GIG CYMRU NHS WALES

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

HEIW Education & Training Targeted Visit Report

General Internal Medicine and Gastroenterology

Morriston Hospital

Swansea Bay University Health Board

Monday, 30th June 2025.

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Section One: Visit Remit

Health Board	Swansea Bay University Health Board	**Site**	Morriston Hospital
Visit Date	30th June 2025	**Risk Rating (Pre visit)**	**9**
Specialty	General Internal Medicine and Gastroenterology	**Grade(s)**	Foundation, ACCS, IMT, GPST and ST
Visit Panel	• Malcolm Gajraj, Director of Quality Management (Chair) • Thomas Cozens, Acute Internal Medicine Training Programme Director • Benjamin Dicken, Faculty Lead (Quality) • Julia Scaife, Faculty Lead (Residents) • 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 • Sophie Henson, Assistant Medical Director (Speciality Medicine) • Rhodri Edwards, Assistant Medical Director (Acute and Geriatric Medicine) • Abi Landeg, Directorate Manager for Medicine • 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 • Carolyn Hodder, Medical HR Operational Manager		
Evidence Considered	• Visit Agenda • Evidence Timeline • Previous Visit Report, December 2024 • Health Board Action Plan • Health Board Medical Outliers Standard Operating Procedure • Health Board Standard Operating Procedure for Paediatric Emergencies at Singleton Hospital		
Residents Present	18 across Foundation, IMT, & ST grades, and 2 locally employed doctors	**Trainers Present**	9
Status Summary	• The previous visit was undertaken on **Monday, 2nd December 2024.** • 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.

General Internal Medicine at Swansea Bay University Health Board has been the focus of six previous HEIW Targeted Visits and has been discussed at meetings between the Quality Unit and the Health Board. Whilst progress has been made on improving training opportunities and the overall environment within the department, concerns had been raised regarding variable access to clinics impacting on the ability of the residents to obtain experience required by their curriculum, and potential patient safety concerns associated with a lack of clarity around responsibility for the 'post-post-take' patients in Emergency and Acute Medicine areas.

The following recommendations were agreed upon during the HEIW Targeted Visit on **Monday, 2nd December 2024**.

Requirements

1. There must be a sustainable system in place to manage post-post-take patients, irrespective of overcrowding and this must include:
   a. Clarity of the arrangements for ensuring consultant oversight of the patients.
   b. Clarity around the recognition of deteriorating patients and the associated escalation pathways.

2. There must be a finalised and fully implemented Standard Operating Procedure (SOP) agreed by HEIW for the management of patients and particularly children attending the Singleton site. (This should be provided to HEIW by 22nd December 2024).

Recommendations

1. Trainees must be exposed to a balance of experience within General Internal Medicine (GIM) and their specialty that allows appropriate training for both.
2. There should be consideration of clinical patterns for consultants that allow for greater continuity, improving patient care and training.
3. There should be sufficient space to allow trainee and trainer discussions in privacy.
4. There should be a review of patient admission pathways including the Emergency Department, the Medical Admissions Unit and use of pod to aid and improve efficiency of the service.
5. That HEIW will provide an update to the GMC on the visit findings. If the Health Board is able to provide HEIW with a robust SOP for the management of the post-post-take patients before 22nd December 2024 as required in recommendation two this would be considered a significant step that we would include in discussion with the GMC and we would consider this to reduce the likelihood that Enhanced Monitoring status would be imposed.
6. That HEIW will arrange a further visit for six months' time to review progress.

Since the previous visit, the Health Board has indicated the following progress in response to the above recommendations.

- The SOP for the management of medical outliers in the Emergency Department was submitted to HEIW on 19th December 2024.

- The Directorate would maintain a locum consultant to oversee the management of medical outliers in the Emergency Department.
- The Directorate would undertake a review of the Medical Outlier Team in the Emergency Department in March 2025.
- Reviews of medical staffing required to support medical outliers in the Emergency Department would be discussed at weekly Medical Staffing Meetings.
- The department would undertake an audit of training opportunities across General Internal Medicine (GIM) in comparison to Speciality experience for all training grades. A survey would also be sent out to garner feedback about this from residents.
- All consultant job plans would be reviewed by 31st March 2025.
- All clinical directors and clinical leads have been asked to ensure educational roles, including the provision of clinical and educational supervision, are appropriately recognised in job plans, as per Health Board guidelines.
- The Health Board published guidance on Consultant and SAS doctor job planning. The guidance advocates that time allocated to teaching and training should be explicitly described rather than counting as time for Supporting Professional Activity (SPA).
- The Health Board will undertake a review of Acute Medicine rotas, with a view to creating three rotas for Acute Medicine, Frailty and GIM areas.
- The Health Board aims to explore options to create a dedicated space within the Emergency Department to facilitate private and confidential discussions and to develop strategies to improve patient flow and decrease overcrowding in the Emergency Department.
- The Health Board aim to review admission pathways to maximise the use of the Acute Medical Unit and Same Day Emergency Care (SDEC) unit. Health Board efforts would also continue to reduce ambulance wait times outside the Emergency Department and consequently the use of “the pod”.

Section Two: Summary Findings

Overall, there was adequate representation from residents across a range of training programmes, Locally Employed Doctors (LEDs), and trainers to allow effective feedback and discussion.

Induction had consisted of a tour of the department from a registrar grade and additional information about departmental shift patterns and processes. Residents reported that the induction provided was adequate to begin their placements but would have appreciated clearer guidance about on-call shift patterns, as well as patient distribution and oversight in Acute Medicine areas.

Initial meetings with Educational or Named Clinical Supervisors had been delayed for a number of residents due to them being assigned to supervisors that had moved to other areas across the Health Board. This oversight had been promptly resolved, and once allocated, Educational and Named Clinical Supervisors were accessible and supportive.

Efforts by the Health Board to improve residents’ access to clinics had continued. Clinics had been incorporated into rotas for most specialities and residents had been able to meet their curriculum requirements. Residents had been facilitated to review patients independently in clinics where appropriate, and consultants had been available to provide support and to oversee Out-Patient Care Assessment Tools

(OPCATs) when required. The frequency of on-calls for some Speciality Training (ST) residents had impacted their ability to attend clinics.

Residents valued the acute clinical and referral experience accessible in the Same Day Emergency Care Unit (SDEC) but believed more regular rostering to SDEC would be beneficial. The Health Board aimed to review rotas within Medicine to ensure ST grades are rostered to SDEC for one week in every twelve to facilitate increased access to acute clinic experience.

Workplace Based Assessments (WBAs) had been achievable for all grades, though some residents had experienced challenges due to workload and availability of senior team members. Several Internal Medicine Training (IMT) residents had stayed past the end of their shifts to ensure consultant oversight and feedback of Acute Care Assessment Tools (ACATs). Consultants had been unaware of residents remaining past their finish times and suggested residents approach consultants at the beginning of shift to ensure oversight and timely feedback for WBAs.

ST residents in Care of the Elderly (COTE) placements had found the opportunity to lead “reverse ward rounds” to be a very beneficial learning opportunity.

Teaching sessions had been scheduled for residents, but attendance had been impacted by service pressures.

Efforts had been made by the Directorate to ensure that Educational Development Time (EDT) was accessible. The faculty team aimed to improve monitoring of EDT by introducing an EDT Day, in which residents would be encouraged to present and discuss the work undertaken with peers and educational leads.

Receipt of residents’ rotas had been timely, and residents were generally positive about the rota application used by the Health Board. However, concerns were raised about the lack of robustness in rotas and a lack of timely action in filling rota gaps. Frustrations that rota gaps were being filled by agency staff instead of being advertised to residents with adequate notice were evident.

Organisation of rotas to cover on-call shifts had been reported to be ineffective, with several staff from one speciality being rostered to on-call shifts at the same time, leaving that speciality short-staffed. The rota system also meant that residents were not regularly assigned to work alongside the same consultants, which consultants believed had negatively impacted team bonds and opportunities for feedback.

Residents who had been on extended periods of leave had felt like they had been left unsupported, having to organise their own phased return to work.

Concerns were raised about the impact of General Internal Medicine commitments on specialty training opportunities, particularly for residents in specialities with a larger volume of procedural experience required by their curriculum. IMT residents had experienced barriers to accessing training in ultrasound and pleural procedures. Department leads proposed that residents shadow Respiratory Nurses or attend pleural clinics but did recognise that cross-site travel may be required to access these opportunities.

Residents in Gastroenterology placements had experienced challenges in accessing Endoscopy training opportunities. Department leads confirmed that residents had been rostered to attend “hot clinic” and scope lists. Endoscopy and acute procedure lists had also been timetabled, and Endoscopic Retrograde Cholangiopancreatography (ERCP) lists had been made available for senior grades.

Since the previous Targeted Visit, the Health Board had implemented a pilot in Acute Medicine by opening Anglesey Ward to manage ‘post-post-take' patients. Residents across all grades perceived the restructure to be helpful and more geographically efficient for patients and staff. Consultants agreed that the outcomes

of the pilot had been positive but cited concerns that the ward could not be overseen by the current consultant cohort in the long term.

Most STs perceived the reorganisation of registrar grade responsibilities across Acute Medicine to have positively impacted training opportunities and workload. ST residents from COTE had been required to cover Frailty on-calls, which had negatively limited their exposure to on-call shifts and subsequent learning opportunities in Acute Medicine.

Residents were aware of Health Board reporting tools, including Datix, but had not been fully utilising them due to high workload and the time required to fill in the forms. No patient safety concerns were raised during the visit. However, instances of ward pressures leading to an almost unmanageable workload and the ineffectiveness of patient transfers to Acute Medicine following the closure of SDEC were acknowledged to be areas of potential risk.

Efforts by trainers to provide quality training experiences were recognised but had been impacted by intervals of increased service pressures. Overall, trainers had been able to undertake their training duties during their weeks away from the ward but believed their training responsibilities, particularly for the Foundation residents, had not been accurately considered in job plans.

Overall, residents perceived the Medicine Directorate to have a positive culture for learning and Morriston Hospital to be a pleasant place to work. The communication channels fostered by the resident doctors' forum were valued, and feedback from department leads regarding changes implemented had been welcomed.

The training experience was reported to have improved, however, staffing and workload concerns in Acute and General Medicine had impacted the accessibility of teaching and clinic opportunities. All residents present at the visit would recommend their posts for training, with the caveat that access to training opportunities when working in Acute Medicine was challenging.

Areas Working Well	Areas for Improvement
• Induction had been adequate for residents to start their placements. • There was good supervision and feedback for Outpatient and Acute Care Assessment tools. • There had been adequate access to clinics for residents to meet their curricular requirements. • Communications channels between residents and department leads were good. • Patient flow had improved following the restructuring of Emergency and Acute Medicine. • Patient management and experience appeared to be better during 'post-post-take' following the utilisation of Anglesey Ward. • The utilisation of "reverse ward rounds" had been a beneficial learning tool for residents in COTE. • There had been improved accessibility of Educational Development Time.	• Inaccurate reflection of time for trainers' educational responsibilities in job plan. • High service pressures had impacted on time for training. • Clarification of long-term planning for the leadership and oversight of Anglesey Ward. • Access to endoscopy and pleural procedures for IMTs and STs. • The impact of General Medicine commitments on training time in speciality areas. • The time available for and ineffective use of reporting tools. • Ineffective transfer and handover of patients from SDEC to the Acute Medical Unit. • Inequitable distribution of on-call rostering amongst Medicine specialities. • Inadequate support for residents returning to the workplace after an extended period of leave.

Requirements and Recommendations

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

Recommendations

1. The Health Board should conduct a review of departmental rotas with the aim of equitably distributing on call commitments across Medicine specialities, to ensure ward staffing levels remain robust and consistent.

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 ensure that residents returning to work after extended periods of leave are provided with an appropriately managed phased return to work plan.

GMC Requirement 3.11
Doctors in training must have appropriate support on returning to a programme following a career break.

3. The Health Board should consider the inclusion of reverse ward rounds for higher grade Speciality Training residents in Acute Medicine settings.

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 make efforts to improve the handover process for patients transferring from the Same Day Emergency Care Unit to the Acute Medical Unit, ensuring patients are tracked appropriately and information provided to the on-call registrar is up to date and robust.

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 make efforts to clarify and encourage communication channels amongst on call teams to ensure efficient distribution and movement of staff within Medicine areas.

GMC Requirements 1.17
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.

6. The Health Board should build upon previous efforts to provide an equitable balance between Speciality and General Internal Medicine commitments for residents in dual training programmes to ensure curriculum requirements are accessible and achievable.

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

7. 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, 1st July 2025**. An action plan has been requested with a response required by **Wednesday, 13th August 2025.**

Risk Rating Recommendation

It was agreed that the current risk of **nine** (high) is reduced to **six** (medium). A further review of the risk rating would be undertaken at the next visit which will be scheduled for six months' time.

Chair's Signature

Signature: 

Director of Quality Management

Date: 19th August 2025