Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	20th November 2018	**Level(s)**	FY/GP/Core and Higher
Type of visit	Triggered	**Hospital**	All Fife
Specialty(s)	Psychiatry	**Board**	NHS Fife

Visit panel	
Ronald MacVicar	Visit Chair - Postgraduate Dean
Chris Mair	GP Programme Director
Alex MacDonald	Lay Representative
Louise Millar	Foundation Programme Director
Richard Steven	Trainee Associate
Dawn Mann	Quality Improvement Manager
In attendance	
Patriche Maguire	Quality Improvement Administrator

Specialty Group Information		
Specialty Group	Mental Health	
Lead Dean/Director	Ronald MacVicar	
Quality Lead(s)	Claire Langridge, Alastair Campbell	
Quality Improvement Manager(s)	Dawn Mann	
Unit/Site Information		
Non-medical staff in attendance	5 including head of nursing and senior charge nurses	
Trainers in attendance	10 Consultants including the ADME	
Trainees in attendance	2 FY,1 GP 4 Core 1 Higher	
Feedback session: Managers in attendance	10 including ADME and clinical services manager	

Date report approved by Lead Visitor	19th December 2018

1. **Principal issues arising from pre-visit review**

This visit was a triggered visit following recommendation of the Foundation and GP QRP's.The purpose of the visit is to meet with all trainee grades and trainers to review training, education and experience within the unit against the requirements of the GMC's *Promoting Excellence: Standards for Medical Education and Training.*

This year's NTS figures showed a worsening of results from previous years with particular concerns in Foundation at Stratheden Hospital, GP at Lynnebank Hospital and all levels at Queen Margaret Hospital.

There were limited responses received from trainees for pre-visit questionnaire and these varied greatly in opinion.

2. Introduction

There are four main sites across Fife where mental health trainees are placed including Whytemans Brae Hospital, Stratheden Hospital, Queen Margaret Hospital and Lynnebank Hospital. There are currently 4 Foundation, 5 GP, 10 Core and 2 Higher trainees based across these sites, attendance on the day of the visit was disappointing. A summary of the discussions has been compiled under the headings in section 3 below. This report is compiled with direct reference to the GMC's Promoting Excellence - Standards for Medical Education and Training. Each section heading includes numeric reference to specific requirements listed within the standards.

We would like to thank the site for their hospitality and assistance in organising the visit.

3.1 Induction (R1.13)

Trainees: Trainees advised that they had attended the Fife-wide induction and received a handbook. Most trainees had been given a tour of their site but no consistent formal local induction and felt there was a need for more site-specific information to enable them to carry out their role.

Trainers: The panel were advised that due to recent feedback from trainees the induction has been reviewed and improved and will be implemented from December. It was felt that due to several consultant retirements there were several processes that fell down including induction.

The induction process has now been formalised and includes a Fife-wide Psychiatry induction for all levels of trainees and site inductions for all trainees. Trainees are given a handbook for reference. We were advised that there is the opportunity for trainees to attend the Foundation intake induction if they miss their induction, but this is not a formal process, there would be an expectation that the supervisor would inform the trainee of important information missed at induction.

Non-medical Staff: Senior nursing staff advised that they would normally meet the trainees as part of ward-based induction.

3.2 Formal Teaching (R1.12, 1.16, 1.20)

FY/GP Trainees: Trainees confirmed that local teaching takes place on a Tuesday with one duty doctor staying on site. We were told it is not always possible to attend FY and GP regional teaching due to the demands of the job, trainees told us they managed to attend approximately 50% of teaching sessions and they are not always bleep free.

Core/Higher Trainees: Trainees advised that they attend the Tuesday morning teaching sessions**,** with one duty doctor covering each site. Sessions are not bleep free. Core trainees attended regional teaching sessions most of the time unless covering the duty rota or dealing with an urgent assessment. Trainees felt that the regional teaching was of a high standard. The higher trainee was involved in running teaching sessions and journal club.

Trainers: The panel were advised that there is a Fife wide teaching programme in place over three terms, with a rotating location each term. This is comprised of a weekly Tuesday morning teaching session including case review and external speakers, followed most weeks by a Journal club. This is aimed at all levels of trainees and has appropriate sessions for all. There is also regional teaching for FY and GP trainees and Core trainees attend sessions in Edinburgh, where they also attend a Balint group and get psychotherapy sessions.

During teaching sessions one duty doctor must remain at each site, the on-call doctor can attend the teaching on site but is not bleep free. The main ward round is scheduled for the same time as the teaching session at Lynnebank Hospital which can be limiting.

Non-Medical Staff: Nursing staff were all aware of the teaching days and tried to limit the trainee's duties at that time.

3.3 Study Leave (R3.12)

Trainees: Trainees advised that they had to arrange their own cover to be able to have study leave and there had been the odd occasion when this was not possible.

Trainers: The trainers were unaware of trainees having any problems accessing study leave

3.4 Formal Supervision (R1.21, 2.15, 2.20, 4.1, 4.2, 4.3, 4.4, 4.6)

FY/GP Trainees: All trainees had assigned educational and clinical supervisors. They had all had initial meetings with their educational supervisors but had not all received midway reviews. The panel were told that most trainees worked with their clinical supervisor on a daily basis and received informal feedback and support, however they did not always receive a scheduled weekly supervision session.

Core/Higher Trainees: Trainees advised that they were told who their educational supervisor was at induction sessions and they had all subsequently met with them to put PDP's in place. Several trainees told us that they had difficulty getting formal weekly supervision sessions although they had raised this and felt action was being taken to improve this.

Trainers: The panel were told that each trainee is assigned an educational supervisor and a substantive clinical supervisor. There was an issue with having enough substantive consultant supervisors due to a lot of retirements, so a buddy system was introduced to assist the Locums and ensure trainees are getting appropriate weekly supervision. The buddy system means that a substantive consultant will provide the weekly supervision for locums working with trainees on a day to day basis and they will offer support to the locum on training matters. Supervisors have time in their job plan and training for the role. Educational supervisors have monthly meetings with the TPDs where the needs of trainees with difficulties are discussed. Educational supervisors are expected to meet with trainees 4 times a year, but this may not always be in person. There are no specific leads for FY and GP.

Non – Medical Staff: Nursing staff felt that the trainees were always aware of who to contact for supervision.

3.5 Adequate Experience (opportunities) (R1.15, 1.19, 5.9)

FY/GP Trainees: Trainees felt that they were exposed to a wide range of cases including outpatient clinics. It was reported that out of hours was beneficial for providing a different type of experience as day to day roles.

Core/Higher Trainees: The Core trainees felt that they were not just there for service provision and the consultants were interested in their educational development. They didn't feel there were any particular competencies that they would struggle to achieve. All trainees attended clinics with access to supervision. Some trainees had two clinics per week and felt that this could be challenging to achieve on top of other work and teaching. The panel were advised that there had not been a higher trainee in place in Fife until recently and it was felt that this caused some uncertainty regarding the competencies and types of experience required. This was raised, and changes have started to be made. It may also take some time for non-medical staff to fully understand the types of tasks it is appropriate for a higher trainee to be carrying out.

Trainers: The panel were told that trainees work on a sector basis which means that they mainly work with one consultant covering both inpatient and outpatient work. It was expressed that trainee's day-to-day experiences would be discussed at weekly supervision so any gaps would be identified and addressed. It was identified in the past that trainees based at Queen Margaret Hospital had a disproportionate amount of outpatient work, but the workload was redistributed to address this.

3.6. Adequate Experience (assessment) (R1.18, 5.9, 5.10, 5.11)

Trainees: All levels of trainees advised that they had regular opportunities to complete assessments.

Trainers: Trainers felt that it was easy for trainees to achieve their assessments, with time allocated weekly for workplace-based assessments. The panel were told that there was a benchmarking activity for workplace-based assessments held a number of years ago but nothing recently.

3.7. Adequate Experience (multi-professional learning) (R1.17)

Trainees: All levels of trainees felt that they had access to multi-disciplinary learning. We were advised that the community mental health team at Queen Margaret's Hospital had not long been established and would take some time for trainees to embed as part of the team.

Trainers: Trainers advised that multi-disciplinary staff were invited to attend training sessions. There are also weekly community mental health team meetings and the trainees work with nurses to carry out joint assessments.

3.8. Adequate Experience (quality improvement) (R1.22)

Trainees: All level of trainees advised that they had access to audits but not all had completed. We were given examples of different projects carried out by trainees and advised they had been supported in these by their supervisors.

Trainers: Trainers advised there is good R&D support in Fife to allow trainees to access audit and quality projects. Trainees can present projects at teaching sessions. NHS Fife have good links with St Andrews University to allow trainees to carry out research projects.

3.9. Clinical supervision (day to day) (R1.7, 1.8, 1.9, 1.10, 1.11, 1.12, 2.14, 4.1, 4.6)

FY/GP Trainees: Trainees advised that they have a list of mobile phone numbers for contacting on call consultants out of hours and feel they are approachable. Sometimes at out of hours they felt pushed out-with their comfort zone but there are experienced nurses to provide support.

Core/Higher Trainees: Trainees felt there was always support available. We were told of an example where a trainee felt out-with their level of competence however this was raised and used as a learning opportunity.

Trainers: Trainers told the panel that FY/GP and Core trainees cover the same rota and staff should be aware of the level of supervision required. Trainers were unaware of instances of trainees dealing with problems they felt were beyond their level of competence.

Non-Medical Staff: Nursing staff seemed unaware of the colour coded badge system in place to identify the different levels of trainees and their level of competence. Nursing staff would raise concerns regarding trainees with their supervisors.

3.10. Feedback to trainees (R1.15, 3.13)

FY/GP Trainees: Trainees advised that they did not receive formal feedback, cases would be discussed at ward rounds.

Core/Higher Trainees: Trainees advised that they receive feedback on patients seen in clinics and they can take cases to supervision to discuss with their supervisor. They felt that they would not receive feedback on cases seen out of hours.

Trainers: Trainers advised that they had received training on providing constructive feedback and trainees received feedback both on an informal day to day basis and at weekly supervision sessions.

3.11. Feedback from trainees (R1.5, 2.3)

Trainees: Trainees were aware of the National and Scottish Training Surveys to enable them to provide feedback on their training. The panel were told prior to the visit that the higher trainee had run a session to source feedback on training. There is no formal trainee forum in place.

Trainers: The panel were told that there are no formal processes in place to gather feedback from trainees regarding their experience within departments. However, the NTS results are analysed and discussed by each site.

3.12. Workload/ Rota (1.7, 1.12, 2.19)

FY/GP Trainees: Trainees felt that workload was manageable during the day and out of hours work was varied but could be very busy. Trainees based at Ravenscraig advised that there was a recent issue with the rota which resulted in there being no cover available one day due to annual leave and night duty. The trainees were unaware in advance of this clash and have now undertaken to be aware of the rota and take responsibility for gaining cover for their annual leave to ensure there is always ward cover. The trainees thought that it would be beneficial to be made aware in advance of their responsibility in avoiding these clashes, so

they can manage cover and for the Rota to be more transparent, so any shortfalls of cover are obvious. Foundation trainees also raised concerns regarding Rota clashes at Queen Margaret Hospital and advised that on occasion all the General Adult Psychiatry (GAP) trainees are off site for different reasons and trainees based in Old Age Psychiatry (OAP) are expected to cover their ward. It was felt this is not always appropriate as they are not trained in those patient's needs.

Core/Higher Trainees: Trainees felt that the workload was manageable during the day but busy when on duty out of hours, which is a 24hr shift. Core trainees also relayed concerns about the Rota clashes as the Urgent Care and Assessment Team (UCAT) Rota does not take into account the other rotas, so wards can be left with no one on shift. This may raise patient safety concerns if inadequate cover is in place.

Trainers: Trainers felt that covering out of hours gives trainees a wider training experience. The panel were told that the sites were aware of some areas where there is a problem providing cover for trainees, which can impact on training and they are currently looking into developing Advanced Nurse Practitioner roles to relieve this.

3.13. Handover (R1.14)

FY/GP Trainees: Trainees advised that there have been recent improvements to the handover system. There is an email handover in place to capture details of clinical issues and there is now a conference call in the mornings with multi-disciplinary staff participation from all sites. This has only been in place for several weeks but was felt to be useful. It was felt that if there was anything urgent to handover a call to UCAT would be welcomed.

Core/Higher Trainees: Trainees advised that there is an email handover system in place and they are all aware to check the inbox when they arrive on shift for any updates. Trainees confirmed that the introduction of the new handover call and thought this was effective.

Trainers: The panel were told that trainees in previous years raised concerns regarding the handover process, these were taken on board and a new procedure has been implemented in the last few weeks.

3.14. Educational Resources (R1.19)

FY/GP Trainees: The panel were informed that there is one computer at Queen Margaret's Hospital for use by six junior trainees, which was felt to be inadequate. The trainees have raised this concern with the site. We were told there is one computer between four on Lomond ward which can also prove a challenge to access. Trainees advised they have trouble accessing the doctors room on the GAP ward in Queen Margaret's Hospital.

Core/Higher Trainees: Trainees felt that accessing computers at Queen Margaret's Hospital was becoming increasingly difficult. They have raised this issue without resolution. There is currently one computer shared among six trainees. Trainees based at other sites didn't raise concerns regarding computer access.

Trainers: N/A

3.15 Support (R2.16, 2.17, 3.2, 3.4, 3.5, 3.10, 3.11, 3.13, 3.16, 5.12)

FY/GP Trainees: Most trainees felt there would be support given for trainees who were struggling.

Core/Higher Trainees: Most trainees thought support would be available for trainees who were struggling. We were advised of challenges with less than fulltime working due to the workload.

Trainers: N/A

3.16 Educational governance (R1.6, 1.19, 2.1, 2.2, 2.4, 2.6, 2.10, 2.11, 2.12, 3.1)

Trainees: Some trainees were aware that the DME and education manager were responsible for the quality of the education at sites.

Trainers: Trainers were aware that the DME Dr Morwenna Wood was responsible for the educational governance in Fife.

3.17 Raising concerns (R1.1, 2.7)

Trainees: N/A

Trainers: N/A

3.18 Patient safety (R1.2)

FY/GP Trainees: Trainees advised that if a friend or relative was admitted they would have some concerns regarding the medical care they would receive due to known issues with some ward-based prescribing issues for patients.

Core/Higher Trainees: Some trainees advised that they would have concerns if a friend or relative was admitted to Queen Margaret's Hospital. We were told that this is a large, very busy ward and it was reported that it is hard to provide patients a high level of care with an element of risk due to the workload for junior doctors.

3.19 Adverse incidents (R1.3)

FY/GP Trainees: Trainees advised that they had not had any adverse incidents to report but were aware of the Datix system. They had not been involved in any shared learning or feedback from incidents.

Core/Higher Trainees: No trainees present had reported an adverse incident but were aware of Datix. The higher trainee had observed a review as part of training. Trainees had not received shared learning or feedback from reviews.

Trainers: Trainers provided us with details of a new adverse incident procedure which has been implemented. Incidents are now assessed and either reviewed locally or passed onto the clinical governance team if it is felt to be a significant incident. A report would be produced, and feedback would be provided to those involved.

3.20 Duty of candour (R1.4)

Trainees: We were told of an incident where a trainee was assaulted at work by a patient and was supported following this with changes in procedures being put in place as a result.

Trainers: N/A

3.21 Culture & undermining (R3.3)

Trainees: Trainees gave examples of incidences of undermining and bullying behaviour by senior colleagues across different sites.

Trainers: The panel were told there are two ADMEs in post in Fife who have regular meetings with the DME where any bullying or undermining concerns would be discussed, and action taken. There was an awareness of incidents in the past which were investigated, and action taken. It was not felt there was a culture of bullying within the psychiatric department.

3.22 Other

We were made aware of trainee safety concerns by some trainees, as trainees of all levels told us that they were not routinely provided with alarms and there was a known shortage of alarms. We were also told that some treatment rooms are a distance from the wards and trainees don't have access to alarms whilst in consultations.

4. Summary

Is a revisit required?	Yes	No	Highly Likely	Highly unlikely

We were told there have been staffing issues in recent years following a number of consultant retirements which provided challenges in providing training, for example in induction and supervision. It was clear that the trainees' feedback has been taken on board and changes have recently started to be put in place to formalise and improve these processes, and we would encourage these improvements to be maintained and monitored.

In response to the poor feedback from trainees at Queen Margaret Hospital, and especially GP Specialty Trainees, and in recognition that we were unable to interview any from there on the day we have sent a DME enquiry asking the DME team to provide an update report on the training experience and plans for improvement. We have requested a similar report regarding Foundation trainees based at Stratheden Hospital due to a lack of attendance from the site on the day.

We have highlighted below both the positive aspects from the visit, and some areas for improvement and requirements.

Positives:

- Changes have been implemented to improve handover, including the introduction of a teleconference across sites with multi-professional staff attendance
- Programme of well-established three-term local teaching rotating around sites, which is generally protected
- Strong support for release to regional teaching for core trainees, which is reported to be of high quality
- Buddying arrangements for supervision for trainees as a pragmatic response to the need for Consultant locum use
- Consultant input, and cohesive approach to maximise learning opportunities & address training challenges
- Strong support for quality improvement and audit
- Clinic experience for all levels of trainee with good access to consultant support

5. Areas of Good Practice

Ref	Item	Action
5.1	Supervision	Buddying system to ensure trainees all have a substantive Consultant as clinical supervisor.

6. Areas for Improvement

Ref	Item	Action
6.1		Queen Margaret Hospital is a concern with poor feedback from trainee surveys especially GPST but, disappointingly we saw no GPSTs from this site on our visit. We heard of busyness, staffing concerns and a feeling of a risky environment.
6.2		A lack of clarity around responsibility for rostering especially in Ravenscraig & Queen Margaret Hospital, leading to patient safety concerns.

6.3		Being on-call for multiple sites provides challenges for trainees in getting feedback on their OOH work
6.6		There was a lack of awareness amongst nursing staff regarding the colour coded badge system for identifying the levels of trainees.
6.7		

7. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
7.1	Departmental induction must be provided which ensures trainees are aware of all of their roles and responsibilities and feel able to provide safe patient care. Handbooks may be useful in aiding this process but are not sufficient in isolation	9 months	All
7.2	There must be active planning of attendance of doctors in training at teaching events to ensure that workload does not prevent attendance.	9 months	FY and GP
7.3	Trainees must have access to personal alarms and appropriate training on how to use them.	immediate	All
7.4	Trainees must receive consistent weekly sessions with their appointed supervisor.	9 months	All
7.5	A trainee forum should be established and supported so trainees can safely raise concerns and provide feedback.	9 months	All
7.6	Provide routine team-based opportunities for trainee learning from clinical incidents/DATIX.	9 months	All
7.7	Provision of additional workstations to enable trainees to fulfil their workload and educational requirements.	9 months	All
7.8	Zero tolerance of undermining behaviours must be promoted.	9 months	All