Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	19 May 2026
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Health Education and Improvement Wales (HEIW) Targeted visit to General Medicine (GGH)
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Mr Mark Henwood, Executive Medical Director
SWYDDOG ADRODD: **REPORTING OFFICER:**	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) targeted follow up visit to General Medicine in Glangwili Hospital (GGH), which took place on the 15 December 2025 and has resulted in escalation to General Medical Council (GMC) Enhanced Monitoring.

Cefndir / Background

Every year the 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. Hywel Dda University Health Board employs around 300 trainees; 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 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 quality risk register.

Where the risks are ongoing, or for higher scoring risks, targeted visits to the respective specialties will be 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 Local Education Provider (LEP – in this case Hywel Dda) to enhance transparency and

where sufficient improvement is not forthcoming, a decision to withdraw trainees from the department will occur.

Asesiad / Assessment

The risks which are included on the HEIW risk register will be dependent upon the results of the NTS in addition to local feedback, investigations, actions and monitoring. Risks are categorised according to specialty, programme specialty, grade and site, summary of issues and risk rating.

Due to fluctuating feedback from the GMC NTS over recent years, particularly concerning clinical supervision, the first HEIW targeted visit to medicine in GGH was undertaken on the 16 June 2025. Although local initiatives had been introduced to address these issues, and the 2024 survey results indicated some improvement, negative feedback regarding clinical supervision persisted and the visit was undertaken to explore the underlying challenges and work collaboratively with the Health Board to develop sustainable solutions.

The visit resulted in a quality risk rating of 9 (this is high and anything over 8 can trigger a targeted visit) and three main requirements for action, which included the need for the Health Board to: -

- 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.
- 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.
- review processes for approving annual leave so that responses are received in a timely manner.

In addition to the primary requirements, a further six recommendations were identified. At this point, HEIW provided Healthcare Inspectorate Wales (HIW) with evidence gathered during the visit relating to patient safety concerns and discussed the possible need to consider an Enhanced Monitoring arrangement with the GMC. The GMC subsequently wrote to the Health Board seeking assurance that action was being taken to meet the requirements set out as part of the visit and enhanced monitoring was not considered necessary at this time.

An action plan was developed, and the clinical team and medical education department undertook worked collaboratively to implement actions in advance of the follow-up visit, which took place on the 15 December 2025.

During the visit residents and trainers described a system under sustained pressure, where staffing shortages, heavy workloads, and rota gaps, limited learning opportunities and contributed to ongoing patient safety risks. Teaching, clinics, and Workplace-Based Assessments were frequently inaccessible, supervision was strained during busy periods, and ineffective processes for patient tracking and handover added further risk. Weekend and on-call pressures were particularly acute, with delays in senior review and inconsistent monitoring. Although improvements to patient flow were being considered, residents continued to experience a culture dominated by service provision rather than education.

The visit resulted in the quality risk rating increasing to 12 and three main requirements for Health Board action, which included the need to: -

- ensure that ward staffing levels are robust and that appropriate time is allotted to allow access to training opportunities including regional teaching programmes, Educational/Self-Development Time (EDT/SDT) and access to clinics as stipulated by the IMT curriculum. Staffing levels should take into account extra work generated by those patients who are accommodated outside of the traditional clinical bed spaces, for example in corridors and 'boarders' within ward areas. provide strong, accessible pastoral support for all residents and trainers, recognising the physical and emotional strain of the work and the risk of burnout that can result.
- ensure that robust pastoral support is accessible to all residents and trainers and that this incorporates an acknowledgement of the effects of working within a physically and emotionally challenging environment and the risk of progression to burnout.
- ensure that training needs are taken into account when re-designing clinical areas and systems to improve patient flow. The local education team must be involved in discussion and planning. It would be desirable to also include trainers and resident doctors, who are likely to have valuable insights into practical aspects of the plans.

Further to the 3 main requirements, a further 8 recommendations were identified, which included HEIW providing an update to the GMC on the findings of the visit with a recommendation that Enhanced Monitoring status be applied.

Confirmation of the escalation to GMC Enhanced Monitoring was confirmed in a letter to the Health Board Chair dated 2 February 2026 (Appendix 1). Entering enhanced monitoring means the organisation must work with HEIW to create and deliver an improvement plan, while targeted visits, sometimes accompanied by a GMC medical expert associate, will be undertaken to monitor progress. Throughout the process, HEIW will provide regular progress updates to the GMC. Where the GMC are not assured that appropriate standards and requirements are being met, conditions on the approval of training within the department may be imposed and where these conditions unmet, or where there is a lack of sufficient progress, trainees will be withdrawn from the department. It should be noted that the medical department at GGH comprises of approximately 57 doctors, with over half being trainees. Any withdrawal of trainees would present a significant challenge for service delivery, impacting patient experience, workforce sustainability and staff wellbeing, as well as the wider reputational implications for the Health Board as a whole (particularly given that enhanced monitoring information are publicly reported by the GMC). This would also result in additional financial pressure for the Health Board, as alternative cover arrangements would need to be secured.

The most important focus for the medical teams and medical education in terms of progress towards meeting requirements set by HEIW, relates to ensuring appropriate staffing levels, appropriate support and supervision and trainees being able to meet training requirements. While a review of medical staffing across the medical departments is in process, where the need for additional staff is highlighted, funding will need to be identified and recruitment processes improved to ensure that we are able to recruit appropriately experienced and skilled medical staff, in a timely way. Further areas for improvement we have identified include the need for additional governance and improved processes around leave allocation and rota design.

An action plan (Appendix 2) has been submitted to HEIW to address the requirements and recommendations made however, positive trainee and trainer experience feedback which highlights adequate progress will be integral to providing the required assurance to HEIW and the GMC going forward.

Full visit reports and correspondence confirming Enhanced Monitoring are included in Appendices 1-5.

Argymhelliad / Recommendation

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

- **RECEIVE ASSURANCE** on the outcome of the Health Education and Improvement Wales targeted visit to General Medicine at Glangwili General Hospital, including the escalation to General Medical Council Enhanced Monitoring and the associated requirements and recommendations;
- **NOTE** the actions being taken through the improvement plan to address the areas identified, including staffing levels, supervision, pastoral support, access to training opportunities and the involvement of medical education in service redesign; and
- **SEEK ONGOING ASSURANCE** that progress against the action plan is being robustly monitored, with future reports providing clear oversight of delivery, risks to training status and service sustainability, and the links to wider medical workforce planning.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
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 Quality and Engagement Act (sharepoint.com)	1. Safe 2. Timely 3. Effective 4. Efficient
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	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 Workforce Stabilisation
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	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

Gwybodaeth Ychwanegol:

Further Information:	
Ar sail tystiolaeth: Evidence Base:	Promoting excellence - GMC (gmc-uk.org)
Rhestr Termau: Glossary of Terms:	Health Education & Improvement Wales – HEIW General Medical Council – GMC Local Education Provider – LEP Self-Development Time – SDT Educational Development Time – EDT National Training Survey - NTS
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Diwylliant, Pobl a Datblygu Sefydliadol: Parties / Committees consulted prior to People, Organisational Development & Culture Committee:	Not applicable

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

General Medical Council

2 February 2026

Dr Neil Wooding
Chair of the Board
Hywel Dda University Health Board
Via email: Neil.Wooding@wales.nhs.uk

3 Hardman Street
Manchester M3 3AW

Email: gmc@gmc-uk.org
Telephone: 0161 923 6602
gmc-uk.org

General Medical Council (GMC) reference: QA14137

Dear Dr Wooding

Notification of General Medicine, Glangwili Hospital entering GMC enhanced monitoring process

I am writing to inform you that we are placing General Medicine, Glangwili Hospital into our enhanced monitoring process. We realise this letter comes at a particularly challenging time for health services across the UK so if you have any questions at any point, please contact us using the contact details at the end of this letter and we'd be happy to discuss them with you.

We use enhanced monitoring to promote local management of serious concerns about the quality and safety of medical education and training. We will ensure that Health Education and Improvement Wales work with you to make improvements to resolve our concerns effectively.

Our concerns

Our Promoting excellence: standards for medical education and training set out the standards and requirements that we expect organisations responsible for educating and training doctors in the UK, to meet.

Following a local quality visit in December 2025 and reviewing relevant information, we're concerned that General Medicine, Glangwili Hospital is not meeting our requirements in relation to:

- **R1.2** *Organisations must investigate and take appropriate action locally to make sure concerns are properly dealt with. Concerns affecting the safety of patients or learners must be addressed immediately and effectively.*
- **R1.7** *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.*

The GMC is a charity registered in England and Wales (1089278) and Scotland (SC037750).

- **R1.12** *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.

- **R1.16** *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.*

What this means for your organisation

Entering our enhanced monitoring process means that:

- You will work with Health Education and Improvement Wales to put in place an improvement plan in response to our concerns. We'll have oversight of this improvement plan via Health Education and Improvement Wales.

- The Medical Deanery will organise visits to check the progress you are making, and we may attend these, along with one of our medical expert associates.

- We will receive regular updates from Health Education and Improvement Wales about your progress in addressing this concern.

We hope we can resolve these concerns together. However, if we aren't assured that our standards and requirements are being met, we may:

- Place conditions on the approval of postgraduate training. For further information about conditions, please see our website**.**

- If our conditions aren't met or there's a lack of sufficient progress in meeting these conditions, we will take further action. This could include withdrawing our approval of training posts and programmes which means that trainees would be redeployed elsewhere.

What information we'll share about the case

We share information about enhanced monitoring cases in the following ways:

- We will publish information about the cases on our website. You can see the type of information we publish on our enhanced monitoring page.

- We will share information about the case with other regulators, such as summaries and updates on progress.

- If there are any medical students attending the site for undergraduate placements, we will make their medical schools aware of the enhanced monitoring status.

Next steps

Health Education and Improvement Wales will liaise with you regarding the next steps and will work with you to put in place an improvement plan addressing the concerns identified. Where available, it may be helpful to draw on examples of good and effective practice, whether within your health board or elsewhere, to inform and guide the improvements needed in the training in this specialty.

We have included two guidance documents with information about the enhanced monitoring process (including conditions) for different audiences. You can use these in your communications with your teams, colleagues and trainees.

We have copied into this letter representatives from medical schools who may have medical students on placement in the unit/department, for their information.

If you have any questions or concerns about enhanced monitoring, we're happy to discuss this with you. You can contact:

- Your Education Quality Assurance Programme Manager - Zoë Makin on zoe.makin@gmc-uk.org

To discuss liaison support we may be able to provide, please contact:

- Gethin Matthews-Jones, Head of GMC Wales on gethin.matthews-jones@gmc-uk.org

Yours sincerely,

Professor Pushpinder Mangat
Medical Director and Director of Education and Standards

Enclosure: LEP guidance on Enhanced Monitoring

Trainee guidance on Enhanced Monitoring

Copied to:

Professor Philip Kloer, Chief Executive, Hywel Dda University Health Board, Philip.Kloer@wales.nhs.uk

Dr Jon Morris, Associate Medical Director, Hywel Dda University Health Board, jon.morris2@wales.nhs.uk

Alex Howells, Chief Executive, Health Education and Improvement Wales, Alex.Howells@wales.nhs.uk

Lee Wisby, Associate Dean (Quality), Health Education and Improvement Wales, lee.wisby2@wales.nhs.uk

Anton Saayman, Interim Postgraduate Medical Dean, Health Education and Improvement Wales, Anton.Saayman2@wales.nhs.uk

Malcolm Gajraj, Director of Quality Management (Medical Deanery), Health Education and Improvement Wales, malcolm.gajraj2@wales.nhs.uk

Mandy Martin, Quality Manager, Health Education and Improvement Wales, mandy.martin@wales.nhs.uk

Gethin Matthews, Head of GMC Wales gethin.matthews-jones@gmcuk.org

Katie Laugharne, Employer Liaison Adviser, GMC Wales, katie.laugharne@gmc-uk.org

Maria Chatters, Regional Liaison Adviser, GMC Wales, maria.chatters@gmc-uk.org

Action plan arising from the HEIW Targeted Visit

to

Medicine, Glangwili Hospital, Carmarthen.

15 December 2025.

Requirement	Actions to be taken	Timeline	Teams affected	Responsible Person	Progress/Current status
1. The Health Board must ensure that ward staffing levels are robust and that appropriate time is allotted to allow access to training opportunities including regional teaching programmes, Educational/Self-Development Time (EDT/SDT) and access to clinics as stipulated by the IMT curriculum. Staffing levels should take into account extra work generated by those patients who are accommodated outside of the traditional clinical bed spaces, for example in corridors and 'boarders' within ward areas.	Review of medical staffing structures across the Health Board to be completed.	March 2026	Medical Departments/Medical Directorate/ Rota Co-ordinators	Dr Karen Brown AMD CIMCG, Dr Eiry Edmunds Deputy MD AHS, Dr Robin Ghosal Clinical Director Carms.	In Progress - Review ongoing into medical department staffing structures across the Health Board. RCP guidance will be used to support the review however; it is acknowledged that this guidance would be the minimum and that educational needs will need consideration. Information has been collated which includes, trainee annual leave, study leave, SDT allocation & possible time out of programme to better calculate staff availability to cover clinical

					activity. Further meetings have been arranged to continue to work on the review, with a view to a paper being ready for submission to the Executive Team by the end of May 2026.
	Create spreadsheet to allow doctors to book to attend diverse specialist clinics across Glangwili & Prince Philip (and wider afield if requested). Clinics will be mapped to IMT and FP curricula.	April 2026		Dr Robin Ghosal Clinical Director Carms., Peta Spiller Rota-Co-ordinators	Complete - rota co-ordinators have collated information and have shared with trainees.

2. The Health Board must ensure that robust pastoral support is accessible to all residents and trainers and that this incorporates an acknowledgement of the effects of working within a physically and emotionally challenging environment and the risk of progression to burnout.	Bi-Monthly meetings to be organised between Clincial Director and trainees in addition to the Resident Doctors Forum to provide a safe environment to keep up to date and be proactive with concerns. These metings will be unstructured allowing free flowing discussion.	April 2026	Trainees, Clinical Dir Carms., Rota co-ordinator	Dr Robin Ghosal Clinical Director Carms., Peta Spiller Rota-Co-ordinators	Complete – regular weekly meetings with resident doctors are being undertaken.
	Raise awareness of and signpost to Health Board's Staff Psychological Wellbeing and Occupational Health Services through email, posters, induction, stands at studay days/core curriculum sessions.		Trainees, Trainers, Medical Education Team	Helen Thomas, Head of Medical Education & Professional Standards	Complete - the Health Board's Staff Psychological Wellbeing and Occupational Health Services is already included as part of induction and we invite the teams to bring along stands to the FP2 study days. Information is included on the Health Board's SharePoint page but we will remind trainees and traines through various platforms and formats.

	Raise awareness of the Health Board's new Doctor Support Hub which will enable medical staff (trainers and other medical staff not in formal training posts) to have open access to a variety of support structures with the aim of maximising personal and professional outcomes, maintaining wellbeing and aiding retention email, posters, induction, stands at studay days/core curriculum sessions.		Trainers, Medical Education Team	Helen Thomas, Head of Medical Education & Professional Standards	Complete – Doctor Support Hub was launched on the 1 April 2026 and engagement and communication plan is being implemented. Doctor Support Hub Manager started in post in March 2026 and has already received a number of requests for support from trainees, trainers, as well as other grades of doctors. We will cotinue to raise awareness of the service.
3. The Health Board must ensure that training needs are taken into account when re-designing clinical areas and systems to improve patient flow. The local educational team must be involved in discussion and	This is service development. Resident doctors will take part in conversations about new service and gain thoughts on pathways e.g.within the newly rebuilt SDEC, helping to	July 2026	Resident Doctors, Clinical Dir Carms.	Dr Robin Ghosal Clinical Director Carms.	In Progress - Rebuilding works are currently ongoing and predicted to be complete by the end of March 2026.

planning. It would be desirable to also include trainers and resident doctors, who are likely to have valuable insights into practical aspects of the plans.	map the environment from a training standpoint so educational opportunities can be maximised.				
	Link with medical education team on service re-design and planning, providing regular updates on progress. Ultimately this is service development.	Immediate	Service Leads, Medical Education Team		Complete - representatives from the service are invited to attend Medical and Dental Education Oversight Group to provide regular updates on progress.
Recommendation	**Actions to be taken**	**Timeline**	**Teams affected**	**Responsible Person**	**Progress/Current status**
1. The Health Board should take steps to ensure that multiple members of the same ward-based team are not routinely scheduled to work out of hours or in an on-call capacity at the same time to avoid resident doctors being	Rotas to be reviewed and amended accordingly.	Immediate	Trainees, Rota co-ordinator	Peta Spiller, Rota Co-ordinator	Complete - rotas have been reviewed and while multiple members of the same team being on-call or working out of hours at the same time cannot be eliminated, it has been limited and lessened as much as possible.

subject to excessive workloads on the wards.					
2. The Health Board should introduce a rostering system to ensure that IMT residents have planned, scheduled access to outpatient clinics as outlined within their curriculum.	Please see action 2 under requirement 1 above.				
3. There should be an effective, Health Board-supported system in place to track patients during the first 72 hours of admission, irrespective of overcrowding. This needs to support resident doctor handovers and their ability to find out about and act upon results.	Digital handover system is in the process of being introduced to the Health Board.	August 2026	IT, Medical Teams	Carolyn Williams, Head of Digital Innovation & Transformation	In Progress - The introduction of the electronic handover system which was being looked into by the digital team was deemed inappropriate for the Health Board's needs however, building upon a project undertaken by Withybush Hospital and the use of an MS Teams solution, trainees in Glangwili have developed a similar system which is currently being piloted.
	FP2 to undertake QI project to ensure that patients who attend A&E on a Friday are included as part of the weekend CDU and medical liaison handover lists.	Immediate	Trainees, A&E/CDU department	FP2 Trainee	Complete - FP2 has introduced a new process whereby ptients are now added to the CDU and Medical Liaison lists over the weekend. The effectiveness of the process will be evaluated over coming months.

4. The Health Board should review current medical handover processes with the aim of ensuring that they are timely, robust, and used to support learning.	Carry out a handover audit to identify specific issues affecting the quality and effectiveness of the handover process.	April 2026	Trainees, medial departrment, medical education	Helen Thomas, Head of Medical Education	Complete - regular, consistent handover takes place at 8am and 8pm daily. Survey has been created and links shared with trainees. Deadline for completion of the survey is the end of May 2026.
	Share audit results with the department for taregeted actions to be implemented.	May 2026		Helen Thomas, Head of Medical Education	
	Consultants to be encouraged to attend both handover meetings (AM/PM).	January 2026		Dr Robin Ghosal Clinical Director Carms.	Complete - email issued to all Consultants in the department and to be reinforced at Medical Consultants Meeting.
5. The Health Board should implement a simple exception-reporting system to monitor residents' ability to attend rostered clinics and access EDT/SDT. These exception reports should be regularly discussed and reviewed to ensure good access is maintained.	Increase understanding and use of the SDT/EDT form among trainees and trainers so that trainees can make the most of their allocated development time – emails, posters, study days etc.	April 2026	Trainees, Trainers, medial departrment, medical education	Helen Thomas, Head of Medical Education & Professional Standards	Complete - SDT/EDT MS Teams form survey was created some time ago – IT has been resent to all trainees for completion. Deadline for survey is the end of May 2026.
	Audit to be undertaken to monitor rostered clinics and SDT/EDT access.				As above - survey has been created and link shared.

6. The Health Board should review lines of communication with trainers and resident doctors to ensure that all parties are aware of improvement plans/activity and the obstacles and challenges which need to be overcome.	Raise awareness of the Hywel Dda Team Meetings, which take place monthly. During these online meetings, staff hear more about what's happening across the Health Board from our Chief Executive, Phil Kloer, and members of the Executive team. Individual views can also be shared and questions asked (emails, posters, study days, reminder notifications etc)	April 2026	Trainees, Trainers, medial departrment, medical education	Head of Medical Education & Professional Standards	Complete - communicated with trainees and trainers at the 26 January 2026 meeting.
7. That HEIW will provide an update to the GMC on the findings of the visit with a recommendation that Enhanced Monitoring status is applied.					Complete – confirmation of enhanced montioring status was received by the Health Board on the 2 February 2026.
8. HEIW will visit again in approximately six months.					In Progress - HEIW have confirmed that they will re-visit the department on Wednesday the 10 June 2026.

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, 15th December 2025

GIG CYMRU NHS WALES | Addysg a Gwella Iechyd Cymru (AaGIC) Health Education and Improvement Wales (HEIW)

Table of Contents

Section One: Visit Remit 3

Section Two: Summary Findings.....4

Requirements and Recommendations 7

Chair's Signature.....10

Section One: Visit Remit

Health Board	Hywel Dda University Health Board	**Site**	Glangwili General Hospital
Visit Date	15th December 2025	**Risk Rating (Pre visit)**	**12**
Specialty	Medicine	**Grade(s)**	Foundation, GPST, IMT and ST
Visit Panel	• Lee Wisby, Associate Dean for Quality (Chair) • Shaun Smale, Head of School for Medicine • Sarah Davidson, Faculty Lead (Trainers) • Ilona Schmidt, Faculty Lead (Residents) • Jo McCarthy, Local Foundation Programme Director (Foundation Year 1) • Islam Abdelrahman, Local Foundation Programme Director (Foundation Year 2) • Mandy Martin, Quality Manager • Vicky Collins, Quality Officer • Caryl Davies, Lay Representative		
LEP Representatives	• Mark Henwood, Executive Medical Director • Eiry Edmunds, Deputy Medical Director • Robin Ghosal, Clinical Director for Carmarthenshire and Respiratory Consultant • Clive Weston, Consultant Acute Physician and Cardiologist • Nicholas Coles, Royal College Tutor and Care of the Elderly Consultant • Helen Thomas, Head of Medical Education and Professional Standards • Nicky Pearce, Lead Medical Education Manager • Bethan Andrews, Assistant General Manager for Unscheduled Care • Sarah Perry, General Manager for Carmarthenshire System • Peta Spillar, Unscheduled Care Rota Manager • Nicola Evans, Hospital Service Manager for Glangwili General Hospital • Carly Hill, Assistant Director for Hafen Derwen • Suzan Abdelgafar, Resident Representative		
Evidence Considered	• Evidence Timeline • GMC National Training Survey Results 2022 – 2025 • Health Board Action Plan • Previous Targeted Visit Report, (16th June 2025)		
Residents Present	19 Foundation, IMT, ST residents. (Locally Employed Doctors were also present)	**Trainers Present**	3
Status Summary	• The previous visit was undertaken on the **16th June 2025.** • This concern is not in Enhanced Monitoring status with the GMC.		

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 primary purpose of the visit was to follow up on progress in addressing concerns identified at the previous Targeted Visit in June 2025. Specifically, concerns with residents' training opportunities which were impacted by workload pressures and low staffing levels, underutilisation of reporting tools to record clinical incidents, and challenges with processes for arranging annual leave. Access to necessary IT systems, adequate space and accessibility of clinics, and opportunities to complete Workplace-Based Assessments (WBA) were also raised as areas of concern.

The Health Board has indicated the following progress in response to the requirements and recommendations given during the HEIW Targeted Visit on **Monday, 16th June 2025.**

- Permanent cover requirements for shortfalls in the on-call rota have been escalated to the Health Board's Financial Control Subgroup. Locum doctors would be utilised as an interim measure to ensure adequate on-call cover is at appropriate levels.
- A Quality Improvement (QI) Fellow had started their post in the Directorate in August 2025 and had commenced a project surrounding the reconfiguration of rooms to increase IT access across the medical department.
- An SBAR reporting staffing issues had been submitted to the Chief Operating Officer. A staffing review has been commenced in order to find a substantive solution to the staffing concerns raised.
- Teaching scenarios that included safety incident reporting in clinical simulations had been developed.
- An incident reporting session would be included in the Health Board induction and reported incidents would be included as part of the Resident Doctor Forum agenda.
- Clinic information from across the Health Board had been collated and would be shared with new Internal Medical Training (IMT) residents during the August 2025 induction.
- The Health Board are in the process of redesigning the "Front Door," with a particular focus on Medical Same Day Emergency Care unit expansion, with greater integration of virtual wards and hot clinics, and potential enhancements of the acute frailty model.
- The Hospital Director had contacted all Educational and Clinical Supervisors regarding the need for them to include evidence of their Continuing Professional Development, as part of the Whole Practice Educational Appraisal requirements.

Section Two: Summary Findings

Residents from a variety of training programmes attended the Targeted Visit. A QI Fellow was also present for the resident meeting and relayed their findings regarding the training environment. Trainer and Health Board representation at the visit was also sufficient to provide valuable nuance to the feedback shared by the residents.

The feedback from residents regarding their training experiences was overshadowed by concerns over workload pressures impacting opportunities to learn and leading to concerns over patient safety. Residents have been using the Datix system to report what they considered to be serious incidents but also drew

attention to perceptions of low-grade and moderate harm coming to patients' multiple times each week but had not reported, due to service pressures contending with the time required to complete Datix Forms.

Residents have raised concerns about low staffing levels through the residents' forum, as well as directly to consultants. Effective communication channels between residents and some trainers were evidenced by trainers' awareness of the concerns raised by residents during the visit.

Trainers noted that clinics were rostered for residents throughout other Health Board sites but, despite requests from trainers, had not been implemented at Glangwili General Hospital. IMTs reported that there was a beneficial range of clinics available but residents had not been able to fully utilise them due to minimal staffing and an unwillingness to leave less experienced colleagues on the ward without support.

Educational Development Time (EDT) had been accessible for most Specialist Training (ST) and IMT residents, though availability had been dependent on staffing levels in residents' base specialties. Most Foundation residents reported having been able to utilise less than half of their EDT. Those that had been able to use EDT reported having to arrange it at times when they would have favoured arranging annual leave, to ensure they could meet the requirements of their curricula.

Multiple residents from the same specialty teams have been rostered for on-call and night shifts at the same time, which has contributed to their base wards becoming short-staffed. Residents reported having raised gaps in rotas and on-call rostering as concerns on numerous occasions but staffing challenges had persisted.

The Health Board had made efforts to appoint locum clinicians to cover rota gaps. Residents mentioned having experienced delays in receiving payment for some locum shifts worked. This had been raised with the rota co-ordinators but was reported to be unresolved at the time of the visit.

The Deputy Medical Director had undertaken a review of staffing levels throughout the Directorate; however, the findings had not been finalised at the time of the visit.

Residents reported having been asked to undertake work in other departments to support gaps in rotas. Workload pressures in the areas residents were moved to had not facilitated many opportunities for learning. Some of the consultant body had recommended locally employed doctors be moved in the first instance to try and ensure residents could undertake training in their base specialties.

Trainers reported that attempts had been made to tailor the topics discussed at teaching sessions towards learning needs. Simulation training sessions had also been made available throughout the week and some weekends.

Most residents had struggled to attend external and local teaching sessions due to workload pressures. IMTs reported challenges in completing Workplace Based Assessments (WBA) in Acute Medicine areas, as rota structures did not facilitate them to clerk sufficient numbers of patients alongside consultants. Trainers expanded upon this concern and noted there to be limited spaces for consultants to examine patients alongside residents, which had contributed to barriers in completing WBAs.

There was minimal feedback from residents regarding the accessibility of clinical supervision, however trainers reported struggling to provide optimal supervision during periods of increased departmental pressure.

Trainers remarked that there was insufficient space in the Accident and Emergency department for acute medical patients to be reviewed. Processes for tracking and monitoring acute medical patients were reported to be ineffective and, in some cases, had led to patients being missed during the "post-take" process. Handovers were noted to be an informal discussion that relied on a paper handover list. Trainers

confirmed that handovers were not regularly utilised as opportunities for learning and consultant involvement was variable.

The high number of patients under the care of the weekend and on-call medical team was noted to be challenging, despite the Health Board adding an additional middle grade to the rota. Staffing numbers and patient flow in Acute Medical areas was raised as an area of particular concern by residents and trainers. Residents acknowledged that a consultant and a medical registrar were available to review deteriorating patients during these shifts but that they were often occupied with the most acutely unwell patients.

Residents reported that acute medical patients are often not reviewed by senior clinicians throughout the weekend, which delayed opportunities for discharging patients where appropriate. Nurses and less experienced residents would review these patients whilst they awaited an assessment with a senior clinician, however, monitoring would often take place on an ad hoc basis, as staffing numbers could not support more regular reviews. Residents raised concerns regarding the effectiveness of the bleep system as the strength of the signal varied throughout the hospital.

Directorate leads confirmed that plans are being considered to re-direct the medical patient intake through the Same Day Emergency Care unit (SDEC) with the aim of optimising patient review times and developing a better environment for learning with increased senior supervision. Trainers were aware that patient flow and staffing levels are under review but said that they have not been approached to contribute to any potential changes.

Trainers observed the working environment within the directorate to be challenging for much of the clinical workforce. A number of residents perceived there to be a culture of facilitating service provision, with little recognisable improvement in access to opportunities for learning, despite concerns having been raised.

Areas Working Well	Areas for Improvement
• Locum clinicians had been allocated to fill gaps in rotas. • The QI Fellow had collated valuable feedback about the local training environment. • Residents had felt able to report concerns via Datix and the resident forum. • Simulation training sessions had been introduced and included incident reporting scenarios.	• Uneven distribution of on-call rostering commitments amongst Medicine specialities. • Access to senior review of acute medical patients. • Monitoring and tracking of acute medical patients and medical outliers. • Effectiveness of handover processes and regularity of consultant participation. • Oversight of residents' Workplace Based Assessments. • Residents not able to attend teaching sessions due to service pressures. • Staffing levels have not facilitated residents to access training opportunities. • Many Foundation residents had been able to utilise less than 50% of their Educational Development Time. • Bleep signal is inconsistent throughout the hospital. • Communication channels between Directorate leads, trainers and residents about changes throughout the Directorate could be improved.

Requirements and Recommendations

The following requirements and recommendations were made on behalf of the HEIW visiting panel in response to the findings of the visit process.

Requirements

1. The Health Board must ensure that ward staffing levels are robust and that appropriate time is allotted to allow access to training opportunities including regional teaching programmes, Educational/Self-Development Time (EDT/SDT) and access to clinics as stipulated by the IMT curriculum. Staffing levels should take into account extra work generated by those patients who are accommodated outside of the traditional clinical bed spaces, for example in corridors and 'boarders' within ward areas.

   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.

2. The Health Board must ensure that robust pastoral support is accessible to all residents and trainers and that this incorporates an acknowledgement of the effects of working within a physically and emotionally challenging environment and the risk of progression to burnout.

GMC Requirement 3.2
Learners must have access to resources to support their health and wellbeing, and to educational and pastoral support, including:
a. confidential counselling services.
b. careers advice and support.
c. occupational health services. Learners must be encouraged to take responsibility for looking after their own health and wellbeing.

GMC Standard 4.2
Educators receive the support, resources and time to meet their education and training responsibilities.

3. The Health Board must ensure that training needs are taken into account when re-designing clinical areas and systems to improve patient flow. The local education team must be involved in discussion and planning. It would be desirable to also include trainers and resident doctors, who are likely to have valuable insights into practical aspects of the plans.

GMC Requirement 2.3
Organisations must consider the impact on learners of policies, systems or processes. They must take account of the views of learners, educators and, where appropriate, patients, the public, and employers. This is particularly important when services are being redesigned.

Recommendations

1. The Health Board should take steps to ensure that multiple members of the same ward-based team are not routinely scheduled to work out of hours or in an on-call capacity at the same time to avoid resident doctors being subject to excessive workloads on the wards.

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.

2. The Health Board should introduce a rostering system to ensure that IMT residents have planned, scheduled access to outpatient clinics as outlined within their curriculum.

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. There should be an effective, Health Board-supported system in place to track patients during the first 72 hours of admission, irrespective of overcrowding. This needs to support resident doctor handovers and their ability to find out about and act upon results.

GMC Standard 1.1
The learning environment is safe for patients and supportive for learners and educators. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers and families.

4. The Health Board should review current medical handover processes with the aim of ensuring that they are timely, robust, and used to support learning.

GMC Requirement 1.14
Handover of care must be organised and scheduled to provide continuity of care for patients and maximise the learning opportunities for doctors in training in clinical practice.

5. The Health Board should implement a simple exception reporting system to monitor residents' ability to attend rostered clinics and access EDT/SDT. These exception reports should be regularly discussed and reviewed to ensure good access is maintained.

GMC Standard 2.1
The educational governance system continuously improves the quality and outcomes of education and training by measuring performance against the standards, demonstrating accountability, and responding when standards are not being met.

6. The Health Board should review lines of communication with trainers and resident doctors to ensure that all parties are aware of improvement plans/activity and the obstacles and challenges which need to be overcome.

GMC Requirement 2.3
Organisations must consider the impact on learners of policies, systems or processes. They must take account of the views of learners, educators and, where appropriate, patients, the public, and employers. This is particularly important when services are being redesigned.

7. That HEIW will provide an update to the GMC on the findings of the visit with a recommendation that Enhanced Monitoring status is applied.

8. 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

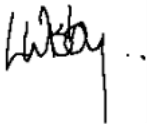
The aforementioned requirements and recommendations were provided to the Health Board verbally on the day of the visit and in writing on **Friday, 19th December 2025**. An action plan has been requested with a response required by **Friday, 6th February 2026.**

Risk Rating Recommendation

It was agreed that the current risk rating of twelve (**high**) remained in place. A further review of the risk rating would be undertaken at the next Targeted Visit.

Chair's Signature

I confirm that this report has been produced on behalf of the HEIW visiting panel and reviewed by those at HEIW with editorial rights.

Signature: 

Lee Wisby, Associate Dean for Quality (Chair)

Date: 5th February 2026

General Medical Council

Enhanced monitoring; guidance for local education providers.

What is Enhanced Monitoring?

When postgraduate training organisations (PTOs) are concerned about the quality and/or safety of the training that doctors in training receive, they need to work with local education providers to make improvements.

If the situation doesn't improve, we then work with all the organisations involved to improve the quality of training through our enhanced monitoring process.

Issues that require enhanced monitoring are those that we believe could adversely affect patient or trainee safety, or the quality of the training environment which may impact the trainee's ability to progress in their training.

Enhanced monitoring means we increase the level of monitoring, participate in activities organised by the PTO to help drive the changes that are required to address the concerns.

We will tailor the support we provide to each enhanced monitoring case, to address the concern and develop a sustainable solution.

How is a concern referred to the Enhanced Monitoring process?

There are two referral routes for enhanced monitoring:

- Internal referral is when we escalate an issue based on the evidence, we hold such as results from the National Training Survey (NTS) or if we hear about serious trainee or patient safety concerns on a quality visit.
- External referral is when we decide to use enhanced monitoring as a result of information from another organisation or individual. Most current enhanced monitoring cased have been referred to us by organisations responsible for the quality and safety of medical education and training, such as PTOs.

We expect these organisations to **consider** escalating an issue to enhanced monitoring if it falls into at least one of the following scenarios:

- Persistent and/or serious patient safety concerns
- Persistent and/or serious concerns for the safety or well-being of doctors in training

The GMC is a charity registered in England and Wales (1089278) and Scotland (SC037750).

- Evidence indicates that the quality of the training environment is seriously and/or persistently below GMC standards.

What happens next?

Enhanced monitoring works with local PTO quality management processes. We expect you to work with them, providing them with information and improvement/action plans which demonstrate that the concerns are being addressed.

The frequency of these updates depends on the nature of the case; however, we expect these updates to be a minimum of every six months. The PTO will agree a due date for the next update with you and we will access this information as appropriate in order to assure ourselves of improvement and to ensure the issues are being managed suitably.

We publish enhanced monitoring cases on our website. All enhanced monitoring cases will be published unless there is a reason they should not e.g, if by publishing:

- we risk identifying individuals
- we risk putting commercially sensitive or confidential information into the public domain

What are Enhanced Monitoring activities?

As part of this process, we may join a PTO quality management visit, meeting or other activity. This organisation and management of the activity remains with the PTO, but we will contribute to any judgements made and may wish to closely monitor further activity, if we are not assured.

If the objective of the activity is to explore new and/or high-risk issues we will usually be represented by a senior GMC staff member, and on some occasions a GMC associate with experience in this field.

What are our statutory powers?

Conditions

When local processes fail to address serious concerns, we may decide to use our legal powers as outlined in the Medical Act (1983) to place conditions on any approval we have given. Conditions may reflect our standards, or reinforce requirements already set by PTOs. Or they may be more prescriptive and impose requirements to deal with a specific issue e.g. *foundation doctors must have on-site supervision provided by a consultant in emergency medicine.*

Withdrawal of approval

If conditions are not met, we may proceed with withdrawal of approval. This means that a site is no longer approved to deliver training within a programme. Depending on the scope of the issues at hand, we can withdraw approval for one or more programmes as delivered at an education provider. This means that cohorts of trainees will be removed.

If we decide to exercise our statutory powers, we will consult with relevant organisations and provide opportunities to put things right before imposing any action. We aim to be proportionate and reasonable in using our powers.

Exiting the Enhanced Monitoring process

There are two exit routes for enhanced monitoring:

- De-escalating to quality reporting: this is when a case no longer meets the thresholds for enhanced monitoring, but the concern is still not fully resolved and therefore is monitored directly through the PTO.
- Resolving the concern: this is when the concern has been resolved and all parties are assured that the original issue has been addressed and the solution in place is sustainable.

How can I find out more about the GMC?

For more information about enhanced monitoring please see our website,

General Medical Council

Enhanced monitoring; guidance for doctors in training.

What is enhanced monitoring?

When postgraduate training organisations (PTOs) are concerned about the quality and/or safety of the training that doctors in training receive, they need to work with local education providers (LEPs) to make improvements.

If the situation doesn't improve, we then work with all the organisations involved to improve the quality of training through our 'enhanced monitoring' process.

Concerns that require enhanced monitoring are those that we believe could adversely affect patient or trainee safety, the quality of the training you receive, or the quality of the training environment you are in.

How is a concern referred to the enhanced monitoring process?

There are two referral routes for enhanced monitoring:

- An internal referral is when we escalate an issue based on the evidence we hold. For example, where a number of concerns regarding sites or departments have been reported through the national training survey or if we hear about issues that affect a trainees' wellbeing or patient safety concerns on a scheduled visit.
- An external referral is when we decide to use enhanced monitoring as a result of information from another organisation or individual. Most of the concerns in enhanced monitoring are referred by organisations responsible for the quality and safety of medical education and training, such as the relevant postgraduate dean.

We expect organisations to **consider** escalating an issue to enhanced monitoring if it falls into at least one the following scenarios:

- Persistent and/or serious patient safety concerns
- Persistent and/or serious concerns for the safety or well-being of trainees
- Evidence indicates that the quality of the training environment is seriously and/or persistently below our standards.

The GMC is a charity registered in England and Wales (1089278) and Scotland (SC037750).

What happens next?

We use enhanced monitoring to promote and encourage local management of concerns about the quality and safety of medical education and training. We expect the LEP and the PTO to work together, to provide information and improvement/action plans to demonstrate that the concerns are being addressed.

We publish information regarding enhanced monitoring cases on our website. All cases will be published unless:

- we risk identifying individuals
- we risk putting confidential or commercially sensitive information into the public domain

Enhanced monitoring activities

One of the ways that we oversee this process is by attending visits, meetings and other activities at the organisation in enhanced monitoring. These activities may take place in person or virtually. The organisation and management of the activity remains with the relevant PTO, and we participate as members of the local visit team. We will contribute to any judgements made and may wish to closely monitor further activity if we are not fully assured that our standards are being met.

If the objective of the activity is to explore new and/or high-risk issues it will usually involve a senior member of GMC staff and a GMC associate. The associate is usually a senior doctor with experience of dealing with educational issues, who provides additional support and advice to the visit team.

Frequently asked questions:

My department is in enhanced monitoring what does this mean for me?

Your training and your daily work will not be affected by the department being in enhanced monitoring. Once an improvement/action plan has been developed by the LEP and the PTO, you may notice changes to policies and processes taking place which should positively impact your training. You may also be asked to take part in activities to explore the concerns and ways of addressing them, which may feed into the action plan.

If there is an enhanced monitoring case in the department where I'm working will I be asked to be involved in the enhanced monitoring activity?

The LEP you are working for will likely ask you to take part in discussion sessions with the visit team. We want to talk to as many doctors in training, supervisors and consultants as possible. It isn't mandatory to attend the discussion sessions and it will not affect your training in any way if you don't attend. However, your input is very valuable and helps us understand what the risks and issues are in your department, and what is working well.

Will my comments during the visit be confidential?

We want you to be open with us, and, though we will record what you tell us, we will protect your anonymity as far as possible. We may wish to know your training level, but we will not routinely ask for names. The only circumstance in which this may not be possible is if you raise a safety concern about a patient or doctor in training. In this instance, the team will discuss the next steps with you, support you through the process, and will not identify you unless necessary.

Who can I ask for support while my department is in enhanced monitoring?

We want all doctors in training to feel supported during an enhanced monitoring case. Your support networks at the hospital you are currently working in i.e. your supervisor or trainee forum should be your first place of contact. However if you require further detailed information about the enhanced monitoring process then please visit our website or contact the relevant PTO.

When will a concern no longer be in enhanced monitoring?

There are two ways we would stop our enhanced monitoring process:

- De-escalating to quality reporting: this is when a case no longer meets the thresholds for enhanced monitoring, but the concern is still not fully resolved and meets the threshold for inclusion in our quality reporting system.

- Resolving the concern: this is when the concern has been resolved; both parties are assured that the original issue has been addressed and the solution in place is sustainable.

How long do enhanced monitoring cases take to resolve?

Each enhanced monitoring case is different and can involve multiple complex issues which need careful consideration to resolve. This means that there is no set timeframe to resolve the case. However, once an improvement/action plan has been developed we work closely with the PTO

and LEP to ensure that deadlines for specific action points are adhered to. We expect that the local trust or health board will do everything they can to resolve the concerns quickly and thoroughly.

What happens if there aren't any improvements in my department?

On the rare occasion that local processes fail to address serious concerns, we may decide to use our legal powers as outlined in the Medical Act (1983) to place conditions on any programme approval we have given. Conditions may reflect our standards, or reinforce requirements already set by PTOs. Or they may be more prescriptive and impose requirements to deal with a specific issue e.g. *foundation doctors must not work in the emergency department between the hours of 22:00 and 08:00.*

If conditions are not met, we may need to proceed with withdrawal of approval. This means that a site is no longer approved to deliver training within a programme. In this instance you will be contacted by the PTO and arrangements will be made to place you into an alternative training environment. We realise that this may be unsettling but the PTO, specialty schools, and programme leads will provide support to ensure the transfer is as stress-free as possible.

If we decide to exercise our statutory powers, we will consult with all relevant organisations and provide opportunities to put things right before imposing any action.

How can I find out more about enhanced monitoring?

For more information please see our website.