Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	8th June 2023	**Level(s)**	FY, GPST, IMT, ST
Type of visit	Triggered visit	**Hospital**	Raigmore Hospital
Specialty(s)	General (Internal) Medicine	**Board**	NHS Highland

Visit panel	
Dr Greg Jones	Visit Chair – Associate Postgraduate Dean – Quality
Dr Reem Al Soufi	Associate Postgraduate Dean – Quality
Dr Claire Gordon	Foundation Programme Director/Training Programme Director
Dr Gary Rodgers	Trainee Associate
Ms Gillian Carter	Quality Improvement Manager
In attendance	
Mrs Lauren Harte	Quality Improvement Administrator

Specialty Group Information	
Specialty Group	Medicine
Lead Dean/Director	Professor Adam Hill
Quality Lead(s)	Dr Greg Jones, Dr Alan McKenzie, Dr Reem Al Soufi
Quality Improvement Manager(s)	Ms Gillian Carter
Unit/Site Information	
Non-medical staff in attendance	13
Trainers in attendance	12
Trainees in attendance	FY 12; GPST 2; IMT 7; ST 4

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

Date report approved by Lead Visitor	14th June 2023

1. Principal issues arising from pre-visit review:

Following review and triangulation of available data at the 2022 Deanery Quality Review Panel (QRP), a visit to General (Internal) Medicine at Raigmore Hospital, Inverness, was requested around the following concerns; red flags for handover, induction and reporting systems and pink flags for local teaching and regional teaching on all trainee National Trainee Survey (NTS) data; red flag for induction and pink flag for teaching on both all trainee and IMT Scottish Trainee Survey (STS) data; red flags for educational environment and teaching and pink flags for handover and induction on ST STS data.

Accordingly, a triggered visit was arranged to General (Internal) Medicine at Raigmore Hospital. The scope included all trainees in Group 1 specialties at the site.

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):

Trainers: Trainers reported that they issue pre-induction information to trainees including a document on roles and responsibilities and offer medicine induction at every changeover. The induction includes pharmacy, IT, culture and how to ask for help and for senior trainees there is an extra component on how to be "registrar ready". For trainees who miss induction they try to catch up with them, but don't have a formal process for this. Trainers noted that they plan to film a short induction video which could be offered to those who miss the initial induction. There was also a handbook produced last year, but trainers recognised that this needed to be more widely promoted.

FY: Most trainees received a hospital induction based in acute receiving and felt this was good, including the coverage of discharges and pharmacy. They noted that the recent induction had been improved from that offered in August 2022. Trainees were aware of a handbook but noted that they found out about this only after a few weeks of working and it was out of date. FY1s had concerns about shadowing as this process lacked leadership from senior colleagues. They felt it would have

been better if they had been allocated a specific person to shadow. Trainees reported that departmental induction was variable with Geriatric Medicine induction described as good, but some departments offering only a sheet of paper.

GPST: Trainees reported that hospital induction was sometimes available depending upon the time of year and it assumed prior knowledge of working at the hospital. They also noted that hospital and departmental inductions often clashed with each other. Trainees felt that, when available, induction included a lot of information but was inadequately facilitated. They also received a handbook by e-mail. They had concerns about the quality of induction for Internal Medical Graduates (IMGs) and locums who were not familiar with the complex hospital systems. Trainees received a departmental induction for General (Internal) Medicine. Trainees felt induction could be improved by providing documents and videos on Microsoft Teams which were accessible year-round and felt it would be beneficial if the hospital had a single induction co-ordinator.

IMT: Trainees reported that they all received a hospital induction which was mandatory to attend and provision was made for this. They noted that hospital induction focused mainly upon acute receiving and they would have found a more general induction useful. In terms of departmental induction, they reported that they received short inductions or induction booklets. Like GPSTs, concerns were expressed regarding the adequacy of induction for IMGs who remained unclear about their job responsibilities following induction. They felt an induction booklet with clear role descriptions would be beneficial for all trainees.

ST: Trainees were not able to comment on induction as they had all been working at the site for a long time.

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

Trainers: Trainers reported that regional teaching is protected for FYs, GPSTs and IMTs with the rota co-ordinator getting dates and times directly from the Deanery. It is noted at handover if any cohort has teaching that day. Senior trainees have a lot of specialty time which they can use flexibly for teaching, clinics or other specialty exposure. Trainers noted that departmental teaching is mapped to specialty curricula with the involvement of senior trainees.

FY: Trainees reported they can usually attend their Deanery-delivered teaching and have met their minimum teaching requirement although only by watching some in their own time. Trainees were not aware of regular opportunities to attend departmental teaching, noting that some departments had informal teaching and audit meetings but not all.

GPST: Trainees reported they could attend regional teaching and had no barriers to being granted study leave for this. They reported there was no departmental teaching available, however they had seen posters for a morbidity and mortality (M&M) and audit meeting recently.

IMT: Trainees reported they could attend regional teaching and were given time off in lieu to watch recordings if they could not attend in person. They described being able to attend 1-1.5 hours of departmental teaching per week, but could struggle to get away from wards and were often interrupted when watching on Microsoft Teams. They felt it would be better if departmental teaching were in-person or there was a dedicated space to watch online.

ST: Trainees reported they could watch regional teaching by video link from Aberdeen and had no issues being granted study leave for this which was a positive aspect of this job. They described having a 1-hour departmental teaching session each week, but noted this had just started mid-way through this year and was trainee-led. Trainees advised it took place in the Centre for Health Sciences and was generally not well attended, possibly due to the location. Trainees described the organisation of departmental teaching as a large burden for ST trainees as there were not many of them at the site.

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 they receive an induction when taking on an educational supervision role and get good support from Training Programme Directors (TPDs) and Foundation Programme Directors (FPDs) at the site. Trainers reported that they conduct curriculum mapping exercises when specialties are allocated ST trainees for the first time and are supported by the Deanery in doing this. Trainers had mixed opinions regarding the sufficiency of time in their job plans with less than half feeling the time available was sufficient.

Trainees: Trainees had all had the required number of meetings with their educational supervisors and had no concerns regarding these.

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 support arrangements are covered at induction and available consultants and senior nurses are named at each safety huddle. They advised that at the weekend there is a consultant available during the day in acute receiving and overnight an ST provides support. Base consultants are available on wards during the week, however they are currently stretched by the number of patients. There is also a medical emergency team available at all times of the day and night in addition to a resus team and these can be called by both doctors and nurses. Nurses will often call this team if they feel support is needed for trainees, for example an FY1 struggling to manage a situation. Trainers felt that trainees knew how to escalate, but the volume of patients could put them under pressure which could lead to their feeling they were working beyond competence.

FY: Trainees always knew who to contact for support and felt their consultants and senior trainees were mostly very supportive except for some locums with whom they had worked.

GPST: Trainees felt they could always find someone to give them advice during their shifts, however they found it difficult to obtain consistent supervision as they rotated every 2 months whilst in General (Internal) Medicine. One of the rotations within this block was to Oncology and the supervision in this post was felt to be inadequate due to lack of consultant presence and lack of ward rounds. Trainees felt that they had to work beyond their competence in Oncology when dealing with very unwell or palliative patients.

IMT: Trainees always knew who to contact for support and felt their consultants were supportive.

ST: Trainees always knew who to contact for support and felt their consultants were supportive, but had sometimes struggled to express their viewpoints when working with locum consultants.

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

Trainers: Trainers advised that clinics are available to STs, IMTs, GPSTs and sometimes FY2s. Clinic time is mandated for STs and built into the rota for IMTs, GPSTs and FY2s. IMTs have a 2-month clinic block which allows them to comfortably meet their clinic requirements. Trainers noted that if there are service pressures IMTs, GPSTs and FY2s will be removed from clinics to support wards. Trainers were aware that more space was required for trainees to participate in physical clinics and reported that 2 additional rooms with video conferencing software had been built in the medical education space for trainees to conduct Near Me clinics.

FY: Trainees felt this post allowed them to develop their skills in managing acutely unwell patients and they were able to meet all of their curriculum competencies. They felt a lot of their tasks in acute receiving were non-educational when on the ward, for example doing immediate discharge letters for patients they had never seen, however clerking was educational. Trainees were concerned that they sometimes missed out on their clerking shifts due to being swapped with locums as clerking was an easier job for them to do. Trainees also noted that tasks can take longer than expected due to the complexity of systems within the hospital. They described issues including; electronic notes being used in acute receiving whilst paper notes were used in wards; multiple systems for requesting imaging; paper blood forms. Trainees reported that the different systems were described in the handbook, however this information was out of date.

GPST: Trainees reported they were able to meet all of their curriculum competencies. They described having 1.5 days on the rota which could be used to attend clinics. They felt their clinical experience was useful, but around 70% of their work was administrative.

IMT: Trainees reported that it could be difficult to complete procedures outside the high dependency unit, particularly pleural aspiration and pneumothorax. They felt that clerking patients was educational, but overall around 90% of their work was non-educational as it included activities like writing immediate discharge letters, taking bloods and inserting cannulas. Whilst they did have a 2-month or 6-week clinic block in IMT2 and IMT3, trainees noted that this could fall after their Annual Review of Competence Progression (ARCP) so they had to try to go to clinics on quieter days to meet their clinic requirement.

ST: Trainees reported that this post allowed them to develop their skills in managing acutely unwell patients and they rarely had to do non-educational tasks. Trainees felt they would like to have more responsibility during the day in terms of doing first senior reviews and making discharge decisions.

2.7 Adequate Experience (assessment) (R1.18, 5.9, 5.10, 5.11) – Not covered

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

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

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: Trainers reported that they were present on the wards and could give feedback to trainees here, however it could be more difficult for them to get feedback in acute receiving. Trainers reported that senior trainees see patients in acute receiving then review their decisions with consultants, however it could be difficult for trainees to get Acute Care Assessment Tools (ACATs) as they rarely review patients with consultants. Trainers reported that trainees could also receive feedback at board rounds. No deficits had been identified in trainees' portfolios in terms of availability of assessments.

FY: Trainees reported that they sometimes got feedback at board rounds, but generally got feedback by checking patients' notes to review consultant comments on their management. Some FY1s felt it would be beneficial if their shifts alternated between clerking and post-take rather than doing these in blocks, however others noted that this was the shift pattern used for FY2s and it was challenging.

GPST: Trainees reported that they got feedback when they asked for this and felt they would be told if they did something wrongly, but described feedback as not being freely given.

IMT: Trainees reported their opportunities to receive feedback were limited as ward rounds were generally split between consultants and trainees and there was insufficient time to get feedback at handover as it already took around 1 hour. They had better opportunities to receive feedback at clinics.

ST: Trainees reported that they got more feedback in their specialties than in acute receiving where they did not get much feedback unless they asked for it. They had good access to clinics and received feedback there. Trainees were able to get ACATs, however they got these mainly on ward rounds as opportunities were limited in acute receiving.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: Trainers reported they regularly ask trainees for feedback and have a trainee feedback meeting every 2 months which includes senior medical staff, a TPD and the rota administrator. Trainers felt that they were receptive to feedback and gave an example of how the rota had been changed in light of trainee feedback.

FY: Trainees reported that there were feedback sessions held within General (Internal) Medicine as well as a wider trainees' forum led by chief residents.

GPST: Trainees were not aware of a trainees' forum or of trainee representatives, however they felt the department was a friendly place to work and they could give feedback openly.

IMT: Trainees were aware of a feedback meeting having taken place on Microsoft Teams, however most could not attend as the timing was unsuitable and there was insufficient computer space to join within the hospital. Trainees reported that the medical director and clinical director had done shifts in acute receiving to better understand the issues faced by trainees and had provided feedback on what they had learned and what issues would be addressed as a result.

ST: Trainees felt consultants were approachable and open to ideas. They reported that they have a platform at the consultants' meeting to provide trainee input.

2.12 Culture & undermining (R3.3)

Trainers: Trainers reported that they set the cultural tone of the department and reassure trainees at induction that they can raise concerns and these will be taken seriously. They felt the department had a flat hierarchy and shared decision-making and responsibility. Trainers reported that the lead for Acute Internal Medicine has been approached about various cultural issues and these have been

addressed quickly. Active Bystander training has been provided by the Director of Medical Education's (DME's) office.

FY: Trainees felt the department was very supportive and particularly commended the supportive tone set in the induction to Acute Internal Medicine. Trainees had not experienced any bullying or undermining, but if they did they would speak to their supervisor or a senior colleague who was present at the time.

GPST: Trainees felt the department was friendly and had a good training culture. They had witnessed a personality clash recently, but this had not been a regular occurrence. If they witnessed bullying or undermining they would speak to their supervisor or the nurse in charge of the ward. They were also aware of the organisational whistle-blowing policy.

IMT: Trainees felt their consultants were approachable and friendly and had not experienced any bullying or undermining. If they witnessed this they would speak to their educational supervisor or, if their supervisor was the source of the issue, their TPD.

ST: Trainees felt their consultants were generally very supportive except some locums with whom they had worked, however they had been able to discuss these instances with substantive consultants. If they witnessed bullying or undermining they would speak to the lead for the department, their educational supervisor or another approachable consultant.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Trainers reported that they try to avoid trainees needing to cover shifts internally by employing locums and clinical development fellows to cover gaps. Consultants will also cover overnight registrar shifts when needed. Trainers did not think the rota compromised trainees' wellbeing, but noted the general pressure within the NHS and the subsequent lack of capacity for teaching. Trainers felt the poor IT infrastructure compromised trainees' wellbeing.

FY: Overall trainees were fairly happy with the medical rota. They reported that the rota co-ordinator was good at filling gaps and they rarely needed to cover shifts internally. As there are fewer STs in the department these gaps can be harder to fill and a trainee reported working for a week in acute

receiving where an FY2 was the most senior trainee due to registrar absence. Trainees had opportunities throughout the year to provide feedback on their rota and were aware of changes which had been made based upon trainee feedback.

GPST: Trainees reported that gaps are filled either by locums or by shifts being offered internally. They felt they could raise concerns about the rota if needed.

IMT: Trainees reported that there are a lot of locums on the rota and gaps are usually adequately filled. They had been given an opportunity to provide feedback to improve the rota for next year. Trainees had some concerns regarding the day-to-day management of the rota including lack of responses to e-mails and lack of information about Annual Leave allowance. They found a particular shift pattern challenging where they had to swap between an 8am-5:30pm shift and 1pm-9pm shift as they did not feel safe to drive when finishing at 9pm and returning at 8am.

ST: Trainees reported that gaps are filled either by locums or by shifts being offered internally. They were often asked to change shifts due to the small numbers on their rota, particularly for night shifts as they are the only grade who can cover these. Trainees had participated in discussions regarding the rota and found the rota co-ordinator very helpful and accommodating when they had specific needs.

2.14 Handover (R1.14)

Trainers: Not asked.

Trainees: Trainees reported that acute receiving has handovers at 8am, 5pm and 9pm as well as a board round at 11:30am. The downstream wards have handovers at 8:30am, 5pm and 8:30pm. Trainees reported that some handovers use a Situation, Background, Assessment, Recommendation (SBAR) model, however they would benefit from being more protocolised. There is variable use of the electronic system for documenting handover. Trainees were aware that quality improvement work was ongoing around handover. Trainees had concerns about the handover of patients admitted late in the week as they could be transferred to a ward at the request of a bed manager without the ward staff being aware of them and not seen by a consultant until after the weekend. They also noted that registrars are often meant to be in 2 places at once during handover as they are meant to attend both

acute receiving and downstream handovers. Registrars had workarounds for this issue and were unsure of the solution.

2.15 Educational Resources (R1.19)

Trainers: Not asked.

Trainees: Trainees felt there were too few computers and those available were unreliable. They described there being 3 computers in the doctors' mess, but some did not work and they were not private. Trainees also described computer facilities being available in the Centre for Health Sciences, but it was not usually possible to access these as they were too far away and they could not leave the hospital carrying an arrest bleep or wearing scrubs. STs had access to offices and laptops.

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 reported that support is available to trainees via their educational supervisor, TPD or FPD, occupational health and the Deanery's Trainee Development and Wellbeing Service. The Assistant DME facilitates a course for consultants to help them support trainees with difficulties.

FY: Trainees felt this was a well-supported job and would contact their educational supervisor for support if needed. They thought occupational health was well signposted.

GPST: Trainees struggled with moving around a lot during their GP training programme and felt support and funding for this could be improved. They also had concerns about IMGs receiving inadequate support.

IMT: Trainees did not have experience of seeking support and were not aware of this being signposted.

ST: Trainees felt the support available to them was very good and trainers were considerate of their individual needs.

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: Trainers reported that a departmental educational governance committee meets quarterly and includes local educational leads and supervisors. Data from the NTS and STS are examined in a timely manner.

Trainees: Not asked.

2.18 Raising concerns (R1.1, 2.7)

Trainers: Trainers reported that they promote an open culture and introduce the datix system at induction which trainees are encouraged to use.

FY: Trainees would raise any patient safety concerns with their supervisor in real time.

GPST: Trainees would raise any patient safety concerns with the on-call consultant in real time.

IMT: Trainees had experience of raising patient safety concerns regarding management by a locum consultant. They raised these with an available consultant and with the service manager and felt the concerns were managed appropriately.

ST: Trainees would raise any patient safety concerns with a consultant or manager. They were aware of M&M meetings for acute receiving and within specialties.

2.19 Patient safety (R1.2)

Trainers: Trainers were aware that trainees had concerns regarding patient volume and boarding.

FY: Trainees did not have patient safety concerns about any individuals, but had concerns about the boarding process as they worried about patients getting lost and felt there were no senior decision-makers involved in the process.

GPST: Trainees had concerns about the boarding process as it was hard to trace patients.

IMT: Trainees had general concerns about patient flow and delays in assessment, but felt this was common to all hospitals. They had specific concerns about boarding including; patients being boarded straight away after arrival; delay in assessment of boarders; lack of clarity about who is responsible for boarded patients; tracking boarded patients; absence of a separate team to manage boarders.

ST: Trainees had concerns about bed pressures and boarding. Trainees felt that boarders received poorer care as they did not receive adequate handovers from acute receiving and medical staff often did not know they had been moved. They knew that consultants had escalated these issues to management but perceived they had not been addressed.

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

Trainers: Trainers reported that a hot de-brief takes place if a traumatic event occurs. There is also an M&M meeting for acute receiving and M&Ms for some specialties.

FY: Trainees did not have experience of completing datix reports and noted that nurses were good at submitting these when needed. They felt well supported when communicating things that had gone wrong to patients.

GPST: Trainees had received constructive feedback on incident reports they had submitted. They had little experience of communicating things that had gone wrong to patients, but felt they would be well supported if they had to do this.

IMT: Trainees had raised a lot of datix reports,but had not received any feedback on them. They had attended some discussions about significant adverse events which had been useful. They felt well supported when communicating things that had gone wrong to patients and trusted consultants to support them with this.

ST: Trainees had raised datix reports, but had not received constructive feedback on these. They felt very well supported when communicating things that had gone wrong to patients.

2.21 Other

Trainees were asked to rate their overall satisfaction with this post out 10. Average scores for each cohort were as follows:

FY: 6.7
GPST: 5.5
IMT: 6.3
ST: 6.7

Multiple trainee cohorts noted that their overall satisfaction scores were high because of excellent colleagues who enhanced the overall training experience for them despite some of the negative points raised during the visit.

3. Summary

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

Overall, the panel commended the department for providing a supportive and engaged training environment which sought to understand and address the issues which concerned trainees. The panel identified some areas of concern, particularly in relation to inadequacy of induction, lack of departmental teaching, lack of feedback to inform learning and concerns surrounding boarding.

Positives

- All trainee cohorts described their trainers as supportive, friendly and approachable. This engendered a positive atmosphere and trainees felt they could raise concerns with their trainers.
- The senior leadership were commended for being engaged, for example doing shifts in the acute medical receiving unit to better understand trainee issues and how these might be resolved.
- Trainees feel they are listened to, for example senior trainees are invited to attend the consultants' meeting.

- The rota is generally working well and is managed efficiently. Trainees were able to get time off for important events and to access study leave. There was some concern about numbers of rota co-ordinators decreasing and the panel hoped that this positive experience could be maintained.
- FYs were particularly satisfied with their global experience of training in the department.

Negatives

- Induction was commended in Acute Internal Medicine and Geriatric Medicine, however issues were identified in other areas including; the induction handbook being out of date; lack of catch-up induction for those who missed the first day; concerns about IMGs and locums starting without adequate induction. The latter led to resulting training issues such as trainees being removed from clerking shifts as this was deemed an easier job for new locums.
- IT issues were identified including the volume and complexity of systems for requesting tests and imaging and the mismatch between electronic records in acute medical receiving and paper records in downstream wards.
- Regional teaching was easy to attend, however trainees described minimal departmental teaching and some were not aware of any. Trainees felt that departmental teaching needed greater consultant input.
- An issue was described whereby acute medicine and downstream handovers took place simultaneously which meant the on-call registrar could not attend both. ST trainees described either starting early or finishing late to accommodate both handovers. Trainees were not clear on the handover system although some mentioned SBAR.
- Boarding was seen as a major risk by all trainee groups due to lack of robust communication when patients are moved, particularly over the weekend. Trainees described patients being admitted on a Friday and not being reviewed until after the weekend when they were found to have deteriorated. There were also concerns about patient selection for boarding as this seemed to be made at a bed management level.
- There are excellent facilities in the Centre for Health Sciences and some computers available in the doctors' mess, however these did not meet trainees' needs regarding computer access as the Centre for Health Sciences was too far away to access during a shift and computers in the doctors' mess were not private. Access to computers within departments would be of benefit to trainees.

- Trainees were aware of the datix system, however responses were felt to be slow and not constructive. Trainees would appreciate more granular feedback to learn from adverse events.
- There is a lack of feedback to trainees for reasons including parallel working. Senior trainees would like the opportunity to see patients more independently with more “light-touch” feedback.

4. Areas of Good Practice

Ref	Item	Action
4.1	The practice of senior medical staff working shifts in the acute receiving unit was commended for supporting trainees and promoting a culture of improvement.	

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	The department should continue to progress plans to upgrade and streamline IT systems.	
5.2	Handover arrangements should be reviewed, particularly regarding the arrangement which requires registrars to attend 2 handovers simultaneously.	
5.3	Access to computers within departments would be of benefit to trainees.	
5.4	Trainees would appreciate more granular feedback on datix reports to learn from adverse events.	

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	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. Handbooks or online equivalent should be up-to-date and may be useful in aiding this process but are not sufficient in isolation.	8th March 2024	FY, GPST, IMT, ST
6.2	A regular programme of formal departmental teaching should be introduced appropriate to the curriculum requirements of trainees. This should have consultant input.	8th March 2024	FY, GPST, IMT, ST
6.3	The site must develop an effective system of safe selection, tracking and management of boarded patients, ensuring appropriate clinical ownership and oversight of patient care.	8th March 2024	FY, GPST, IMT, ST
6.4	Feedback to all levels of trainees on their management of acute receiving cases must be provided to inform their learning and training (aiming for this in at least 40% of opportunities).	8th March 2024	FY, GPST, IMT, ST