GIG CYMRU NHS WALES

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

HEIW Education & Training Targeted Visit Report

Internal Medicine and Gastroenterology

Morriston Hospital

Swansea Bay University Health Board

Monday, 26th January 2026

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Section One: Visit Remit

Health Board	Swansea Bay University Health Board	**Site**	Morriston Hospital
Visit Date	26th January 2026	**Risk Rating (Pre visit)**	**6**
Specialty	Internal Medicine and Gastroenterology	**Grade(s)**	Foundation, ACCS, IMT, GPST and ST
Visit Panel	• Malcolm Gajraj, Director of Quality Management (Chair) • Shaun Smale, Head of School for Medicine • Thomas Cozens, Acute Internal Medicine Training Programme Director • Louise Allman, Acute Care Common Stem (ACCS) Training Programme Director* • Caroline Burford, ACCS Internal Medicine Lead** • Benjamin Dicken, Faculty Lead (Quality) • Mandy Martin, Quality Manager • Vicky Collins, Quality Officer • John Benbow, Lay Representative		
LEP Representatives	• Rajesh Krishnan, Deputy Medical Director • Balwinder Bajaj, Assistant Medical Director (Education and Training) • Mark Ramsey, Service Group Medical Director • Rhodri Edwards, Assistant Medical Director (Acute and Geriatric Medicine) • Clare Parker, Interim Associate Medical Group Director • Rhian Finn, Respiratory Consultant • Rachel Shakespeare, Gastroenterology Consultant • Donna Hole, Head of Education and Learning • Sade Bewsher-Griffiths, Deputy Head of Education and Learning • Llinos Hodder, Medical and Dental Education Manager • Bethany Jones, Postgraduate Medical and Dental Supervisor		
Evidence Considered	• Evidence Timeline • Previous Visit Report, June 2025. • Health Board Action Plan • GMC National Training Survey Results 2022 - 2025		
Residents Present	10 across Foundation, IMT, and ST grades	**Trainers Present**	3
Status Summary	• The previous visit was undertaken on **30th June 2025.** • This concern is not in Enhanced Monitoring status with the GMC.		

**Present for the resident feedback meetings.*
***Present from the trainer meeting onwards.*

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 Targeted Visit was arranged to follow up on the progress in addressing the concerns identified in previous visits. The Health Board had made considerable advancements in improving the induction package, clinical supervision, and the implementation of an effective forum to support communication between residents, clinical leads and the Directorate. Additionally, clinic access had improved for some grades.

Specialty training opportunities for residents in dual training programmes had been impacted by General Internal Medicine (GIM) rota commitments. The unbalanced distribution of on-call commitments across the Directorate had also impacted staffing levels in the residents' base specialties. Multiple patient referral pathways into Acute Medicine remained and were heavily dependent on the Medicine “Registrar” grade during out-of-hours shifts. Unclear handover processes for the transfer of patients from the Same Day Emergency Care (SDEC) unit to the Acute Medical Unit (AMU) had further contributed to the workload pressures for the on-call Medical Team.

The Health Board has indicated the following progress in response to the recommendations given during the HEIW Targeted Visit on **Monday, 30th June 2025.**

- The Health Board planned to undertake a two-week audit to review doctor ward allocations and the distribution of on-call commitments by November 2025.
- The Health Board aimed to contact all supervisors and higher-grade resident doctors regarding the implementation of reverse ward rounds by October 2025.
- The Health Board planned to develop and implement a Standard Operating Procedure (SOP) covering the handover of patients between the Same Day Emergency Care (SDEC) unit and the Acute Medical Unit (AMU).
- A review would be undertaken of medical handover processes to ensure staff were distributed fairly to compensate for absence.
- The distribution of resident doctors across the Acute Medicine footprint would be discussed at the weekly medical staffing meeting to ensure distribution reflected service demand.
- The Medical Education Team would encourage regular engagement at resident forums to ensure residents could feed back regarding the balance between specialty medicine and General Internal Medicine training.
- The Health Board would ensure there is educational representation at the monthly clinical leads meeting to support an appropriate balance of training.
- The Health Board planned to develop and circulate a return-to-work guidance document that clearly articulated the Health Board’s responsibilities and the responsibilities of the individual.
- Residents would be encouraged to discuss any curriculum requirements or concerns with Educational Supervisors. Educational support systems would be reiterated at Induction.

Section Two: Summary Findings

The Health Board reported facing heightened service pressures at the time of the Targeted Visit. Resident attendance was relatively low; however, those who participated were able to provide feedback from a range of specialties. Trainer attendance at the visit offered valuable nuance to the resident feedback. No Acute Care Common Stem (ACCS) or General Practitioner Specialty Training (GPST) residents were present at the meeting, so feedback about their training experiences could not be gathered.

Educational Supervisors were accessible and supportive of residents' training needs. Some Internal Medicine Training (IMT) residents were unaware of who their Named Clinical Supervisors were but had received good support from their offsite Educational Supervisors.

Foundation and Internal Medicine Training (IMT) residents had been well supported by "registrar" colleagues. Consultants were approachable and regularly prompted residents to contact them for guidance, particularly during out-of-hours shifts.

Residents had found the overall induction package to be useful. The induction handbook had been updated by residents following the induction with information they believed would be valuable to future resident cohorts.

All grades reported the training environment in their base specialties to be positive. Residents valued the opportunity to undertake specialty outpatient clinics and procedure lists at other sites throughout the Health Board. However, they acknowledged it reduced the number of clinicians available to cover staff shortages at Morriston Hospital.

Resident participation in clinics had been rostered in most specialties. However, several IMT year 3s reported not having been rostered for clinics and subsequently had to use Educational Development Time (EDT) to ensure they could meet their curriculum clinic requirements.

Pleural procedure training was primarily accessible via Advanced Nurse Practitioners (ANPs). Residents confirmed that the training provided by the ANPs was beneficial, however, there was a lack of clarity about the appropriateness of ANP signoff for procedural competencies in residents' portfolios.

Teaching sessions were regularly scheduled in most specialties and were beneficial to residents' learning.

Residents had experienced challenges completing Acute Care Assessment Tools (ACATs) whilst working in Acute Medicine. The main barriers reported were due to service pressures and difficulties in clerking the required number of patients alongside a consultant. Trainers considered achieving ACATs was possible in the current system, but believed the "registrar" twilight shift that was to be introduced in the near future would provide greater opportunities.

Rostering and frequency of on-call shifts were raised as a concern by trainers and residents, due to multiple members of the same speciality being rostered for on-call shifts at the same time, significantly limiting the number of staff available to work on specialty wards. Residents in Less Than Full Time (LTFT) posts reported being regularly asked to cover wards with reduced staffing, further limiting their opportunities to train.

Most residents were aware of formal reporting tools and all residents felt confident in their ability to raise concerns with a member of staff in the Directorate. Overall, the Doctors' Forum was thought to be an effective tool for discussing concerns.

Training opportunities in the Acute Medicine Unit (AMU) were noted to be very limited due to service pressures. The numerous referral pathways into the AMU had made organising a workplan and prioritising patient acuity particularly challenging. Trainers recognised the increased pressures experienced by the on-call medical "registrar" but also believed there was an unwillingness from some residents to move between departments to assist colleagues in areas with greater service pressures.

Both residents and trainers perceived the lack of Acute Medical Physicians to have adversely impacted department oversight, patient flow, and continuity of senior patient care in Acute Medicine areas. There was ambiguity amongst the resident cohort regarding the effectiveness of the GP led Same Day Emergency Care (SDEC) unit. Concerns were also raised about SDEC units accepting referrals until 15 minutes before

the SDEC closed, which had led to many patients transferring from the SDEC units to the AMU with minimal investigations having taken place.

Residents were unaware of the procedures in place for the handover of patients transferred from the SDEC to the AMU. ST grades reported that the information transferred with patients was sometimes of poor quality and in some cases incorrect, which had made it difficult to prioritise patient acuity and manage department workload. Health Board leads confirmed that formal handover processes had been put in place for the SDEC unit and were unsure of the reason why these processes were not being followed.

Despite current system pressures, no patient safety incidents were raised, though residents referenced instances of patients being missed from ward rounds due to having been placed in transient clinical areas. Patients had been reviewed daily, though not continually, by a consultant. Patient flow had been supported by “in reach” processes, aiding patient transfers to the specialty best suited to provide the patient with care. The lack of weekend ward rounds on the AMU was considered to have reduced opportunities for training and for discharging patients.

All grades raised concerns about service pressures and system structures limiting training opportunities in Acute Medicine areas, particularly during on-call shifts, so would not recommend their dual accredited posts for training in GIM.

Areas Working Well	Areas for Improvement
• The induction handbook had been updated. • Educational Supervisors were engaged and supportive of residents' learning needs. • The staff forum was an effective tool for facilitating communications amongst the Directorate. • Teaching sessions were regularly scheduled and of good quality. • Clinics were rostered for most residents and were a beneficial training experience. • Senior clinical support was accessible at all times. • Specialty training opportunities were well facilitated and beneficial to residents’ learning. • The “in reach” system is beneficial to patient flow.	• Inadequate clinic opportunities for IMT year 3s • There is limited consultant oversight of the Acute Medical Unit (AMU). • General Internal Medicine rota commitments had limited residents’ specialty training opportunities. • The distribution of on-call rostering to ensure specialities are not short staffed. • Opportunities for completion and oversight of ACATs in Acute Medicine. • Referral pathways to the Acute Medical Unit (AMU). • Guidance to support residents’ ability to challenge inappropriate referrals to the AMU. • Handover processes and the quality of information transferred from the GP led SDEC to the AMU. • Clarity regarding ANP suitability for the oversight and signoff of procedural competencies.

Requirements and Recommendations

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

Recommendations

1. The Health Board should review the admission processes for the Acute Medical Unit (AMU) to ensure the referrals received are appropriate, appropriately triaged, and communicated in a clear and proficient manner to the on-call "registrar" grade doctor.

   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.

2. The Health Board should take further steps to ensure all Internal Medicine Training (IMT) residents are able to access sufficient clinics to meet the requirements of their curricula without having to utilise Educational Development Time. Particular attention should be made towards the clinic needs of IMT year 3 residents.

   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 make efforts to strengthen processes surrounding the handover of patients from the Same Day Emergency Care (SDEC) unit to the AMU, to ensure GMC Standards regarding handovers are met.

   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.

4. The Health Board should take steps to ensure that multiple members of the same ward-based team are not routinely scheduled to work in an on-call capacity at the same time.

   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.

5. The Health Board should ensure health professionals receive appropriate training and support to allow them to train, oversee, and validate residents' training competencies.

GMC Requirement 5.11

Assessments must be carried out by someone with appropriate expertise in the area being assessed, and who has been appropriately selected, supported and appraised. They are responsible for honestly and effectively assessing the doctor in training's performance and being able to justify their decision. Educators must be trained and calibrated in the assessments they are required to conduct.

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 recommendations were provided to the Health Board verbally on the day of the visit and in writing on **Tuesday, 27th January 2026.** An action plan has been requested with a response required by **Wednesday, 11th March 2026.**

Risk Rating Recommendation

It was agreed that the current risk rating of six (**medium**) remained in place. Given the positive feedback gathered about the training environment in Gastroenterology, the department will no longer be included in Targeted Visit processes. A further review of the training environment in Internal Medicine 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: 

Malcolm Gajraj, Director of Quality Management (Chair)

Date: 27th February 2026