Date of visit	Monday 28 September 2020	**Level(s)**	Foundation/GP/IMT/IST/Specialty
Type of visit	Immediate Triggered Visit (virtual)	**Hospital**	Dr Gray's Hospital
Specialty(s)	General Medicine, General Surgery, Anaesthetics & Emergency Medicine	**Board**	NHS Grampian

Visit panel	
Professor Adam Hill	Lead Dean Director (Chair)
Professor Alastair McLellan	Lead Dean Director
Dr Geraldine Brennan	Associate Postgraduate Dean (Foundation)
Dr Reem Al-Soufi	Associate Postgraduate Dean (Medicine/Surgery)
Dr Mo Al-Haddad	Associate Postgraduate Dean (EM/Anaesthetics)
Dr Nick Dunn	Associate Postgraduate Dean (General Practice)
Professor Rona Patey	Undergraduate Representative
Mr David Ramsay	Lay Representative
Ms Vicky Hayter	Quality Improvement Manager
Ms Jill Murray	Senior Quality Improvement Manager (shadowing)
Mr Alex McCulloch	Quality Improvement Manager (shadowing)
In attendance	
Mrs Susan Muir	Quality Improvement Administrator

Specialty Group Information	
Specialty Group	Surgery
Lead Dean/Director	Professor Adam Hill
Quality Lead(s)	Dr Kerry Haddow, Mr Phil Walmsley, Dr Reem Al-Soufi
Quality Improvement Manager(s)	Ms Vicky Hayter/Mrs Jennifer Duncan
Unit/Site Information	
Trainers in attendance	4 (2 Medicine/1 Emergency Medicine/1 Surgery)
Trainees in attendance	3 x Foundation, 4 X GP/higher
Feedback session: Managers in attendance	10
Date report approved by Lead Visitor	28th October 2020

1. Principal issues arising from pre-visit review

Following concerns raised by a number of Specialty Quality Review Panels in August/September 2019 and the deterioration of survey data, the Deanery Quality team agreed to undertake a whole site visit to Dr Gray's Hospital in March 2020. Unfortunately, due to the current pandemic this was cancelled. Further concerns were raised therefore an immediate triggered visit was arranged virtually for General Medicine/General Surgery/Anaesthetics and Emergency Medicine. Although this visit was a joint visit with an undergraduate representative no undergraduate medical students were seen on the day of the visit.

Both current and previous trainees in 2020 from foundation, general practice (GP), medicine and surgery were sent the pre-visit questionnaire before the virtual visit, the results are included within the report. The number of trainees who completed the pre-visit questionnaire: Foundation – 14, GP – 6, Medicine – 3 Surgery - 4.

Year 5 medical students rotate to Dr Gray's hospital for medical and surgical placements which includes time with emergency medicine and anaesthetics. The survey evaluation from medical students in the last academic year (2019/20) had shown increasing concern across the year about the learning environment and that they had witnessed undermining / bullying behaviour. The evaluation had been reported and investigated by senior management in Dr Gray's Hospital. NHS Grampian had subsequently appointed 2 additional cost of teaching (ACT) funded programmed activities (PAs) in a Dr Gray's senior medical consultant's job plan and also increased the administrative support for medical student teaching. Students were being carefully monitored in this academic year (2020/21). Reports are positive about the learning experience and learning environment at this time.

Previous Visit

There was a visit to this unit in March 2016 which highlighted recommendations listed below:

- IT passwords must be available to trainees when they commence post and before their first on call shift
- Trainees to be supported with their requests to videoconference (VC) into mandatory teaching.
- Review responsibility for medical boarders on surgical wards, currently medical ST3 or GP trainees which limits access to clinics.

- Medical Hospital@Night (H@N) team to be made aware they cover psychiatry patients and a psychiatry team member to be included in handover.
- Clinical lead to ensure the medicine ST3 trainee is not on the same rota as the foundation and GP trainees in order to be given the opportunity to develop clinical decision making and leadership skills.
- The general surgical trainees' nightshift commitments to be reviewed to ensure they can access learning opportunities throughout the day
- General surgical training programme director (TPD) and local educational supervisors to review the trainee experience following any changes in 8.6 and map the surgical Dr Gray's placement within the overall programme. This mapping should balance opportunities available in Dr Gray's with experience gained in other parts of the programme.
- Establish a formal induction programme for foundation trainees in General Surgery.
- General surgery and trauma & orthopaedic handovers should involve more senior staff than just FY1 to FY1, timing and team input requires review to improve patient safety and educational component of these
- All references to "SHO's" and "SHO Rotas" must cease. The SHO grade ceased to exist with the introduction of modernising medical careers (MMC) and whilst it is colloquially used to refer to non-ST level trainees, the terminology and its potential for mis-interpretation can give rise to patient safety issues as it is broad based and can incorrectly imply that a trainee may possess certain skills, knowledge and experience that they do not actually have. This scenario was the background to a fatality in Southampton and as a result is actively discouraged by General Medical Council (GMC).
- Continued work to develop a long-term sustainable workforce which supports training, specifically focusing on providing suitable training for the ST3 trainees in general surgery and medicine and reducing reliance on medical staff for roles which can be shared.

A summary of the discussions has been compiled under the headings in section 2 below. This report is compiled with direct reference to the GMC's Promoting Excellence - Standards for Medical Education and Training. Each section heading below includes numeric reference to specific requirements listed within the standards.

The panel met with the following groups:
Foundation Trainees
General Practice Trainees
Core Trainees
Specialty Trainees

However, there was a poor turnout of trainee staff across all grades. Trainees who did attend reported it was difficult to find a quiet space with both webcam and microphone to join the visit.

Before the visit commenced a number of presentations were given across medicine/surgery/emergency medicine and anaesthetics directorates. The number of red and pink flags from the National Training Survey (NTS) had been recognised and the department had been working on aligning improvements in each area. The presentation showed ambition to improve training. It was clear established consultants are committed to taking on responsibilities but do not have enough time due to a lack of substantive consultants.

2.1 Induction (R1.13)

Trainers: Trainers advised that NHS Grampian run the corporate induction which is accurate but doesn't encapsulate the day to day running of the clinical areas. This year's induction was challenging as it was held via teams and did not cover as much as previous years. The site had changed due to COVID and trainees were taken to a central hub and shown around in small groups with orientation around the hospital. Trainers from Emergency Medicine and General Surgery reported challenges as trainees did not have badges and IT access before commencing in post. One trainee could not attend due to nightshift and was given links to the website, Moodle and teams. There is no formal induction to high dependency unit (HDU), but foundation trainees have this as part of shadowing.

Foundation Trainees: The majority of trainees received both hospital and departmental induction and felt this was neither good nor poor, a number of suggestions were given to improve both such as receiving logins, learning how to send a sample and prescribe blood, tour of the hospital and details of red and green zones. Trainees reported an induction that prepared them to be a safe doctor but not to work within Dr Gray's Hospital. There was no ward or unit induction. Trainees had no logins set up before commencing in post.

GP Trainees: All trainees received both hospital and departmental induction. Trainees would have like more information on the handover procedures and how teams were allocated.

IM/Higher Trainees: The majority of trainees received hospital induction and commented it was poor or very poor. All trainees received departmental induction which ranged from very good to very poor. Suggested improvements relate to information on handover, ward rounds, huddles, boarding and an up to date handbook.

Surgery Trainees: Trainees reported a poor hospital induction and no departmental induction.

All trainees: Trainees advised that induction had been changed due to COVID. Instructions on the email were incorrect and some trainees turned up in person which the hospital was not expecting. Medicine trainees had an informal chat with the consultant. Trainees advised they would have benefited from information regarding resuscitation in light of COVID. One trainee did not receive induction due to being on-call and no provision made for this at a later date.

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

Trainers: Trainers reported it is impossible to provide teaching which is bleep free however trainees are encouraged to give bleeps to advanced nurse practitioners, but this can be difficult. Foundation teaching is aligned to the curriculum. All higher trainees now have access to recorded teaching sessions with Raigmore and Aberdeen Royal Infirmary. Trainers advised that teaching has been difficult given the current epidemic.

Foundation Trainees: Trainees reported no issues attending teaching. On occasion trainees have been let away early to prepare for presentations. The pre-visit questionnaire stated that teaching was reported as not bleep free and an excessive workload and busy ward could prevent attendance.

GP Trainees: Trainees had received teaching with no issues. The pre-visit questionnaire stated that teaching for GPs was not bleep free and workload can prevent attendance.

IM/Higher Trainees: Due to COVID trainees had not received teaching as yet but believe there would be no issues if they required time away to attend.

Surgery Trainees: Trainees commented there was no local teaching with no enthusiasm to organise.

2.3 Study Leave (R3.12)

Trainers: Trainers advised that in medicine and surgery study leave requests are covered internally as the workload gets shared between locums. In emergency medicine study leave is also covered internally but it was advised that it can be difficult if a trainee is on nights, there is very little locum cover however days can be swapped to accommodate requests.

GP/IM/Higher Trainees: Trainees reported no issues taking study leave.

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

Trainers: Trainers reported there are only 2 supervisors as posts are filled with locums and not substantive posts in medicine. There is remote supervision of some trainees from Raigmore Hospital. Trainers do not have adequate time within their job plans to undertake the educational role and do not supervise the way they would like due to lack of time and the numbers of trainees assigned to each trainer. If there were known concerns regarding a trainee these would be documented in ‘step forms’ from the university for FY1s and case conferences and monthly meetings for FY2s. Higher trainees with concerns are not always flagged beforehand however mechanisms are in place to discuss them through the TPD, eportfolio and regular monthly meetings.

Foundation Trainees: Trainees stated that they have met with both their clinical and educational supervisors and had discussed objectives.

GP Trainees: All trainees were allocated an educational supervisor and had discussed objectives.

IM/Higher Trainees: The majority of trainees had not been allocated an educational supervisor by the end of the first month in post.

Surgery Trainees: The majority of trainees stated that clinical supervision is very good, and consultants are approachable.

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 having 3 consultant locums at various levels in 3 weeks in medicine. The quality has been variable, and the trainers recognise that sometimes trainees can struggle to access advice for patient care. If there is an issue, datix is used to report the incident which is investigated, and performance reviewed. Trainees know who to contact the duty manager on call and this can be escalated to the lead clinician for support out of hours (OOH). Emergency medicine have a written protocol of escalation which is covered at induction. There are no issues in relation to consenting patients as this is done by consultants.

Foundation Trainees: Trainees reported that within HDU it is clear who to contact both during the day and at night. The medical rota is circulated every week and informs everyone who to contact during the day and OOH. Trainees advised they have not felt they have worked beyond their competence as they can access support via middle grades although it is not always clear who the middle grade is within medicine. The pre-visit questionnaire stated that the majority of trainees reported dealing with problems beyond their competence or experience. Additional comments relate to lack of middle grade staff and few experienced staff OOH.

GP Trainees: Trainees advised they know who to contact during the day and OOH and are well supervised however some trainees reported working beyond their level of competence with minimal consultant input.

IM/Higher Trainees: Trainees reported a lack of supervision and working beyond level their level of competency. Trainees cover the medical registrar bleep over the weekend and night unsupervised and act as team lead for emergency calls. Trainees stated that the number of substantive consultants is reducing and those remaining are much busier therefore the time spent as a supervisor may be less than optimal. Trainee's reported being on call when just starting in post with no consultant based in the hospital and would have benefited from more support. Trainees on the middle grade rota reported there is no clear guidance for nursing staff as to what level of competency they are able to work to as this rota is populated by FY2, GPST and higher trainees.

Surgery Trainees: Trainees reported working beyond their level of competence managing unwell or complex patients without senior support.

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

Foundation Trainees: Trainees all agreed that core competencies are achievable and advised that it was easy to find opportunities. Trainees reported a lot of vacant posts and a high turnaround of consultant locums. A high turnover of consultant locums can make it quite difficult as a junior as there is no consistency and trainees have to adapt to different ways of working which can impact on training. Trainees advised they are quite confident they will achieve the required competencies for this post.

GP Trainees: Trainees advised they are quite confident they will achieve the required competencies for this post.

IM/Higher Trainees: There was a varied response as to whether trainees would meet core competencies ranging from quite confident to not very confident.

Surgery Trainees: Trainees reported this post does not support curricular progression and core competencies will not be met due to lack of theatre and clinic sessions. Trainees believe that their skills have regressed and reported less training in this post than in FY2. Trainees stated their education and training is affected by the rota and exposure and learning has been severely limited. Additional comments relate to on-call commitments and 1 in 6 rota limits training opportunities. The average emergency work is 1-2 cases per week which is insufficient operative exposure for the trainee's stage of training.

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

N/A

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

N/A

2.9 Adequate Experience (other) (R1.22)

N/A

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: Trainers in medicine advised they work closely with trainees and provide regular constructive feedback which is fairly informal. Trainers in emergency medicine review every case either immediately or the next morning. Feedback can also be given via teams and workplace-based assessments. Trainers in surgery provide feedback daily and also during educational supervision and teams sessions.

Foundation Trainees: Although there is no formal procedure to receive feedback trainees reported they have no issues receiving it from middle grades and consultants and receive this weekly or less frequently than weekly. Within HDU the consultant discusses the daily procedures which trainees advised helps improve their priority skills. All advised getting and receiving feedback was a 2-way process.

GP Trainees: The majority of trainees reported receiving feedback either weekly or two to three times a week.

IM/Higher Trainees: Trainees reported they are given regular constructive feedback as they work closely with consultants every day. The pre-visit questionnaire reported a mix response with some receiving feedback weekly and others not receiving any.

Surgery Trainees: Half of trainees reported receiving feedback less frequently than weekly.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: Trainers reported that trainees can feedback via the junior doctors' forum which is held monthly. Trainers work directly with trainees and emphasise that their door is always open to discuss any issues or concerns.

Foundation Trainees: Trainees reported they can feedback any concerns regarding the quality of training via the junior doctors' forum, allocated consultant or directly through the management team. Although there have only been 2 meetings issues raised about induction and feedback have already been acted on.

GP Trainees: Trainees advised they can feedback during their educational supervisor meeting or via the junior doctors' forum.

IM/Higher Trainees: Trainees advised they are aware of a junior doctors' forum which is well publicised but can be difficult to attend. Feedback can also be given during consultant meetings.

Surgery Trainees: Trainees advised they can feedback to trainers on the job.

2.12 Culture & undermining (R3.3)

Trainers: Trainers in medicine advised they hold regular face to face meetings with foundation trainees to create a team culture. Trainers assign trainees to one consultant to make it easier if they require support and are given handheld phones and can VC between green and red areas. Emergency medicine trainers advised that space is a challenge at the moment but being social is a high focus and trainers offer tea and cake and are very open and available to trainees. Surgery trainers advised they do not meet as a department as there is no space. The team can be fragmented as there is no social interaction except during ward rounds. All trainers reported that trainees are told who to contact in relation to bullying and undermining as part of the formal induction. This could be their educational supervisor, TPD, trainee forum leads, medicine education team or datix.

Foundation Trainees: Trainees reported some senior staff created an unpleasant environment especially at morning handovers. Harsh criticism was reported with little constructive feedback and staff were not treated well which resulted in poor morale.

GP Trainees: Trainees reported persistent behaviour that undermined their confidence or self-esteem and aggressive arguing between the consultant body at handover.

IM/Higher Trainees: Trainees reported approachable consultants and felt supported. Trainees have witnessed open undermining by consultants during handover. This is between consultants and/or locum consultants and not with trainees.

Surgery Trainees: One example of undermining was given regarding a consultant's behaviour towards a trainee.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Medicine trainers reported some unexpected rota gaps however 2 long term locums have filled these, and the trainees have not been impacted. Emergency medicine reported a reduction in locums due to financial constraints therefore trainees are required to swap shifts if required. Surgery trainers reported any rota gaps are covered internally.

Foundation Trainees: Trainees reported that any rota gaps have not impacted on their roles. ANPs cover rota gaps within HDU. The rota accommodates trainees attending teaching. Annual leave can be difficult as there is a "preferential window" for when this can be taken. All reported no issues with well-being workload and rotas. One third stated their education and training is adversely affected by the rota due to lack of attendance at teaching. One trainee reported workload impacting on the quality or safety of patient care with comments relating to rushing aspects due to workload, staffing pressures and no clearly defined roles which cause confusion.

GP Trainees: Trainees reported rota gaps which are usually filled by locums. On occasion trainees can be asked to cover shifts.

IM/Higher Trainees: The current rota design does not facilitate attendance at clinics. COVID has had an added impact on clinics and some trainees have not attended any. Trainees advised the rota does not compromise their well-being. Trainees reported that a lack of continuity of care has not been factored into the rota which impacts on education and training and patient safety.

Surgery Trainees: Trainees stated the rota affects their education and training as 80% of shifts they are on-call and there is no provision for annual leave. One trainee stated their health had suffered as a consequence of the working pattern and that the workload had affected training or patient safety.

2.14 Handover (R1.14)

Trainers: Trainers advised that handover was an excellent learning opportunity for the last few years however due to COVID and socially distancing measures a lot of trainees no longer attend. Handover checklists have been created to streamline and standardise across substantive and locum staff and all patients are discussed. Trainers advised things will improve once socially distancing eases.

Foundation Trainees: Trainees reported handover can regularly last until 30 minutes after their shift has finished which can result in working 2.5 hours extra per week. Trainee shifts finish at 9pm and handover can last until 9.30pm. Trainees have discussed this at the junior doctor's forum. Trainees advised handover is information transfer only and not used as a learning opportunity.

GP Trainees: Trainees advised that handover is logged on a white board and focuses on the previous day rather than unwell patients however trainees introduced a new structure towards the end of the block.

IM/Higher Trainees: Trainee's reported a disorganised handover in the morning and an evening handover which is a free for all.

Surgery Trainees: Trainees reported an unsatisfactory handover which is shared with the orthopaedic trainees and not used as a learning opportunity.

2.15 Educational Resources (R1.19)

GP/IM/Higher Trainees: Trainees reported it can be difficult to get access to a camera and microphone for Microsoft (MS) Team meetings. There is a lack of a doctors' office and computers can be very slow although these are currently in the process of being upgraded.

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

Foundation Trainees: Trainees reported if they required any support regarding the job or health, they would contact the advanced nurse practitioners (ANP).

GP/IM/Higher Trainees: Trainees advised having a lack of substantive consultants can make it difficult for trainees to be supported. Trainees reported if there were more specialty trainees, they would feel more supported and this would put less pressure on the existing consultants.

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: During the initial presentation the director of medical education discussed a well described educational governance structure within NHS Grampian. There has also been the introduction of the monthly junior doctor's forum since the previous visit and trainees have direct access to talk about their experience with the senior management team.

2.18 Raising concerns (R1.1, 2.7)

Trainers: All trainers reported trainees are encouraged and supported to raise concerns about patients' safety during handover, via the trainee forum, their education supervisor or datix. In emergency medicine any issues are addressed during a de-brief or datix. Trainers reported it can be difficult to see patients due to space which is small and frequently congested and risk of infection to staff and outpatients is a risk.

GP/IM/Higher Trainees: Trainees would raise any patient safety concerns with their allocated supervisor or senior nursing staff.

2.19 Patient safety (R1.2)

Trainers: Trainers reported that there are patient safety mechanisms in place which the trainees are encouraged to use. The trainers advised they have worked hard to create a safe environment. There are concerns in relation to space, for example there are no negative pressure equipped clinical areas in emergency medicine and there is a concomitant risk of infection.

Foundation Trainees: Trainees advised if they had any patient safety concerns, they would raise them with a middle grade or consultant and would feel supported. Trainees can also raise issues during handover or via the junior doctors' forum. Trainees would have no concerns if a friend or relative was admitted. Trainees advised they are given more responsibility as a foundation trainee in

Dr Gray's as it is a small hospital but there is always a senior on the ward and a consultant contactable by phone. Boarding can be difficult if there are changes in junior staffing or a consultant is on annual leave. Trainees reported moving around a lot usually every few days which impacts on patient care. Trainees reported patient safety concerns in the pre-visit questionnaire due to lack of supervision and staff and having to work above the standard level of training.

GP/IM/Higher Trainees: The majority of trainees would have no concerns if a friend or relative was admitted however as Dr Gray's is a small component of NHS Grampian patients can wait longer for tests if these involves services that are based in Aberdeen. Trainees reported due to a high turnover of locum staff there can be a lack of continuity of care which can impact on communication and can be frustrating for patients and relatives and a potential patient safety concern. Trainees reported a lack of clear differentiation among the different levels of trainees and frequent referencing to SHOs who feature on the same rota and are asked to attend unwell patients. Trainees advised that overall locum consultants can help with training, but they do not always do things as per NHS Grampian guidelines. One trainee reported being out of depth when commencing in post and would have liked more support.

Surgery Trainees: Trainees reports several patient safety concerns and gave specific examples.

2.20 Adverse incidents and Duty of Candour (R1.3)

N/A

Average overall satisfaction scores:

Foundation trainees average score 7/10
GP/Higher trainees: average score 5/10

Additional questions:

Trainers: Trainers reported that locums and clinical development fellows are aware of medical students and know their responsibilities.

Foundation trainees: Trainees can be allocated year 5 medical students however there is no notification beforehand and no information on what their role or learning outcomes should be. They were not aware of the student assistantship role and what was expected.

GP/IM/Higher Trainees: Trainees reported working with enthusiastic medical students however no formal instruction or guidance is given as to what they can or cannot do.

Summary

There are significant concerns about the training environment in Dr Gray's highlighted through the GMC NTS and Scottish Training Survey (STS). The pre-visit questionnaire reported trainees at all grades working beyond their competence and some raising patient safety concerns. The turnout from the trainees at this visit was very poor. In view of the challenges facing Dr Gray's as a training environment the panel will seek the GMC's views as to whether escalation to their 'enhanced monitoring' process would be appropriate to support NHS Grampian & staff at Dr Gray's Hospital to address the concerns and to ensure training can be optimised and meet the standards set by the GMC.

We have highlighted below both the positive aspects from the visit, and some areas for improvement and requirements.

What is working well:

- Commitment and engagement of the small numbers of substantive consultants to address the concerns around training.
- Positive feedback from trainees regarding the trainee forum as an opportunity to raise concerns.
- Well described educational governance structure within NHS Grampian.

What is working less well:

- There was a poor turnout of trainees across the trainee grades and no surgery trainees were interviewed.
- Issues with lack of corporate induction for those trainees out of synchrony. Lack of hospital and unit induction.

- Issues of trainees regularly attending handover out of rostered hours. At times it was reported that negative comments were made about other consultant colleagues' practices.
- The trainer cohort described the lack of substantive consultants, particularly in medicine and surgery, potentially risking the supervision and training of trainees. Consultants described working in excess of 12/13 PAs and not having enough time in their job plan for the burden of training and supervision of trainees that that is borne by the few consultants in post.
- Some of the trainees across the training grades reported working beyond their level of competency.
- There has been a heavy reliance on locum consultants; some, it was reported, have been of variable quality with implications for the quality of training experience.
- There is a potential safety risk due to the lack of clear differentiation among the different competence levels of FY2, GP, IM & ST3 trainees, who feature on the same rota, and can be called by nursing staff to attend to unwell patients.
- Due to reported pressures with staffing and workload, the trainees reported being unable to access training opportunities, for example, outpatient clinic experience. The trainees reported lack of continuity on wards that hindered training and impacted on the quality of their care to patients.

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

5. Areas of Good Practice

Ref	**Item**

6. Areas for Improvement

Ref	Item	Action
6.1	Guidance for those supervising medical students on their supervisory responsibilities and the placement learning outcomes for the students	

7. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
7.1	There must be sufficient substantive consultant trainers to support the supervision and training of the doctors in training in General Medicine and General Surgery	December 2020	All
7.2	Hospital and departmental induction must be provided which ensures trainees are aware of all of their roles and responsibilities and feel able to provide safe patient care.	June 2021	All
7.3	A process must be put in place to ensure that any trainee who misses their induction session is identified and provided with an induction.	June 2021	All
7.4	The morning and/or evening handover must be scheduled within the rostered hours of work of the trainees.	June 2021	All
7.5	All consultants, who are trainers, must have time within their job plans for their roles to meet GMC Recognition of Trainers requirements.	June 2021	Trainers
7.6	All staff must behave with respect towards each other and conduct themselves in a manner befitting Good Medical Practice guidelines.	June 2021	All
7.7	Doctors in training must not be expected to work beyond their competence.	December 2020	All
7.8	The level of competence of trainees must be evident to those that they come in contact with and all references to ‘SHOs’ and to ‘SHO rotas’ must cease.	December 2020	All

7.9	The Board must provide sufficient IT resources to enable doctors in training to fulfil their duties at work efficiently and to support their learning needs.	June 2021	All
7.10	Trainees must be able to access learning opportunities to meet curricular objectives including, for example, outpatient clinics.	June 2021	GP/Core/Higher
7.11	Lack of continuity on wards creates a barrier to training and compromises quality of care of patients.	June 2021	All
7.12	Initial meetings and development of learning agreements must occur within a month of starting in post for Medicine trainees.	June 2021	Medicine
7.13	The department must develop and sustain a local teaching programme relevant to curriculum requirements of higher Surgical trainees including a system for protecting time for attendance.	June 2021	Surgery