

**PWYLLGOR DIWYLLIANT, POBL A DATBLYGU SEFYDLIADOL  
PEOPLE, ORGANISATIONAL DEVELOPMENT & CULTURE COMMITTEE**

<b>DYDDIAD Y CYFARFOD: DATE OF MEETING:</b>	19 August 2025
<b>TEITL YR ADRODDIAD: TITLE OF REPORT:</b>	Update - Health Education and Improvement Wales (HEIW) Targeted Visits to General Surgery, Withybush Hospital & General Medicine, Glangwili Hospital
<b>CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:</b>	Mr Mark Henwood, Executive Medical Director
<b>SWYDDOG ADRODD: REPORTING OFFICER:</b>	Mrs Helen Thomas, Head of Medical Education & Professional Standards

**Pwrpas yr Adroddiad (dewiswch fel yn addas)  
Purpose of the Report (select as appropriate)**

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA  
SBAR REPORT**

**Sefyllfa / Situation**

This report presents an update on the Health Education and Improvement Wales (HEIW) quality assurance processes which monitor and report on the quality of medical education and training across Hywel Dda University Health Board (HDdUHB). There have been 2 targeted visits to specialties in HDdUHB since April 2025. The first visit was made to the General Surgery Department of Withybush Hospital on the 24 April 2025 and the other visit was made to the General Medicine Department of Glangwili Hospital on the 16 June 2025.

**Cefndir / Background**

The General Medical Council (GMC) run the annual National Training Survey (NTS) to gain a deeper understanding of the experiences of our trainees and trainers. The survey is open for responses between the months of March and May and is an integral part of the GMC's work to monitor and report on the quality of medical education and training. HDdUHB employs a total of 275 trainees, which the survey is reflective of, therefore it is important to ensure that we are able to provide the best training experience possible.

As part of their role in the commissioning, delivery and quality management of postgraduate medical education and training across Wales, HEIW's Quality Unit review the results of the National Training Survey (NTS) to ensure that training and educational experiences meet national standards. Acknowledgement is made of areas of good practise identified and where the results of the survey suggest that further improvement is needed, risks are created and included as part of the HEIW risk register.

Where the risks are ongoing, or for higher scoring risks, targeted visits to the respective specialties are arranged. In the event of ongoing challenges in ensuring the delivery of a sustainable solution, specific GMC input may be recommended, with an escalation to enhanced monitoring. GMC input can be useful for complex issues and experiences from similar challenges in other parts of the UK can be beneficial. However, GMC involvement will also raise the level of scrutiny both around the concern and the management of the concern.

Enhanced monitoring concerns are published on the GMC website in collaboration with HEIW and the LEP to enhance transparency.

It should be noted that HEIW does not limit its evidence sources to the NTS and will consider all sources of evidence in the management of training concerns. However, all current risk register concerns have come to light via the GMC survey.

### Asesiad / Assessment

There are currently 18 risks on the HEIW risk register. HEIW request regular updates on the risks included on the register and meetings are held three times a year between the Quality Unit and the Senior Medical Education Faculty Team, to discuss progress and updates. Of the risks included on the register, 4 are considered high risk, 12 are considered medium risk and there are 2 which are considered low risk. Many of the lower scoring risks are those which have scored higher in the past are managed sufficiently that they are no longer considered a priority. These will be removed where no further concerns are reported.

There were 21 risks included on the HEIW risk register in August 2024, which was the last time that a report was provided to PODCC and so progress has been made in terms of the educational experience offered in some departments. Significant improvements have been made in Trauma & Orthopaedics at Glangwili and in General Medicine at Bronglais, resulting in a notable decrease in the risks associated with the training experience in these areas. However, the level of risk associated with other areas including, the General Medicine and General Surgery departments of Glangwili and Withybush Hospitals has increased, as well as the department of Clinical Radiology in Glangwili.

The increase in risk led to a targeted visit being made to the General Surgery Department of Withybush Hospital on the 24 April 2025 and to the General Medicine Department of Glangwili Hospital (GGH) on the 16 June 2025. A date for a further visit to the General Medicine Department in Withybush Hospital (WGH) is in the process of being confirmed and it is likely that a visit will be made to the Clinical Radiology Department of GGH, although this has yet to be confirmed by HEIW. Despite the high scoring risk associated with General Surgery in GGH, HEIW has not indicated whether a visit will be made to this department. During the visit to the General Surgery Department at WGH, HEIW expressed appreciation for the department's commitment to supporting trainee development, particularly in facilitating their attendance. Several positive developments were acknowledged, including notable improvements to the rota—such as the removal of the 12-day stretch—and the rescheduling of the teaching programme to improve accessibility. Trainees also reported increased opportunities to gain theatre experience and the inclusion of dedicated educational development time within rotas. Additionally, there was strong evidence of collaboration among trainees, with reports highlighting effective teamwork across the department.

Despite this progress, trainees raised additional concerns. These included instances of unprofessional behaviour by senior medical staff, excessive workload for Foundation Doctors, absence of teaching ward rounds, insufficient induction for clinical fellows, and a lack of professional, constructive feedback. As a result, the risk score was elevated, prompting the need for a follow-up visit.

Findings from the targeted visit to General Medicine department in GGH demonstrated that although improvements were observed in areas such as supervision (including out-of-hours), induction, handover, and the reporting of concerns, significant issues remained. In particular, reduced staffing levels on Tuesdays, Thursdays, and weekends were resulting in increased workloads and raised patient safety concerns. Resident doctors reported challenges in

providing timely care and treatment during these periods. HEIW considered these issues serious enough to refer the findings to Healthcare Inspectorate Wales (HIW) and the GMC. The GMC is currently assessing whether enhanced monitoring of the department's training offering is warranted and will work closely with HEIW to track progress in accordance with the educational risk management framework.

In response to the requirements and recommendations arising from both visits, action plans were submitted to HEIW, and efforts are ongoing to implement the necessary measures. Visit reports can be found at Appendix 1 and 2, and action plans at Appendix 3 and 4.

Dates for follow up visits are in the process of being confirmed but both visits will most likely go ahead before the end of December 2025.

For all other risks listed in the register, the Medical Education Teams collaborate closely with educational and clinical supervisors, service leads, and managers to support improvements in the quality of training provided to trainees and to help lower associated risk scores.

### Argymhelliad / Recommendation

The People, Organisational Development & Culture Committee is requested to:

- NOTE the outcome of the targeted visits from the Health Education and Improvement Wales (HEIW) to General Surgery, Withybush Hospital and General Medicine, Glangwili Hospital and subsequent recommendations .
- TAKE ASSURANCE from the attached action plans which outline the completed and planned work being undertaken to address identified areas for improvement.

<b>Amcanion: (rhaid cwblhau)</b>	
<b>Objectives: (must be completed)</b>	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	2.3 To provide assurance to the Board on the organisation's ability to create and manage strong, high performance, organisational culture arrangements
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	To be confirmed
Parthau Ansawdd: Domains of Quality <a href="#">Quality and Engagement Act (sharepoint.com)</a>	1. Safe 2. Timely 3. Effective 4. Efficient
Galluogwyr Ansawdd: Enablers of Quality: <a href="#">Quality and Engagement Act (sharepoint.com)</a>	1. Leadership 2. Culture and valuing people 3. Data to knowledge 4. Learning, improvement and research
Amcanion Strategol y BIP: UHB Strategic Objectives:	1. Putting people at the heart of everything we do 2. Working together to be the best we can be 3. Striving to deliver and develop excellent services 4. The best health and wellbeing for our individuals, families and communities

Amcanion Cynllunio Planning Objectives	1. Putting people at the heart of everything we do
Amcanion Llesiant BIP: UHB Well-being Objectives: <a href="#">Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022</a>	2. Develop a skilled and flexible workforce to meet the changing needs of the modern NHS 5. Offer a diverse range of employment opportunities which support people to fulfill their potential

<b>Gwybodaeth Ychwanegol: Further Information:</b>	
Ar sail tystiolaeth: Evidence Base:	<a href="http://gmc-uk.org">Promoting excellence - GMC (gmc-uk.org)</a>
Rhestr Termau: Glossary of Terms:	Not applicable
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Diwylliant, Pobl a Datblygu Sefydliadol: Parties / Committees consulted prior to People, Organisational Development & Culture Committee:	Not applicable

<b>Effaith: (rhaid cwblhau) Impact: (must be completed)</b>	
<b>Ariannol / Gwerth am Arian: Financial / Service:</b>	Not applicable
<b>Ansawdd / Gofal Claf: Quality / Patient Care:</b>	Not applicable
<b>Gweithlu: Workforce:</b>	Potential positive impact on staff morale and future engagement opportunities
<b>Risg: Risk:</b>	Not applicable
<b>Cyfreithiol: Legal:</b>	Not applicable
<b>Enw Da: Reputational:</b>	Not applicable
<b>Gyfrinachedd: Privacy:</b>	Not applicable
<b>Cydraddoldeb: Equality:</b>	Not applicable



GIG  
CYMRU  
NHS  
WALES

Addysg a Gwellfa Iechyd  
Cymru (AaGIC)  
Health Education and  
Improvement Wales (HEIW)

# HEIW Education & Training Targeted Visit Report

General Surgery

Withybush General Hospital

Hywel Dda University Health Board

Thursday, 24<sup>th</sup> April 2025



## Table of Contents

Section One: Visit Remit .....	3
Section Two: Summary Findings .....	4
Requirements and Recommendations .....	7
Chair's Signature.....	9

## Section One: Visit Remit

<b>Health Board</b>	Hywel Dda University Health Board	<b>Site</b>	Withybush General Hospital
<b>Visit Date</b>	24 <sup>th</sup> April 2025	<b>Risk Rating (Pre visit)</b>	<b>9</b>
<b>Specialty</b>	General Surgery	<b>Grade(s)</b>	Foundation
<b>Visit Panel</b>	<ul style="list-style-type: none"> <li>• Malcolm Gajraj, Director of Quality Management (Chair)</li> <li>• Antony Varekattu Matthew, Foundation Programme Director (Withybush Hospital)</li> <li>• Ilona Schmidt, Faculty Lead (Residents)</li> <li>• Sarah Davidson, Faculty Lead (Trainers)</li> <li>• Jon Morris, Faculty Lead (Quality)</li> <li>• Leanne MacPherson, Specialty Training Manager Secondary Care*</li> <li>• Mandy Martin, Quality Manager</li> <li>• Vicky Collins, Quality Officer</li> <li>• Ronnie Alexander, Lay Representative</li> </ul>		
<b>LEP Representatives</b>	<ul style="list-style-type: none"> <li>• Mark Henwood, Interim Medical Director</li> <li>• Anand Ganesan, Assistant Medical Director (Education and Training)</li> <li>• Andrew Burns, Withybush Hospital Director</li> <li>• John Evans, Deputy Director for Medical Directorate</li> <li>• Caroline Lewis, Service Delivery Manager for ENT &amp; General Surgery</li> <li>• David Lewis, Service Manager for General Surgery &amp; Associated Services</li> <li>• Rebecca Noyce, Assistant Head of Workforce</li> <li>• Jegadish Mathias, Colorectal Surgeon and Health Board Cancer Lead</li> <li>• Helen Thomas, Head of Medical Education and Professional Standards</li> <li>• Shirly Mathias, Medical Education Manager for Withybush Hospital</li> </ul>		
<b>Evidence Considered</b>	<ul style="list-style-type: none"> <li>• Agenda</li> <li>• Evidence Timeline</li> <li>• 2024 GMC National Training Survey Results</li> <li>• Health Board Action Plan in response to 2024 NTS Results.</li> </ul>		
<b>Residents Present</b>	Foundation x 10	<b>Trainers Present</b>	x 2
<b>Status Summary</b>	<ul style="list-style-type: none"> <li>• This is the first visit to the department.</li> <li>• This concern is not in Enhanced Monitoring status with the GMC.</li> </ul>		

\* In attendance for Resident feedback session only.

*In the context of this report, the term 'Residents' refers to Postgraduate Doctors in training unless otherwise specified.*

### Visit Background

Targeted Visits are the responsive component of HEIW's quality framework. The overall purpose of visits is to support the identification of areas which are working well and those which may require further attention. Evidence obtained prior to and at the visit is considered in relation to GMC standards outlined within Promoting Excellence. The visits provide a constructive way of enabling HEIW and Local Education Providers to collaborate in supporting the provision of high quality postgraduate medical education and training in Wales.

Concerns within General Surgery at Withybush General Hospital were originally identified through the 2021 GMC National Training Survey. The results identified Reporting Systems and Overall Satisfaction as below outliers, and Clinical Supervision Out-of-hours, Adequate Experience, Curriculum Coverage, Feedback, Rota Design and Educational Governance as lower quartiles. Between 2021 and 2023, the Health Board implemented rota adjustments to increase on-call coverage, and access to senior support. Senior staff members had been nominated to lead on teaching programmes and surgical pathway changes throughout the Health Board were reviewed. Resident feedback had been incorporated into changes implemented. Discussions by the Health Board regarding potential closure of the surgery department at Withybush took place in 2023 but this was not agreed. There were also reconfiguration issues with regard to RAAC (Reinforced Autoclaved Aerated Concrete) at the site which impacted training, and which required additional mitigation to be in place.

GMC National Training Survey results from 2023 and 2024 showed further concerns in Clinical Supervision, Overall Satisfaction, Reporting Systems, Teamwork, and Clinical and Educational Supervision. The Health Board encountered challenges in maintaining implemented improvements due to staffing constraints, balancing varying curriculum requirements alongside service provision within the rota, and the ongoing debate around the future of Surgery within Withybush General Hospital. Subsequently, targeted visits with HEIW were initiated to support, feedback and monitor the education and training of residents undertaking placements in General Surgery.

A summary of the Health Board action plan in response to the 2024 GMC National Training Survey Results is provided below.

- Allocation of Supporting Professional Activities (SPA) time for training roles would be taken forward.
- To emphasise to residents when bedside teaching is taking place.
- Implementation of a twelve-day rota was to be considered.
- To inform residents of how to raise concerns and where to access support outside of the department.
- To provide advanced notification of Morbidity and Mortality meetings to residents, as well as to enable them to participate more meaningfully.
- Ensure adequate induction and on-call support for residents transitioning from Foundation year 1 (F1) to Foundation year 2 (F2).
- To ensure teaching is consultant led by moving teaching sessions to a Monday. Attendance at teaching sessions was to be monitored.
- To increase senior led teaching and clinical skills training.
- To formalise theatre allocations and agree learning outcomes at the start of the placement.

## Section Two: Summary Findings

Resident presence during the targeted visit was good, with Foundation residents from the previous cohort also in attendance.

Residents that had recently started their placements in General Surgery received a thirty-minute departmental induction from a senior member of the General Surgery team at the beginning of their placements. The induction included a departmental information handbook; however, the information within the booklet was outdated.

Residents were informed of their Named Clinical Supervisors with plenty of notice and initial meetings with Named Clinical Supervisors had been arranged for the current resident cohort. Residents from the previous group had experienced difficulties contacting and arranging meetings with their Named Clinical Supervisors. A few were still awaiting their end of placement meetings, though these had now been diarised. Consultants' high workload and cross site working were recognised as contributing factors towards the obstacles experienced in arranging meetings with supervisors. Nevertheless, when meetings with Named Clinical Supervisors were scheduled, the feedback received was constructive and beneficial to learning.

Consultants attended the ward to undertake ward rounds, but outside of these times consultant presence on the ward was minimal. Residents were able to access beneficial support from surgical and medical registrars when needed. Residents were given the phone numbers of some consultants; however, this had not been the case across the consultant body, limiting consultant accessibility for residents.

There was confusion amongst residents about the escalation protocols for patients that experienced complications post-surgery. If the patient's complication appeared to be of medical origin, residents would directly contact the on-call medical registrar for support, rather than contacting a member of the General Surgery team for guidance first. Department leads confirmed that a member of the General Surgery team should be contacted in the first instance, however, there had previously been a medical registrar working within the General Surgery team to optimise the management and discharge of post-operative patients as well as providing medical support for residents in the team. Department leads felt this may have contributed to confusion in the escalation process and confirmed that clarity of this process would be included in future inductions.

Teaching sessions were regularly rostered, and a member of the consultant body would be present for the sessions. A rota for the presentation of surgical cases had been incorporated into the teaching sessions and residents were encouraged to take part. Designated theatre lists had also been made available so residents could attend and have minor involvement in theatre procedures.

Residents regarded their rota more positively following recent changes that had decreased the number of days residents would work in a row. The increased workload of consultants' "Take week" was cited as challenging, particularly towards the end of residents' long shift periods.

Consultants' team structures within General Surgery had varying numbers of team members. The experience levels throughout these teams also varied. Disparity between the workloads of Foundation residents and locally employed 'Senior House Officers' (SHOs) was also raised as a concern. Furthermore, some SHOs employed by the Health Board had not been informed of hospital and departmental procedures and systems prior to undertaking their roles, leading to them seek support from less experienced members of their teams, including residents.

Residents experienced challenges in completing Workplace Based Assessments (WBAs) with a consultant due to consultants' limited ward presence, however residents were able to complete WBAs under the supervision of registrars during on-call shifts.

Residents recognised efforts made to make ward rounds a learning opportunity by some of the consultants. Feedback about patient management from some consultants was at times negative, non-constructive and relayed to residents in public spaces. Registrar grades recognised the inappropriate methods of feedback and would often provide residents with constructive feedback following these public incidents. However,

registrars also advised residents not to raise concerns about the format in which feedback was provided, as no changes had been apparent following previous concerns raised.

During the visit, examples were given of some consultants exhibiting unprofessional, inappropriate and undermining behaviours towards members of their teams, including residents. Residents suggested these behaviours were normalised within the wider General Surgery team.

Departmental leads confirmed that previous issues of uncivil behaviour within General Surgery had been investigated, and appropriate actions taken, including non-renewal of a locum consultant's contract. Health Board leads and the Medical Education team were also aware of wider concerns about unprofessional behaviours in Withybush Hospital and had arranged group meetings and anonymous surveys to gather feedback to accurately target areas of particular concern.

Overall, residents believed their current placements were tailored towards service provision rather than towards education and training. None of the residents in attendance at the visit would recommend their posts for learning.

Areas Working Well	Areas for Improvement
<ul style="list-style-type: none"> <li>• Regularly scheduled and good quality teaching programme.</li> <li>• Rostered Educational Development Time.</li> <li>• Good input and feedback from Named Clinical Supervisors.</li> <li>• Changes in rota structure.</li> <li>• Exposure to theatre.</li> <li>• Support and accessibility of registrar grades.</li> </ul>	<ul style="list-style-type: none"> <li>• Methods of feedback that are of benefit to learning.</li> <li>• Equitability of workload between 'Senior House Officers' and Foundation residents.</li> <li>• Updating of departmental handbook.</li> <li>• The level of workload was very high and had little educational value.</li> <li>• Tackling the normalised culture of unprofessional behaviours.</li> <li>• Provision of adequate information to locally employed doctors prior to them starting their roles.</li> <li>• Clarification of escalation pathways for patients requiring post-operative escalation.</li> <li>• Accessibility of the consultant body within the ward setting.</li> <li>• Implementation of a teaching ward round.</li> <li>• Awareness and encouragement of reporting channels.</li> <li>• Openness of feedback following concerns being raised.</li> </ul>

## Requirements and Recommendations

The following requirements and recommendations were made in response to the findings of the visit process.

### Requirements

1. The Health Board must ensure that:
  - a. Inappropriate behaviours, including bullying, discrimination, misogyny, and undermining are eliminated from the workplace.
  - b. Robust monitoring must be implemented, with an appropriate response to transgression and feedback provided to the reporter.
  - c. Pathways for reporting inappropriate behaviours should be promoted and encouraged, to ensure that any such behaviours are reported and challenged promptly.

#### **GMC Requirement 3.3**

Learners must not be subjected to, or subject others to, behaviour that undermines their professional confidence, performance, or self-esteem.

#### **GMC Requirement 2.7**

Organisations must have a system for raising concerns about education and training within the organisation. They must investigate and respond when such concerns are raised, and this must involve feedback to the individuals who raised the concerns.

2. The Health Board must review the workload of Foundation Year 1 residents to ensure that they are able to complete their work requirements before the end of their workday. Furthermore, the tasks undertaken by other clinical staff within the department should be monitored to ensure an equitable distribution of the team workload.

#### **GMC Requirement 1.12**

Organisations must design rotas to:

- a. make sure doctors in training have appropriate clinical supervision.
  - b. support doctors in training to develop the professional values, knowledge, skills, and behaviours required of all doctors working in the UK.
  - c. provide learning opportunities that allow doctors in training to meet the requirements of their curriculum and training programme.
  - d. give doctors in training access to educational supervisors.
  - e. minimise the adverse effects of fatigue and workload.
3. The Health Board must ensure that a minimum of one teaching ward round takes place per week within the General Surgery department.

#### **GMC Requirement 1.16**

Doctors in training must have protected time for learning while they are doing clinical or medical work, or during academic training, and for attending organised educational sessions, training days, courses, and other learning opportunities to meet the requirements of their curriculum. In timetabled educational sessions, doctors in training must not be interrupted for service unless there is an exceptional and unanticipated clinical need to maintain patient safety.

4. The Health Board and the Directorate must ensure that clinicians new to the Health Board, particularly International Medical Graduates, are provided with adequate information to be able to undertake their clinical duties, before starting their roles. This process should not be overly reliant upon Foundation doctors.

**GMC Requirement 1.7**

Organisations must make sure there are enough staff members who are suitably qualified, so that learners have appropriate clinical supervision, working patterns and workload, for patients to receive care that is safe and of a good standard, while creating the required learning opportunities.

5. The Health Board must make sure that feedback provided to residents about their management of patients is constructive and beneficial to learning.

**GMC Requirement 1.15**

Organisations must make sure that work undertaken by doctors in training provides learning opportunities and feedback on performance, and gives an appropriate breadth of clinical experience.

**Recommendations**

1. The Health Board should ensure there is clarification on the roles and responsibilities of 'Senior House Officers' (SHOs). The workload of SHO's should be monitored to ensure patient care is optimised.

**GMC Requirement 1.7**

Organisations must make sure there are enough staff members who are suitably qualified, so that learners have appropriate clinical supervision, working patterns and workload, for patients to receive care that is safe and of a good standard, while creating the required learning opportunities.

2. The Health Board should review the deployment of medical staff throughout the General Surgery team to help ensure a fair division of departmental workload.

**GMC Requirement R1.17**

Organisations must support every learner to be an effective member of the multiprofessional team by promoting a culture of learning and collaboration between specialties and professions.

3. The Health Board should ensure that escalation protocols for deteriorating patients under the care of the General Surgery team are clearly and widely communicated, to ensure patients are appropriately managed by the surgical team prior to external team involvement. This approach should be monitored.

**GMC Requirement 1.6**

Organisations must make sure that learners know about the local processes for educational and clinical governance and local protocols for clinical activities. They must make sure learners know what to do if they have concerns about the quality of care, and they should encourage learners to engage with these processes.

4. The Health Board should update the departmental information handbook provided to residents during induction.

**GMC Requirement 1.13**

Organisations must make sure learners have an induction in preparation for each placement that clearly sets out:

- a. their duties and supervision arrangements.

- b. their role in the team.
  - c. how to gain support from senior colleagues.
  - d. the clinical or medical guidelines and workplace policies they must follow.
  - e. how to access clinical and learning resources.
5. The Health Board should ensure that all Foundation Year 1 residents are able to achieve two consultant-led Workplace Based Assessments per rotation.

#### **GMC Requirement 1.15**

Organisations must make sure that work undertaken by doctors in training provides learning opportunities and feedback on performance, and gives an appropriate breadth of clinical experience.

6. HEIW will visit again in approximately six months.

#### **GMC Requirement 2.6**

Medical schools, postgraduate deaneries and LETBs must have agreements with LEPs to provide education and training to meet the standards. They must have systems and processes to monitor the quality of teaching, support, facilities and learning opportunities on placements, and must respond when standards are not being met.


### **Next Steps**

The aforementioned requirements and recommendations were provided to the Health Board verbally on the day of the visit and in writing on **Monday, 28<sup>th</sup> April 2025**. An action plan has been requested with a response required by **Tuesday, 10<sup>th</sup> June 2025**.

### **Risk Rating Recommendation**

It was agreed that the risk rating of **nine** (high) would be increased to **twelve** (high) given the concerns raised around training and unprofessional behaviours. A further review of the risk rating would be undertaken at the next Targeted Visit, which will be scheduled in around six months' time.

### **Chair's Signature**

Signature: 

Malcolm Gajraj, Director of Quality Management

**Date: 13<sup>th</sup> June 2025**



GIG  
CYMRU  
NHS  
WALES

Addysg a Gwella Iechyd  
Cymru (AaGIC)  
Health Education and  
Improvement Wales (HEIW)

# HEIW Education & Training Targeted Visit Report

Medicine

Glangwili General Hospital

Hywel Dda University Health Board

Monday, 16<sup>th</sup> June 2025



## Table of Contents

Section One: Visit Remit .....	3
Section Two: Summary Findings .....	5
Requirements and Recommendations .....	7
Chair's Signature.....	9

## Section One: Visit Remit

<b>Health Board</b>	Hywel Dda University Health Board	<b>Site</b>	Glangwili General Hospital
<b>Visit Date</b>	16 <sup>th</sup> June 2025	<b>Risk Rating (Pre visit)</b>	<b>9</b>
<b>Specialty</b>	Medicine	<b>Grade(s)</b>	Foundation, GPST, IMT & ST
<b>Visit Panel</b>	<ul style="list-style-type: none"> <li>• Lee Wisby, Associate Dean for Quality (Chair)</li> <li>• Shaun Smale, Head of School for Medicine</li> <li>• Sarah Davidson, Faculty Lead (Trainers)</li> <li>• Jon Morris, Faculty Lead (Quality)</li> <li>• Ilona Schmidt, Faculty Lead (Residents)</li> <li>• Jo McCarthy, Local Foundation Programme Director</li> <li>• Islam Abdelrahman, Local Foundation Programme Director</li> <li>• Mandy Martin, Quality Manager</li> <li>• Vicky Collins, Quality Officer</li> <li>• Lynda Davies, Lay Representative</li> </ul>		
<b>LEP Representatives</b>	<ul style="list-style-type: none"> <li>• Eiry Edmunds, Deputy Medical Director</li> <li>• Anand Ganesan, Assistant Medical Director (Education and Training)</li> <li>• John Evans, Interim County Director (Pembrokeshire)</li> <li>• Robin Ghosal, Hospital Director for Glangwili General Hospital</li> <li>• Clive Weston, Clinical Director for Medicine</li> <li>• Nicholas Coles, Royal College Tutor</li> <li>• Aashish Kumar, Consultant Gastroenterologist</li> <li>• Nicola Evans, Hospital Service Manager for Glangwili General Hospital</li> <li>• Nicky Pearce, Medical Education Manager</li> <li>• Stuart Bancroft, Assistant General Manager (H DUHB)</li> <li>• Peta Spiller, Unscheduled Care Rota Manager</li> <li>• Sarah Price, Unscheduled Care Rota Co-ordinator</li> <li>• Suzan Abdelgafar, Resident Representative (IMT)</li> <li>• Lisa Jones, Resident Representative (Foundation)</li> </ul>		
<b>Evidence Considered</b>	<ul style="list-style-type: none"> <li>• Evidence Timeline</li> <li>• 2024 GMC National Training Survey Results</li> <li>• Health Board Action Plan in response to the 2024 GMC National Training Survey Results</li> </ul>		
<b>Residents Present</b>	18 across Foundation and IMT grades	<b>Trainers Present</b>	5
<b>Status Summary</b>	<ul style="list-style-type: none"> <li>• This is the first visit to the department.</li> <li>• This concern is not in Enhanced Monitoring status with the GMC.</li> </ul>		

*In the context of this report, the term 'Residents' refers to Postgraduate Doctors in training unless otherwise specified.*

## Visit Background

Targeted Visits are the responsive component of HEIW's quality framework. The overall purpose of visits is to support the identification of areas which are working well and those which may require further attention. Evidence obtained prior to and at the visit is considered in relation to GMC standards outlined within Promoting Excellence. The visits provide a constructive way of enabling HEIW and Local Education Providers to collaborate in supporting the provision of high quality postgraduate medical education and training in Wales.

The visit was undertaken due to fluctuating feedback reported in GMC National Training Surveys over time, particularly in relation to clinical supervision. Whilst local efforts were made to address these concerns, with some evidence of improvement suggested by the 2024 GMC National Training Survey results, adverse feedback in relation to clinical supervision continued and visit processes were therefore instigated to understand the challenges and collaborate with the Health Board to implement sustainable solutions.

The Health Board has indicated the following progress in response to the 2024 GMC National Training Survey.

- Residents reported feeling adequately supervised for the most part. However, supervision concerns were raised by residents working with the Gastroenterology and Care of the Elderly (COTE) teams.
- Out-of-hours supervision was described as very good. Residents reported that they were well supported by the Hospital at Night Team.
- Internal Medicine Training (IMT) residents undertook a survey following concerns being raised about high workload during on-calls. Two-thirds of the recommendations suggested by IMTs had been taken forward by their team for senior signoff.
- Resident attendance at teaching sessions had been monitored by the Health Board. This had identified that 52% of available teaching sessions had been attended by residents on placement in Medicine. Reasons for non-attendance were a lack of staff, high workload, and ward commitments. Supervisors had been requested to encourage residents to attend teaching sessions.
- The induction provided by the Medical Education Centres had been effective, however the value of departmental inductions varied. A Foundation Programme Director, Educational Supervisors and local leads had commenced reviews of departmental inductions.
- Handover had been made a standing item on the Resident Doctors' Forum agenda. Handovers in Medicine specialities were described as good, thorough, and contained a list of patients prepared for discussion.
- The Health Board included information about how to raise and escalate concerns in the hospital induction. This information was reaffirmed with residents throughout their placements, including at the Resident Doctors' Forum.
- Challenges with staffing and supervision had been recognised and were in the process of being addressed.
- The Health Board had appointed a fixed-term Teaching Fellow to support medical departments and had also begun to review the possibility of adding a Teaching Registrar to the team.
- The department had introduced a new process whereby annual leave was arranged through the clinical team as opposed to the rota co-ordinators, following concerns from Foundation residents about accessing leave.

## Section Two: Summary Findings

Good attendance from resident doctors of all grades, trainers and Health Board representatives was evident at the visit. Residents' main concerns raised during the visit related to low staffing which resulted in an unmanageable workload and significant compromise to patient safety, particularly during out-of-hours and at weekends.

Residents found the consultant body, as well as their wider teams, to be approachable and supportive. However, staffing structures and high workload levels had limited residents' time working alongside consultants as well as learning from peers with more experience.

Workplace Based Assessments were manageable, but workload had led to residents staying behind after their shifts had ended to facilitate signoff and obtain feedback from consultants.

Educational Development Time (EDT) had been incorporated into residents' rotas. Internal Medicine Training (IMT) residents had been able to utilise EDT to attend taster days and to undertake quality improvement projects.

Weekly teaching had been scheduled for Foundation and IMT grades and the sessions had been beneficial to learning. Residents were encouraged to attend monthly Mortality and Morbidity meetings and found these informative. However, residents suggested including concerns raised via Datix, alongside those raised via patient complaints would have provided a more rounded understanding of the concerns process.

Clinics had not been incorporated into rotas, but were confirmed to be of good training experience, with valued guidance provided by consultants. Some IMT residents had struggled to attend clinics due to workload and, when able to attend, had to continue to answer their bleeps.

Residents found the rotas to be challenging due to the frequency of consecutive shifts without a break, alongside the consistently high volume of work within the department. They had also experienced challenges accessing annual leave, with responses to requests for annual leave often delayed.

Limited access to enough computers to undertake clinical duties had been raised as a concern. Residents also raised concerns about a lack of rooms in Acute Medicine contributing to delays in the timely review of patients. This was echoed by trainers, as minimal room availability had led to them being unable to access a confidential space to provide residents with feedback about their patients and performance.

Generally, trainers believed their job plans adequately reflected the time required for their educational and clinical responsibilities. They did, however, raise concerns about the effectiveness of the Health Board trainer appraisal processes and perceived there to be a lack of recognition of Continuing Professional Development credits specific to training roles.

Both residents and trainers considered Acute Medicine to be inadequately staffed and the workload to be chaotic, particularly during on calls and at the weekends. Multiple members from the same team could be rostered for on-calls at the same time, which regularly left their main speciality with very limited staffing. Support from auxiliary staff had been limited and irregular, further increasing residents' workloads.

Patient safety concerns had been raised during the visit. Examples of delays in responses to urgent blood test results and to the provision of intravenous antibiotics, painkillers and medication for syringe drivers were conveyed to be commonplace due to the heavy workload. Residents had raised concerns about the impact of low staffing and high workload at the Resident Doctors' Forum and had also undertaken quality improvement projects to highlight the lack of staffing across Medicine, but a lack of apparent improvement and re-assurance had led to disillusionment, causing reporting systems such as Datix being underutilised to record incidents. The consultant body and department leads had also submitted suggestions to the

Health Board to bolster the workforce across Medicine, but regular refusals had led to these efforts seeming like an ineffective use of consultants' time.

Overall, both residents and trainers expressed concern around the chaotic working environment and the impact of workload and low staffing levels upon patient safety. They stated that patients were coming to harm on almost every weekend shift and that the majority of these incidents went unreported. Exposure to an unmanageable workload and a lack of varied training had left residents demoralised. The evidence in the action plan provided by the Health Board was not reflected in the feedback provided during the Targeted Visit and the lack of effective incident reporting had led to both residents and trainers being discouraged and unsure of how service and training provision would be improved.

Areas Working Well	Areas for Improvement
<ul style="list-style-type: none"> <li>• Residents had been able to complete their Workplace Based Assessments (WBAs).</li> <li>• Educational Development Time was accessible and IMTs had been able to attend taster days.</li> <li>• Teaching was scheduled weekly and was of good quality.</li> <li>• The Consultant Body and their wider teams were approachable and supportive.</li> <li>• Attendance at Mortality and Morbidity meetings had been a beneficial learning experience.</li> <li>• Consultant job plans reflected their clinical and educational duties.</li> </ul>	<ul style="list-style-type: none"> <li>• Frequently need to stay beyond their scheduled working hours to complete WBAs.</li> <li>• Inadequate room availability within Emergency Department and Acute Medicine for patients to be reviewed in a timely manner and for consultants to provide feedback to residents in a confidential setting.</li> <li>• Accessibility of computers and IT systems.</li> <li>• The uneven distribution of on-call responsibilities across Medicine specialities.</li> <li>• Clinic access for IMT grades was insufficient and where access was possible residents were often disturbed.</li> <li>• Responses to annual leave requests were not provided in a timely manner.</li> <li>• Inadequate staffing levels to ensure patient safety and access to training for residents.</li> <li>• Prioritisation and monitoring of Datix reporting.</li> <li>• Effective feedback channels between residents, Trainers and the Health Board.</li> <li>• Inadequate medical and non-medical staffing.</li> <li>• Ineffective Trainer appraisal process.</li> </ul>

## Requirements and Recommendations

The following requirements and recommendations were made in response to the findings of the visit process.

### Requirements

1. HEIW will share the evidence regarding patient safety concerns gathered at the Targeted Visit with Health Inspectorate Wales, to facilitate greater support to the Health Board to remedy the patient safety and staffing level concerns in Acute Medicine.

#### **GMC Requirement 2.17**

Organisations must have a process for sharing information between all relevant organisations whenever they identify safety, wellbeing or fitness to practise concerns about a learner, particularly when a learner is progressing to the next stage of training.

2. The Health Board should undertake an urgent review of resident workload, particularly during on-calls and weekends, to ensure patient safety and to support staff wellbeing and training opportunities. This will need to be facilitated by ensuring that the level of medical staffing is appropriate for the demand and that there is trust and faith in a system for reporting incidents as they occur. Guidance from the Royal College of Physicians on safe staffing levels should be consulted in assessing the workforce need.

#### **GMC Requirement 1.12**

Organisations must design rotas to:

- a. make sure doctors in training have appropriate clinical supervision.
  - b. support doctors in training to develop the professional values, knowledge, skills and behaviours required of all doctors working in the UK.
  - c. provide learning opportunities that allow doctors in training to meet the requirements of their curriculum and training programme.
  - d. give doctors in training access to educational supervisors.
  - e. minimise the adverse effects of fatigue and workload.
3. The Health Board should review and support the usage of the clinical incident reporting system by front-line staff. A significant majority of known incidents of harm are currently not being reported.

#### **GMC Requirement 1.1**

Organisations must demonstrate a culture that allows learners and educators to raise concerns about patient safety, and the standard of care or of education and training, openly and safely without fear of adverse consequences.

4. The Health Board should review processes for approving annual leave so that responses are received in a timely manner.

#### **GMC Requirement 1.12**

Organisations must design rotas to:

- a. make sure doctors in training have appropriate clinical supervision.
- b. support doctors in training to develop the professional values, knowledge, skills and behaviours required of all doctors working in the UK.

- c. provide learning opportunities that allow doctors in training to meet the requirements of their curriculum and training programme.
- d. give doctors in training access to educational supervisors.
- e. minimise the adverse effects of fatigue and workload.

## Recommendations

1. The Health Board should ensure that IMT residents are able to access and complete an adequate number of clinics to meet their curriculum requirements, particularly residents in Internal Medicine Training (IMT) posts.

### **GMC Requirement 1.16**

Doctors in training must have protected time for learning while they are doing clinical or medical work, or during academic training, and for attending organised educational sessions, training days, courses, and other learning opportunities to meet the requirements of their curriculum. In timetabled educational sessions, doctors in training must not be interrupted for service unless there is an exceptional and unanticipated clinical need to maintain patient safety.

2. The Health Board should review working arrangements to ensure that residents are able to achieve Acute Care Assessment Tool (ACAT) workplace-based assessments as required by their curriculum.

### **GMC Requirement 1.15**

Organisations must make sure that work undertaken by doctors in training provides learning opportunities and feedback on performance, and gives an appropriate breadth of clinical experience.

3. The Health Board should ensure there is sufficient space to allow timely patient review, and subsequent discussion, training and confidential resident feedback within Acute Medicine areas.

### **GMC Requirement 1.19**

Organisations must have the capacity, resources, and facilities to deliver safe and relevant learning opportunities, clinical supervision and practical experiences for learners required by their curriculum or training programme and to provide the required educational supervision and support.

4. The Health Board should improve access to necessary IT equipment across Medicine areas.

### **GMC Requirement 1.19**

Organisations must have the capacity, resources, and facilities to deliver safe and relevant learning opportunities, clinical supervision and practical experiences for learners required by their curriculum or training programme and to provide the required educational supervision and support.

5. The Health Board should make efforts to ensure that the appraisal of educational roles is meaningful and robust.

### **GMC Requirement 4.1**

Educators must be selected against suitable criteria and receive an appropriate induction to their role, access to appropriately funded professional development and training for their role, and an appraisal against their educational responsibilities.

- HEIW will discuss escalation of concern and the need to consider an Enhanced Monitoring arrangement with the GMC and organise a review visit in approximately 6 months.

### **GMC Requirement 2.6**

Medical schools, postgraduate deaneries and LETBs must have agreements with LEPs to provide education and training to meet the standards. They must have systems and processes to monitor the quality of teaching, support, facilities and learning opportunities on placements, and must respond when standards are not being met.

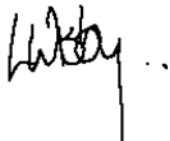
### **Next Steps**

The aforementioned requirements and recommendations were provided to the Health Board verbally on the day of the visit and in writing on **Wednesday, 18<sup>th</sup> June 2025**. An action plan has been requested with a response required by **Thursday, 31<sup>st</sup> July 2025**.

### **Risk Rating Recommendation**

It was agreed that the risk rating of **nine** (high) would be increased to **twelve** (high) given the patient safety concerns associated with Acute Medicine. A further review of the risk rating would be undertaken at the next Targeted Visit.

### **Chair's Signature**



**Signature:**

Associate Dean for Quality

**Date: 16<sup>th</sup> July 2025**



**Action plan arising from the HEIW Targeted Visit**

**to**

**Surgery, Withybush**

**24<sup>th</sup> April 2025**

Requirement	Actions to be taken	Timeline	Teams affected	Responsible Person	Progress/Current status
<p>1. The Health Board must ensure that:</p> <p>1. Inappropriate behaviours, including bullying, discrimination, misogyny, and undermining must be eliminated from the workplace.</p> <p>2. Robust monitoring must be implemented, with an appropriate response to transgression and feedback provided to the reporter.</p> <p>3. Pathways for reporting inappropriate behaviours should be promoted and encouraged, to ensure that any such behaviours are reported and challenged promptly.</p>	<p><b>General Surgery</b></p> <p>The clinical lead for general surgery will send an email to all senior clinicians within the general surgery department, health board wide. The email will be a reminder that inappropriate behaviour is not acceptable and that it must be eliminated from the workplace in line with the health board values.</p> <p>Monitoring will be undertaken locally by consultants and in the wider department by the clinical lead and management team. Appropriate will be taken and fed back to the reporter.</p> <p>Pathways for reporting inappropriate behaviours will be formalised and encouraged. These will be included in the email from the clinical lead and the departmental induction handbook.</p>	<p>30/06/2025</p> <p>Immediate effect</p> <p>Pathways verbally reiterated during the meetings on 11/06/2025</p>		<p>Clinical Lead/ Management Team</p> <p>Site Consultants, Clinical Lead</p> <p>Clinical Lead</p>	<p>Clinical lead and management team met with consultants, SAS level doctors and resident doctors on 11/06/2025. The clinical lead and management team has verbally addressed the concerns regarding inappropriate behaviour with the team and ensured that it must be eliminated from the workplace. There was agreement to this and an agreement for the clinical lead to share the message with the wider team across the health board.</p> <p>Pathways for reporting concerns were agreed and it was agreed that these will be included in the departmental induction handbook and shared verbally during departmental induction.</p>

	<p>The service has ensured that there are a number of methods of reporting inappropriate behaviours within the department, some of which are not on the site that they work on to ensure there is confidence that they will be dealt with impartially.</p> <p>Methods of reporting within the department:  Assigned educational supervisor – on site  Another consultant – on site  Clinical lead – from another site  Management team – health board wide</p> <p><b>Wider Health Board</b></p> <p>Microsoft Teams Link to be sent to trainees for the anonymous escalation of unprofessional behaviours</p> <p>Professionalism, active bystander and speaking up workshop to be mandated for all trainers in the department.</p>	<p>Email 30/06/2025</p> <p>Induction Handbook August 2025</p> <p>Immediate</p> <p>August 2025</p>		<p>Clinical Lead/ Management Team</p> <p>Medical Education &amp; management Team</p> <p>Medical Education/ Professional Standards Team</p> <p>Professional Standards Team/ Equality &amp; Diversity Team/ Workforce &amp; OD</p>	<p>Handbook has been updated in readiness of the August changeover.</p> <p>Teams link created and shared with trainees:-  <a href="https://forms.office.com/e/50evZGi2P6">https://forms.office.com/e/50evZGi2P6</a>  Trainees have submitted concerns via the form and this has led to further action being taken in accordance with the professional standards processes.</p> <p>Half day educational workshop is in the process of being put together incorporating an introduction to professionalism and unprofessional</p>
--	---	---	--	--	---

	<p>Professionalism in providing feedback to be included as part of the Trainer Development Day agenda (20/06/2025)</p> <p>Well-being support to be offered to those trainees who have been subject to/witnessed unprofessional behaviour. This will be taken forward by medical education.</p>	<p>20/06/2025</p> <p>Immediate</p>		<p>Medical Education</p> <p>Medical Education</p>	<p>behaviours, active bystander training and speaking up training, this will start to be piloted from the end of August 2025 and will start in the Withybush Surgery Department.</p> <p>Trainer development day agenda includes professionalism in providing feedback – taking place on the 20<sup>th</sup> June 2025.</p> <p>Trainees have been sign posted to the Health Board’s wellbeing services as well as the PSU.</p>
<p>2. The Health Board must review the workload of Foundation Year 1 residents to ensure that they are able to complete their work requirements before the end of their workday. Furthermore, the tasks undertaken by other clinical staff within the department should be monitored to ensure an equitable distribution of the team workload.</p>	<p>The rota will be updated to move away from the F1, F2 and clinical fellows being under a named consultant, resident doctors will be clearly allocated duties on the rota and the team will be split into:</p> <p>On call team Post take team Ward team</p> <p>During the ward team week, trainees will be given the</p>	<p>August 2025</p>	<p>Resident doctors</p> <p>SAS Level doctors</p> <p>Clinical fellows</p> <p>Consultants</p> <p>Management team</p>	<p>Mr J Mathias</p> <p>David Lewis</p> <p>Mr M Elmorsy</p>	<p>Clinical lead and management team met with consultants, SAS level doctors and resident doctors on 11/06/2025. The arrangements were agreed at all levels and it was agreed that Mr Mathias, Mr Elmorsy and David Lewis would work on the rota in readiness for the August rotation of trainees.</p> <p>The SAS level doctors were reminded about the importance of providing support and supervision during the working day. They were also reminded that, whilst undertaking the on-call,</p>

	<p>opportunity to attend theatre, clinics and MDT as part of their learning.</p> <p>There will be a designated specialty doctor responsible for co-ordinating the rota and monitoring the equitable distribution of duties alongside the management team.</p> <p>The resident doctors are verbally fully informed of how to escalate clinical information and ask for advice from senior colleagues when on call. The formalised escalation procedure will be written and shared.</p>	July 2025	Rota co-ordinator		between the hours of 5pm-9pm Monday to Friday and 9am-5pm weekends, they are resident on-call and are expected to be in the hospital.
3. The Health Board must ensure that a minimum of one teaching ward round takes place per week within the General Surgery department.	Whilst daily ward rounds take place and there is an opportunity for teaching, the Wednesday and Thursday ward round by the on-call consultant will become a formalised teaching ward round. The actions undertaken in point 2 will allow the resident doctors to attend teaching ward rounds under multiple consultants.	Formal teaching ward round 18/06/2025  Induction handbook updated by August 2025	Resident doctors  SAS Level doctors  Clinical fellows  Consultants  Management team	Consultants  SAS Level doctors  Management team	Clinical lead and management team met with consultants, SAS level doctors and resident doctors on 11/06/2025. The arrangements were agreed at all levels. The first formal teaching ward round will take place on 18/06/2025, during Mr Umughele's on-call.

	<p>Daily handover takes place in the registrars room and this is also a teaching opportunity and an opportunity for resident doctors to present cases. This will be reiterated in the induction handbook.</p> <p>Resident doctors will be informed that they should complete a WBA on each of their on-call weeks. 1 with a consultant and 1 with an SAS level doctor. This will be included in the induction handbook.</p>				
<p>4. The Health Board and the Directorate must ensure that clinicians new to the Health Board, particularly International Medical Graduates, are provided with adequate information to be able to undertake their clinical duties, before starting their roles. This process should not be overly reliant upon Foundation doctors.</p>	<p>From a general surgery perspective, the service will be prepared for clinicians that are new to the health board and international medical graduates, by ensuring that rotas are adequately covered for a sufficient shadowing period, an educational supervisor is in place to offer support and that the new recruit is released to attend supportive training sessions available within the health board. These arrangements will be discussed and put in place on the day that</p>	<p>August 2025</p>	<p>Recruitment team</p> <p>Medical education</p> <p>Consultants</p> <p>Management team</p> <p>Rota co-ordinator</p>	<p>Recruitment team</p> <p>Medical education</p> <p>Consultants</p> <p>Management team</p> <p>Rota co-ordinator</p>	<p>Clinical lead and management team met with consultants, SAS level doctors and resident doctors on 11/06/2025. It was agreed that the responsibility of supporting of international medical graduates falls on the consultants and SAS level doctors and not the foundation doctors. Discussions regarding what support is available from the wider health board and an agreement for the management team to take this forward.</p>

	<p>the candidate accepts the post rather than when they start in the health board.</p> <p>A named person within the department will be responsible for sharing the induction handbook with all newly recruited doctors on their first day.</p> <p>It has been reiterated that it is the responsibility of the consultants and SAS level doctors to support and guide newly recruited international clinical staff.</p>				
<p>5. The Health Board must make sure that feedback provided to residents about their management of patients is constructive and beneficial to learning.</p>	<p>The clinical lead will be sending an email to all consultants and SAS Level doctors across general surgery, health board wide.</p> <p>Formal feedback should be given during WBA's, Good practice shared during teaching ward rounds. Remediation should be done privately and delivered constructively, examples can be used to generate points of teaching.</p>	30/06/2025	<p>Clinical lead</p> <p>Consultants</p> <p>SAS Level doctors</p> <p>Resident doctors</p>	Clinical lead	<p>Clinical lead and management team met with consultants, SAS level doctors and resident doctors on 11/06/2025. A detailed discussion took place regarding providing constructive feedback to resident doctors. The clinical leadv agreed to send out an email to senior clinicians within general surgery, across the health board.</p>

Recommendation	Actions to be taken	Timeline	Teams affected	Responsible Person	Progress/Current status
<p>1. The Health Board should ensure there is clarification on the roles and responsibilities of 'Senior House Officers' (SHOs). The workload of SHO's should be monitored to ensure patient care is optimised.</p>	<p>The SAS level doctors have been informed that they are responsible for the supervision of SHO's and that the SHO's are responsible for the supervision of foundation doctors. Any concerns should be escalated to the consultants or management team.</p> <p>SHO's to be reminded about time keeping and the management of the bleep whilst on-call. They will also be reminded of their supervisory responsibilities towards the resident doctors.</p> <p>The resident doctors are verbally fully informed of how to escalate clinical information and ask for advice from senior colleagues when on call. The formalised escalation procedure will be written and shared.</p>	<p>11/06/2025</p> <p>15/07/2025</p> <p>July 2025</p>	<p>Resident doctors</p> <p>SAS Level doctors</p> <p>Clinical fellows</p> <p>Consultants</p> <p>Management team</p> <p>Rota co-ordinator</p>	<p>SAS Level doctors</p> <p>Management team</p>	<p>Completed – SAS Level</p>
<p>2. The Health Board should review the deployment of</p>	<p>The rota will be updated to move away from the F1, F2 and clinical fellows being under a</p>	<p>August 2025</p>	<p>Resident doctors</p>	<p>Mr J Mathias</p> <p>David Lewis</p>	<p>Clinical lead and management team met with consultants, SAS level doctors and resident doctors on 11/06/2025.</p>

<p>medical staff throughout the General Surgery team to help ensure a fair division of departmental workload.</p>	<p>named consultant, resident doctors will be clearly allocated duties on the rota and the team will be split into:</p> <p>On call team Post take team Ward team</p> <p>During the ward team week, trainees will be given the opportunity to attend theatre, clinics and MDT as part of their learning.</p> <p>There will be a designated specialty doctor responsible for co-ordinating the rota and monitoring the equitable distribution of duties alongside the management team.</p>		<p>SAS Level doctors</p> <p>Clinical fellows</p> <p>Consultants</p> <p>Management team</p> <p>Rota co-ordinator</p>	<p>Mr M Elmorsy</p>	<p>The arrangements were agreed at all levels and it was agreed that Mr Mathias, Mr Elmorsy and David Lewis would work on the rota in readiness for the August rotation of trainees.</p>
<p>3. The Health Board should ensure that escalation protocols for deteriorating patients under the care of the General Surgery Team are clearly and widely communicated, to ensure patients are</p>	<p>The resident doctors are verbally fully informed of how to escalate clinical information and ask for advice from senior colleagues when on call. The formalised escalation procedure will be written and shared.</p>	<p>July 2025</p>	<p>Resident doctors</p> <p>SAS Level doctors</p> <p>Clinical fellows</p> <p>Consultants</p>	<p>Consultants</p> <p>SAS Level doctors</p> <p>Management team</p>	<p>Clinical lead and management team met with consultants, SAS level doctors and resident doctors on 11/06/2025. Escalation procedure was agreed and it was agreed for the management team to formally write it and share with the team.</p>

appropriately managed by the surgical team prior to external team involvement. This approach should be monitored.					
4. The Health Board should update the departmental information handbook provided to residents during induction.	Departmental handbook to be updated and reviewed regularly to ensure it's relevant and accurate for new starters.	August 2025	Resident doctors SAS Level doctors Clinical fellows Consultants Management team	Consultants Management team	Clinical lead and management team met with consultants, SAS level doctors and resident doctors on 11/06/2025. The departmental induction handbook has been updated in May 2025, there are additional pieces of information to be added following the discussion. It was agreed that this would be updated in readiness for the August 2025 intake of resident doctors.
5. The Health Board should ensure that all Foundation Year 1 residents are able to achieve two consultant led Workplace Based Assessments per rotation.	Resident doctors will be informed that they should complete a WBA on each of their on-call weeks. 1 with a consultant and 1 with an SAS level doctor. This will be included in the induction handbook.	August 2025	Resident doctors Consultants SAS Level doctors	Consultants SAS Level doctors Management team	Clinical lead and management team met with consultants, SAS level doctors and resident doctors on 11/06/2025. Arrangments regarding WBA's were discussed and agreed by the consultants and SAS Level doctors. The management team will update the induction handbook in readiness for the August 2025 intake of resdent doctors.



**Action plan arising from the HEIW Targeted Visit**




**to**

**General Medicine, Glangwili**

**16/06/2025**

Requirement	Actions to be taken	Timeline	Teams affected	Responsible Person	Progress/Current status
<p>1. HEIW will share the evidence regarding patient safety concerns gathered at the Targeted Visit with Health Inspectorate Wales, to facilitate greater support to the Health Board to remedy the patient safety and staffing level concerns in Acute Medicine.</p>	<p>HEIW action</p>		<p>General Medicine Department, Glangwili Hospital</p>	<p>Quality Management Team, HEIW</p>	
<p>2. The Health Board should undertake an urgent review of resident workload, particularly during on-calls and weekends, to ensure patient safety and to support staff wellbeing and training opportunities. This will need to be facilitated by ensuring that the level of medical staffing is appropriate for the demand and that there is</p>	<p>Re-escalate the need for additional doctor on-call cover for a Tuesday and Thursday to the Financial Control Sub Group.</p>	<p>End of July 2025</p>	<p>Resident on call team</p>	<p>S Bancroft</p>	<p>The healthboard recognises the shortfall in Tuesday and Thursday resident doctor on call cover, originally omitted due to shortfall in rota funding for an additional doctor on the team. The requirement for a rota change and banding increase to permanently cover this had been escalated to the Financial Control Sub Group prior to the targeted visit and a funding stream is in the process of being identified. Interim measure put in place with locum shifts to ensure cover whilst seeking approval for funding to cover permanently.</p>

<p>trust and faith in a system for reporting incidents as they occur. Guidance from the Royal College of Physicians on safe staffing levels should be consulted in assessing the workforce need.</p>	<p>Schedule the Medical Education Teaching Fellow/Quality Improvement Fellow's clinical sessions on days where there is a shortfall in staff.</p>	<p>August 2025</p>	<p>Resident on call team/ Teaching Fellows</p>	<p>Helen Thomas</p>	<p>The Medical Education Department is in the process of recruiting a Quality Improvement Fellow whose weekly timetable will include 2 days of clinical work, scheduled for a Tuesday and Thursday. This will help to alleviate some of the pressure on the medical teams on the shortfall days however, this arrangement will be based on a 9am-5pm shift, rather than an 8am-8:30pm shift. We will have locums in place until a more substantive solution is confirmed. It is anticipated that the new QI Fellow will be in place by the 6<sup>th</sup> August 2025.</p>
	<p>Exploration of the moving of Internal Medical Trainee doctors from Prince Philip Hospital to Glangwili Hospital is in the process of being discussed. This will be proposed to new and existing IMTs in August.</p>	<p>August 2025</p>	<p>IMTs</p>	<p>Dr Robin Ghosal</p>	<p>An SBAR has been written reporting the staffing issue to the Chief Operating Officer. This will be discussed with the Health Board Executive team, who will then agree a substantive solution.</p>
	<p>An indepth Healthboard review of medical staffing structures is being undertaken in line with Royal College of Physicians guidance which will feed into a wider medical</p>	<p>Review to be completed by Oct 2025.</p>	<p>All resident on call doctors</p>	<p>Carly Hill, Assistant Director – Medical Directorate</p>	

	workforce plan for the Health Board.				
3. The Health Board should review and support the usage of the clinical incident reporting system by front-line staff. A significant majority of known incidents of harm are currently not being reported.	<p>Include safety incident reporting in clinical simulations that include a safety incident. Debrief with a focus on how and why to report, and what happens afterward.</p> <p>Include incidents as part of the Resident Doctor Forum agenda so that they can be discussed and that doctors can be further encouraged to report (if not already done so).</p> <p>Display posters in key areas which highlight the importance of reporting incidents, the reasons why as well as how it can be done - QR code to incident reporting form.</p> <p>Include incident reporting session during induction, include information around what happens when an incident is reported and present anonymized examples</p>	<p>July/August Changeover 2025</p> <p>Immediately</p> <p>July 2025</p> <p>August 2025</p>	<p>Teaching Fellows/Trainees</p> <p>Medical Education Teams and Resident Doctors</p> <p>Medical Education Teams/Clinical Staff</p> <p>Datix Team/Medical Education Teams/Trainees</p>	<p>Helen Thomas</p>	<p>Complete - Teaching Fellows and Simulation Tutors have developed scenarios which will be used during simulation sessions offered during induction on the 30<sup>th</sup> &amp; 31<sup>st</sup> July and ongoing during future sessions.</p> <p>Complete - Agenda template has been updated to include incident reporting and dates of meetings confirmed.</p> <p>   Agenda%20Resident%20Doctor%20Forum DATES%20of%20Resident%20Doctors%20</p> <p>Complete - Poster has been created and displayed in key areas.</p> <p>  Incident reporting poster July 2025.pdf</p> <p>Currently awaiting a confirmed date for training delivery. Session will take place before the end of the August rolling induction programme.</p>

	of incidents where reporting led to system improvements or prevented future harm.				
4. The Health Board should review processes for approving annual leave so that responses are received in a timely manner.	Remind doctors of the new leave approval process and ensure that they are responded to in a timely manner by the leave approvers.	Annual Leave requesting procedure to be re-circulated through Medical Education team by end July 2025	All resident doctors	Peta Spiller	Complete - over the last 6 months we have introduced a new way of requesting annual leave that ensures consultant/registrar teams are authorisers of annual leave, with the rota co-ordinators completing the admin task of signing it off Intpreid when updating the rotas. This has had a positive impact on the leave application process which has since seen a lesser number of incidents where annual leave has not been processed in a timely way.
<b>Recommendation</b>	<b>Actions to be taken</b>	<b>Timeline</b>	<b>Teams affected</b>	<b>Responsible Person</b>	<b>Progress/Current status</b>
1. The Health Board should ensure that IMT residents are able to access and complete an adequate number of clinics to meet their curriculum requirements, particularly residents in Internal Medicine Training (IMT) posts.	<p>Ensure that time for clinics is incorporated into rotas.</p> <p>Collate clinic information and contact details for access from across the Health Board to share with IMT trainees.</p> <p>Develop SharePoint page which includes the</p>	<p>Sept 2025</p> <p>August 2025</p> <p>Oct 2025</p>	Medical Education Teams/IMT trainees	<p>Peta Spiller</p> <p>Helen Thomas</p> <p>Helen Thomas</p>	<p>This is in the process of being explored.</p> <p>Clinic information from across the Health Board has been collated and will be shared with new IMTs during the August induction.</p> <p>SharePoint page is in progress.</p>

	information above and which can be accessed easily by IMTs.				
2. The Health Board should review working arrangements to ensure that residents are able to achieve Acute Care Assessment Tool (ACAT) workplace-based assessments as required by their curriculum.	Ensure that Requirement no.2 is addressed. This will mean that the trainee workload becomes more manageable and thus provide adequate time to facilitate sign off and obtain feedback.	Oct 2025	Resident doctors	Service management team	As per progress Requirement no.2
3. The Health Board should ensure there is sufficient space to allow timely patient review, and subsequent discussion, training and confidential resident feedback within Acute Medicine areas.	Estate review of general medicine and the emergency care departments to ensure that there is sufficient capacity to appropriately assess and treat patients with dignity, along with enabling effective and confidential training discussion and feedback.	December 2025	Trainers	Sarah Perry	We are in the process of redesigning the Front Door with a particular focus on Medical SDEC expansion with greater integration with ICMDT/virtual wards and hot clinics and potentially enhancements of the acute frailty model. This means the vast majority of the medical intake could run through SDEC allowing a better training environment for the resident doctors to complete and get feedback on ACATs and other assessments
4. The Health Board should improve access to necessary IT equipment across Medicine areas.	Review of IT requirements is being arranged with the IT team	Dec 2025	Resident doctors/ Medical Education/Service and IT Teams	Stuart Bancroft/Helen Thomas/Gavin Jones	Meeting took place on the 22/07/2025 to discuss IT issues encountered by the trainees.  Issues reported relating to IT systems in A&E. The department uses Imprivata software which requires

					<p>additional log in details to access and this can at times cause issues, especially upon commencement in post. This has been noted by the Medical Education Team who will link in with the IT department to ensure that access is arranged prior to them starting in post. The software also currently blocks the reliable clinical decision making sites such as NICE and antimicrobial guidance and so IT have asked that the sites which trainees need to be able to access are collated so that the blocks can be lifted.</p> <p>Being able to access a physical computer on the medical wards was also reported as an issue and so a review is to be undertaken of what is currently available and what is required in order that this can be addressed. Findings will inform a QI project for the new QI fellow, and will be reported to the Chief Clinical Information Officer.</p>
5. The Health Board should make efforts to ensure that the appraisal of educational roles is meaningful and robust.	Reminder will be sent out to all educational and clinical supervisors on the need to include evidence of CPD which relates to their trainer roles as part of the Whole	End of July 2025	Educational and Clinical Supervisors	Dr Robin Ghosal	Complete – message has been sent out to all trainers.

	<p>Practice Educational Appraisal requirements.</p> <p>Appraisers to be reminded of the need to discuss educational roles as part of the appraisal discussion and to highlight areas for development (i.e. sufficient CPD etc).</p>	<p>Appraiser Forum 01/10/2025</p> <p>Email reminder end of July 2025</p>	<p>Appraisers</p>	<p>Helen Thomas</p>	<p>This will be included as a standing item on Appraiser Forum Agendas.</p>
--	---	--	-------------------	---------------------	---