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Health Education and
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HEIW Education & Training Targeted Visit Report

Internal Medicine

Morriston Hospital

Swansea Bay University Health
Board

Monday, 27th July 2026



Table of Contents

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

Section One: Visit Remit

Health Board	Swansea Bay University Health Board	Site	Morrison Hospital
Visit Date	27 th July 2026	Risk Rating (Pre visit)	5
Specialty	Internal Medicine	Grade(s)	Foundation, ACCS, IMT, GPST and ST
Visit Panel	- Malcolm Gajraj, Director of Quality Management (Chair) - Shaun Smale, Head of School for Medicine - Caroline Burford, Acute Care Common Stem (ACCS) Acute Medicine Lead - Benjamin Dicken, Faculty Lead (Quality) - Mandy Martin, Quality Manager - Vicky Collins, Quality Officer - John Benbow, Lay Representative		
LEP Representatives	- Mark Ramsey, Interim Deputy Medical Director - Balwinder Bajaj, Assistant Medical Director (Education and Training) - Clare Parker, Interim Associate Medical Group Director - Timothy Scale, Interim Clinical Director for Renal Medicine - Rhian Finn, Respiratory Consultant - Donna Hole, Head of Education and Learning		
Evidence Considered	- Concerns Summary and Evidence Timeline - Health Board Action Plan - Previous Visit Report, January 2026 - GMC National Training Survey Results 2023 - 2026		
Residents Present	4 across IMT and ST grades	Trainers Present	9
Status Summary	- The previous visit was undertaken on 26th January 2026. - 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 Targeted Visit was arranged to review progress against concerns identified during previous visits. Whilst progress had been made across several areas, efforts to ensure Internal Medicine Training (IMT) year 3 residents were able to access sufficient clinics had yet to be fully embedded. Efforts to reduce staffing shortages across Medicine subspecialties due to on-call rostering, as well as the impact of General Internal Medicine commitments on residents' training time in specialty areas had also not yet been resolved.

A lack of clarity regarding referral pathways and points of access to the Acute Medical Unit (AMU), as well as inconsistencies in the quality of handovers from the two Same Day Emergency Care (SDEC) units to the AMU were also raised as concerns.

The Health Board has indicated the following progress in response to the recommendations made during the HEIW Targeted Visit on **Monday, 26th January 2026**.

- The AMU Improvement Group aimed to establish a workstream to support communication between Single Point of Access (SPOA) and the registrar responsible for AMU admissions by May 2026.
- AMU Improvement Matrons had been charged with developing a Single Point of Access protocol.
- Directorate Leads planned to undertake a review of all medical rotas by May 2026. The review would include written timetables detailing Educational Development Time (EDT) and Outpatient clinic sessions. The rota review would also be used to identify occasions where multiple doctors from the same team were scheduled to be on call simultaneously.
- Directorate Leads planned to contact all clinical leads to ensure EDT and clinics are rostered for all resident posts, especially for IMT year 3 residents.
- The Directorate planned to introduce a twilight medical registrar shift by May 2026.
- Evening handovers between the SDEC and AMU teams were scheduled to take place at 18:30. Handover processes would be monitored and audited by the AMU Improvement Group.
- The Medical Education team aimed to ensure appropriate training and support is available for all trainers, both locally and externally.

Section Two: Summary Findings

Comparable to the previous Targeted Visit, resident attendance was low. However, those who participated were able to provide feedback from a range of specialties. Trainer attendance at the visit was good, allowing trainers to provide feedback about the training environment in their base specialties, as well as across General Internal Medicine and Acute Medicine areas. No Foundation, 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.

Overall, residents' feedback regarding the training environment in their base specialties was positive. Consultants were described as approachable, willing to teach, and supportive of residents' learning and development.

Educational support across Medicine sub-specialties was reported to be appropriate and responsive to residents' learning needs. Internal Medicine Training (IMT) residents reported a notable improvement in the accessibility of training opportunities required by their curricula.

Clinic time was reported to be protected in most subspecialties, and separate rooms had been allocated to allow residents to assess patients independently. Some of the required clinic experience was obtained in the Same Day Emergency Care unit. Supervision arrangements for clinics were reported to be appropriate and proportionate to the residents' level of experience, and feedback from consultants was constructive and of good educational quality.

Residents indicated that Acute Care Assessment Tools (ACATs) were achievable; however, several residents reported challenges in presenting sufficient numbers of patients to a single consultant due to frequent consultant shift rotations.

Procedural training competencies had been adequately accommodated; however, several residents reported difficulties leaving their base specialties to travel off-site when service pressures increased. Consultants noted that periods of heightened rota gaps had been experienced in some Medicine specialties; however, the Directorate had appointed a number of additional clinical fellows to enhance rota resilience and improve residents' access to training opportunities.

Ward rounds were consistently structured, and consultant feedback for patient management plans was constructive and beneficial to residents' learning.

Simulation training sessions had been unavailable for an extended period due to the previous simulation training lead leaving their post. However, this post had now been filled, and department leads confirmed that simulation training sessions would resume soon. Despite being regularly scheduled, resident participation in local teaching sessions was poor. The College Tutor planned to monitor residents' engagement with teaching activities and investigate reasons for non-attendance.

Educational Development Time (EDT) and annual leave were reported to be accessible; however, rota instability across some areas of Medicine had resulted in requests for study leave being declined. Additionally, there was a perception amongst residents that some rota teams within the Medical Directorate did not prioritise time required to attend exams.

Residents acknowledged that there had been some improvements to rota arrangements within Medicine. All residents were now working from a single rota, which feedback had suggested had resulted in a more equitable distribution of both training and learning opportunities across the resident cohort. The revised rota structure was perceived to have enabled greater exposure to a wider range of clinical settings, thereby enhancing residents' training experience.

Residents and trainers indicated that on-call commitments continued to be rostered in a way that left some specialty teams understaffed. Additionally, the frequency of on-call shifts for residents was reported to be high. Trainers noted this to be particularly evident for Foundation residents who were reported to spend only 10-15 days of their four-month posts in their base specialties. Amendments to the rota, planned from August, were expected to address this.

Initial feedback for the recently introduced twilight registrar shift suggested that the role had contributed to improvements in patient safety, workload management, and support during periods of increased system pressures. However, concerns were raised that twilight shifts had not been prioritised when rota gaps occurred.

Despite consultants' efforts to strengthen handover processes, several residents raised significant concerns that evening handovers had deteriorated to the point of feeling unsafe. The main factors affecting the reduced effectiveness of handover were that the room designated for handover to take place was frequently locked, as well as the time required to travel from the Emergency Department to the handover room.

There is currently no dedicated Clinical Lead in Acute Medicine, and consultant cover had been organised on a rolling rota. Whilst this ensured that senior oversight was generally available, many of the consultants on the rolling rota also had responsibilities in other Medicine subspecialties, limiting their capacity to support and oversee operational changes.

Whilst additional locum clinicians had been sought to support clinical workload, recruitment and retention of Acute Medicine physicians and registrar grade doctors was identified as a continuing challenge that had impacted service continuity and team stability.

Despite Health Board and residents' efforts to streamline SPOA communication pathways, residents indicated that referral criteria for the different areas within Acute Medicine, as well as the Emergency

Department remained unclear. Processes around the handover of patients from the SDEC units to AMU had not been fully resolved and the Standard Operating Procedure (SOP) no longer reflected current practice and required review.

Residents considered the new layout of the AMU to be insufficiently equipped to manage acutely unwell patients requiring immediate resuscitation or enhanced monitoring. Whilst consultants agreed with residents' feedback regarding space limitations in AMU, they did not perceive this to present overt patient safety issue.

Residents were aware of local reporting mechanisms, felt able to voice concerns, and were confident that issues raised would be listened to and responded to appropriately. Residents acknowledged that whilst there was a regular resident forum, resident engagement was variable. They suggested that a mechanism to document and communicate topics discussed at fora would be helpful for those unable to attend.

Whilst most residents acknowledged and valued the specialty training accessible within their current posts, most stated that they would not recommend a post in General Internal Medicine at Morriston Hospital to a colleague for training if a large proportion of the placement was to be spent in Acute Medicine.

Areas Working Well	Areas for Improvement
• IMT residents' access to clinics had improved. • Consultant feedback was constructive and beneficial to residents' learning. • Practical procedure competencies were achievable. • Trainers are committed to supporting residents' educational development. • Rota amalgamation had improved access to training opportunities for most residents. • The appointment of clinical fellows had enhanced rota resilience. • Senior clinical support was consistently accessible in most subspecialties. • EDT and annual leave were appropriately accommodated in most subspecialties. • The twilight registrar shift had been beneficial to workload and patient safety. • Ward rounds were well structured and had good educational value.	• Resident attendance at the Targeted Visit was very low. • Consultant oversight of the SDEC and AMU was sporadic. • There is no clinical lead in Acute Medicine. • The distribution of on-call rostering remains unbalanced. • Evening handovers were ineffective, and staff participation was inconsistent. • Residents reported difficulties in attending formal teaching sessions. • Simulation training had not been available. • There are no mechanisms in place to communicate topics discussed at the resident forum. • Referral criteria for patients directed to the Emergency Department (ED) and areas of Acute Medicine are unclear. • The workload pressures on and responsibilities of medical registrars were perceived to be excessive. • Cover arrangements for the twilight registrar shift had not been prioritised.

Requirements and Recommendations

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

Requirements

1. The Health Board must undertake a formal review of the management pathways for high-acuity medical referrals. This review should result in a clearly defined SOP detailing referral and admission criteria for the Emergency Department and the Acute Medical Unit (AMU), including escalation processes where patient acuity exceeds the capabilities of the receiving area. The review should also provide assurance that appropriate safeguards, senior clinical oversight, and risk mitigation measures are in place for patients admitted directly to AMU or who subsequently deteriorate while under AMU care.

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 must review night-time handover processes to ensure all handovers are safe, effective, 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.

Recommendations

1. All vacant shifts, including twilight shifts, should be proactively offered for locum cover to ensure adequate workforce capacity, protect residents' access to supervision and learning opportunities, and continue the delivery of safe, high-quality patient care.

GMC Requirement 1.7

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

2. The Health Board should take steps to identify a Clinical Lead for the Acute Medicine service to provide clear leadership and accountability for the development of the service, and to ensure educational opportunities within the acute setting are optimised to enhance residents' experience, supervision, and achievement of learning outcomes.

GMC Requirement 1.22

Organisations must support learners and educators to undertake activity that drives improvement in education and training to the benefit of the wider health service.

3. The Health Board should make further efforts to find an effective balance between the delivery of General Internal Medicine (GIM) and specialty training.

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.
4. The Health Board should take further steps to ensure that multiple members of the same Medicine sub-specialty 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 HEIW Panel supports the Directorate's proposal to implement a robust process for recording, monitoring, and reviewing attendance at educational activities, including formal teaching programmes and simulation-based training. The findings should be used to inform targeted interventions that optimise residents' access to, and participation in, locally and regionally organised educational programmes.

GMC Requirement 1.16

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

6. The Health Board should ensure a summary of key discussions, feedback, and agreed actions from the Residents' Forum are communicated to all residents, including those unable to attend, in order to facilitate wider communication, support transparency, and promote awareness of actions implemented in response to concerns raised.

GMC Requirement 1.5

Organisations must demonstrate a culture that both seeks and responds to feedback from learners and educators on compliance with standards of patient safety and care, and on education and training.

7. The Health Board should ensure that residents are granted appropriate leave to attend mandatory examinations.

GMC Requirement 1.18

Organisations must make sure that assessment is valued and that learners and educators are given adequate time and resources to complete the assessments required by the curriculum.

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 verbally to the Health Board on the day of the visit and confirmed in writing on **Tuesday, 28th July 2026**. An action plan has been requested, with a response required by **Friday, 11th September 2026**.

Risk Rating Recommendation

It was agreed that the current risk rating of **five** (medium) 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:

Malcolm Gajraj, Director of Quality Management (Chair)

Date: 1st September 2026