concerned about boarding decisions, particularly out of hours.
- There were concerns about the efficacy of handover from IAU to the wards and overnight handover from the night to day team.
- Access to educational opportunities was limited by workload and space, particularly access to local teaching. There were particular concerns about the lack of appropriate teaching space in Acute Internal Medicine.

Progress against 2024 visit requirements

Requirement	**Status**
Handover arrangements must be reviewed, particularly for patients moved under the GlasFLOW system and handover from the front door to downstream wards.	Not yet met
Work must continue to ensure sufficient staffing, including medical staffing, is available for the workload and to ensure trainees have access to quality training; this includes ensuring FY1, FY2, GPST and IMT trainees are supported to attend an average of around 2 hours per week of local teaching opportunities, and ensuring GPST and IMT trainees are supported to attend sufficient clinics without compromise because of service needs.	Not yet met
All staff must behave with respect towards each other and conduct themselves in a manner befitting Good Medical Practice guidelines.	Met

4. Areas of Good Practice

Ref	Item	Action
4.1	The panel commended the ongoing use of the GIM app including the Right Decision service.	

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	Work should continue to ensure access to suitable and accessible teaching spaces for each specialty.	
5.2	Consideration of GlasFLOW arrangements should include reviewing the boarding process as there are concerns regarding the selection and management of boarders which relate to the implementation of GlasFLOW.	

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	Handover arrangements must be reviewed, particularly for patients moved under the GlasFLOW system and handover from the front door to downstream wards.	30th August 2025	FY, GPST, IMT, ST
6.2	Work must continue to ensure sufficient staffing, including medical staffing, is available for the workload and to ensure RDITs have access to quality training; this includes ensuring FY1s, FY2s, GPSTs and IMTs are supported to	30th August 2025	FY, GPST, IMT

	attend an average of around 2 hours per week of local teaching opportunities, and ensuring GPSTs and IMTs are supported to attend sufficient clinics without compromise because of service needs.		