

Scotland Deanery Quality Management Visit Report



Date of visit	31 January 2019	Level(s)	FY/GP/Core
Type of visit	Revisit	Hospital	Argyll and Bute Hospital
Specialty(s)	Mental Health	Board	NHS Highland

Visit panel	
Claire Langridge	Visit Chair
Geraldine Brennan	Quality Lead
Stuart Ritchie	Programme Director Rep
Dawn Mann	Quality Improvement Manager
Archie Glen	Lay Representative
In attendance	
Patriche McGuire	Quality Improvement Administrator

Specialty Group Information		
Specialty Group	Mental Health	
Lead Dean/Director	Ronald MacVicar	
Quality Lead(s)	Claire Langridge and Alastair Campbell	
Quality Improvement Manager(s)	Dawn Mann	
Unit/Site Information		
Non-medical staff in attendance	3	
Trainers in attendance	5	Consultants including ES
Trainees in attendance	4	1 FY2, 1 GP, 2 Core
Feedback session: Managers in attendance	10 attended including DME and ADME	

Date report approved by Lead Visitor	28 February 2019
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1. Principal issues arising from pre-visit review

This was a revisit following a triggered visit on 30 January 2018 which highlighted the following requirements:

- Trainees told us of differing management approaches amongst the senior staff, including variation in adherence to referral pathways that had put a trainee in a position of personal risk on more than one occasion. Trainees can feel 'caught in the middle' of decision making. These issues must be addressed as a matter of priority.
- There has been a pattern of over-filling trainees' clinics, both in terms of numbers and case-mix. There is an awareness of this issue and it has been addressed with some change in approach. The trainees that we talked to confirmed that this change has occurred. This change must be maintained.
- Induction was described as '*pretty bad*', '*not good*' or '*non-existent*' depending on which group we talked to. This must change and we were pleased to hear of the detailed plans and programme for the coming trainee change-over. There is an opportunity to include the wider team in this process and in particular, we would encourage the involvement of the senior nurses in ensuring the proper implementation of personal alarms (R1.13)
- The Core Trainees that rotate through the Argyll and Bute Hospital are in the first year of their psychiatry training and their experience must be foundational and address curricular needs rather than supervisors' special interests. There is an awareness of this issue and it has been addressed with some resulting change in approach. The trainees that we talked to confirmed that this change has occurred. This change must be maintained. (R1.15)
- There has been a pattern of distant supervision for very junior trainees with those trainees feeling exposed. This has been recognised and working patterns have changed since the changes in educational leadership, with a policy now that '*lone working has been absolutely stopped*'. The trainees that we talked to confirmed that this change has occurred. This change must be maintained. (R1.8)
- Doctors in training must receive feedback on incidents that they raise and there must be a forum for learning from adverse events (R1.4)

The following areas for improvement were also highlighted:

- Trainees carry the load of medical management of in-patients who are now situated in the Mid Argyll Hospital. Medical support has historically been provided from the Lorn and the Isles Hospital in Oban which is one hour away, despite there being a staffed intermediate care facility onsite. We would urge the Health Board to put in place the necessary arrangements/ agreements to ensure that trainees are better supported in managing medical issues by enabling them to access this on-site support
- The on-call Rota is described as a 'feast or a famine'. The trainee group could not however come up with a better model than is currently in place but we heard of a pattern of clinics being booked after a night on-call and would ask that this be revisited
- We heard of training needs for the senior staff in terms of their approaches to workplace assessment and their approaches to providing feedback. We would encourage the use of the academic programme sessions as an ideal time to learn together with the trainee group
- We heard of plans to establish a trainee forum and would strongly encourage this development
- Trainees reported to us that there is a lack of available computer access for them in the ward and we would ask that this be addressed.

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*.

The visit will assist the units in identifying strengths and areas for improvement and is an opportunity for trainees and trainers to raise current issues relating to postgraduate medical education and training with Deanery staff. It will also give the Deanery an opportunity to assess if improvements have been made since our last visit.

2. Introduction

The Argyll and Bute hospital is based in Lochgilphead and covers the whole of Argyll and Bute. Psychiatric inpatient care was transferred to the Mid Argyll Community Hospital in July 2017. There are currently 1 FY2, 1 GP and 2 Core Trainees based at the site.

The visit team met with Foundation, General Practice and Core trainees as well as senior Nursing staff, Educational Supervisors and members of the senior management team. The panel wish to thank the site for their organisation and support of the visit.

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.

3.1 Induction (R1.13)

Trainers: The panel were told the induction has been revised and an induction booklet introduced. Unfortunately, the trainees did not receive the induction booklet until after the induction. This will be addressed for future sessions. The induction included a session by Pharmacy and one by the administration staff. Previous feedback was that the volume of information was overwhelming, so some topics are now covered as training sessions in the first few months of placements. Trainees were sent IT forms prior to starting their placement to ensure passwords were in place on the day however there were still problems with this that have proved challenging to resolve, trainers advised they have requested access to IT support on the day for the next induction session.

Non-Medical Staff: The panel were advised nursing and social work staff are not involved in the current induction but would be happy to participate.

Trainees: Trainees advised they did receive an induction at the start of placement however they did not all receive the handbook or have IT passwords prior to this. Trainees advised that they still don't have access to certain systems or have to use a generic log in. The induction included a walk round of the ward and involvement from admin staff. Trainees advised the induction did not leave them feeling prepared for their role especially if they were new to Psychiatry. Suggested improvements include; information on what is expected from trainees, what their day to day role will be like, the mental health act, how to arrange an admission, how to complete relevant forms and how to do dictation. It was also felt it would be helpful to have involvement from senior nursing staff and AHPs and if possible from current/previous trainees.

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

Trainers: The site has a new consultant who will now act as clinical lead for teaching. Currently there is a journal club with case presentation on a Monday for all trainees and a more academic session on a Friday. There is also a weekly Balint group in place. The panel were told that one trainee will have the bleep, but it is not common for it to go off and no scheduled activity will be put on trainees' timetables for teaching time. Trainees get protected time to attend Regional teaching sessions.

Trainees: Trainees advised there is a Monday teaching session involving a case presentation by a trainee and journal club. There is also a Friday teaching session led by the new clinical tutor which involves a variety of speakers, followed by Balint group. Trainees felt the teaching could be better aligned to their various curricula. If a trainee has worked through the night, they will miss Monday teaching, but we were told that is not a common occurrence. Trainees advised they all had protected time for regional teaching.

Non-Medical Staff: The panel were informed that historically non-medical staff were not involved in teaching sessions, but the new clinical tutor is keen to involve everyone. It was thought if the teaching took place at the new hospital this would be easier to achieve.

3.3 Study Leave (R3.12)

Trainers: Trainers were not aware of any trainee concerns regarding study leave.

All trainees: No trainee reported having problems getting study leave.

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

Trainers: Due to limited consultants core trainees will all have the lead clinician as their educational supervisor. Trainees will be advised of their clinical supervisor approximately 3 weeks before starting their post. We were informed a training session was held following our

last visit for trainers. All trainers have allocated time in their job plan and their role will be discussed at appraisal.

Non-Medical Staff: It was felt that if a consultant is in clinic trainees can find it challenging contacting them for support. We were told that bed management was a big problem for trainees.

Trainees: All trainees were aware of who their educational supervisor was and had met with them.

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

Trainers: Following the last Deanery visit clinics for trainees have been revised and each trainee is now allocated 1 clinic per week. Trainers viewed the wide range of patients at the site as an educational strength. Trainers raised concern regarding trainee involvement in bed management, when the hospital is at capacity it has been falling to the trainee doctors to secure a bed for patients. This is a time consuming, non- educational task which is felt should not be the role of trainees. This concern has been raised with local management, but no alternative arrangements have been agreed.

Trainees: Trainees felt the placement allowed them to see a diverse range of patients and provided good exposure. As there are no registrars they have direct contact with the consultants which has educational benefits. It was felt it can be tricky to get access to ECT training due to limited sessions. Trainees felt the educational balance between work and service provision for tasks like bloods and ECG was good however all trainees voiced concern regarding the time spent on bed management. Trainees advised that currently there is no-one responsible for bed management so if the ward is full and a patient needs to be admitted, trainees can spend up to 4 hours a day calling round other hospitals which impacts negatively on their training.

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

Trainers: The panel were informed that Foundation trainees had to inform supervisors of recent curriculum changes as this information had not been communicated to them. Trainers felt it was easy for trainees to achieve their competencies.

All Trainees: Trainees felt it was easy to complete assessments and these were consistent among substantive consultants, but the quality could vary among locums.

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

Trainers: A morning huddle was introduced shortly before the previous visit which includes trainees, consultants and multi-disciplinary staff (MDT) and has been successfully maintained. It is felt this is used as a learning opportunity. VC facilities have been introduced to community sites to allow everyone to attend MDT meetings which the trainees are invited to.

Non- medical Staff: The panel were advised the morning huddle is used as a learning opportunity and is attended by trainees, consultants and nursing staff. We were told that VC is now used to make it easier for community MDT staff to attend meetings.

Trainees: Trainees advised there are numerous opportunities for multi professional learning including ward rounds, pharmacy teaching sessions and weekly VC MDT meetings.

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

Trainers: It was felt trainees are supported to carry out quality improvement and audit projects.

Trainees: Some trainees were involved in quality management projects and all trainees had been offered opportunities and support.

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)

Trainers: Trainees are advised who to contact for support both during the day and out of hours at induction. Trainers were not aware of instances where trainees have had to deal with problems beyond their competence and advised that consultants stay onsite whilst on call so

are easily accessible for advice. The trainers were unaware of the GMC recommended colour coded badge system to help identify doctors at different stages of training and so this has not been introduced.

Non-medical Staff: Staff advised they were not explicitly told the level of trainees and there was an expectation that the same level was sent to the same sites each rotation. The coloured badge system is not in place. When asked if there were instances trainees were expected to carry out duties out with their experience we were advised that trainees are expected to find beds for patients when the site is full, and this is not their role.

Trainees: The panel were told trainees were always aware of who to contact for support both during the day and out of hours. Trainees felt senior colleagues are supportive and approachable. Not all trainees received regular weekly supervision, there did not appear to be timetabled slots for supervision and the trainees were required to do some chasing to ensure it was carried out. It appeared not all clinical supervisors were substantive consultants.

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

Trainers: Trainers advised trainees work closely with consultants due to the size of the site and felt they received regular feedback. Cases would also be discussed at the morning huddle and feedback provided.

Trainees: Trainees were comfortable they received constructive and regular feedback directly from consultants and at the morning huddle.

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

Trainers: Trainers advised trainees are encouraged to provide feedback within supervision sessions and feedback has been requested following recent induction and teaching changes. Changes have been implemented following trainee feedback.

Trainees: Trainees told us there is a regular consultant meeting and a trainee representative is expected to attend for the first part to feed in any concerns they may have. Trainees felt comfortable providing feedback to their clinical and educational supervisors.

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

Trainers: Rota monitoring has taken place and the current rota is believed to be compliant. Following our previous visit, a rest day has been introduced following weekend on call if the trainee advises they have been called out during the night. The standard rota is issued to trainees from management and trainees are responsible for identifying clashes and swapping shifts accordingly.

Trainees: Trainees felt the rota was manageable both during the day and out of hours and had no implications for patient safety. We were told nursing staff are highly skilled and resourceful and mindful of when it is appropriate to call in a junior doctor. We were told that since the last Deanery visit rest days have been introduced following weekend on call. It is the responsibility of the trainee to advise if they have worked overnight and the Monday clinic will be cancelled. Trainees asked if they could get advice from consultant staff as to whether they should cancel their clinic. Trainees asked for more involvement producing the rota as originally it was incompatible, and this allows trainees to arrange swaps between themselves which are supported by the site.

3.13. Handover (R1.14)

Trainers: The morning huddle has been maintained to ensure an effective handover.

Trainees: As the on call is 24 hour or a full weekend this reduces the need for trainee handovers. There is a morning huddle every weekday attended by all levels of staff which includes handover and a written record is kept. A less formal morning huddle takes place at weekends. Trainees will review patient charts from overnight.

Non-Medical Staff: It was felt the morning huddle was an effective handover.

3.14. Educational Resources (R1.19)

Trainers: trainers advised there is a Library on site and problems have been resolved so there is now Wi-Fi access available at trainee's residence. The panel were told trainees now have access to an office on the ward with two computers and a printer.

Trainees: Trainees advised that recently they have been given an additional computer so there are now two computers in a shared room for trainees to access. Trainees advised it has been difficult to get appropriate IT access and passwords with some still not having appropriate access months after starting their placement. Some trainees use generic log ins which they reported were non-auditable and were felt to be not ideal.

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

Trainers: The panel were advised there is a monthly senior medical staff meeting held where a trainee representative attends for part of the meeting to feedback concerns regarding training.

Trainees: It was felt support would be available for trainees who were struggling with the job or health issues.

Non-Medical Staff: Non- medical staff advised they would be comfortable raising concerns regarding trainees' behaviour with consultants or the clinical lead.

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

Trainers: The site has a good relationship with the DME office who manage the quality of education. A consultant representative attends monthly west of Scotland meetings.

Trainees: Trainees were unaware of who is responsible for the quality of education and training at the site.

3.17 Raising concerns (R1.1, 2.7)

Trainers: The panel were advised that trainees can raise patient safety concerns at the morning huddle, monthly senior medics meeting or directly with the consultants.

Trainees: Trainees advised they would raise concerns through Datix, at the morning huddle or direct with consultants.

3.18 Patient safety (R1.2)

Trainers: Since the last Deanery visit there is now onsite medical care available for patients which it was felt makes the environment safer for patients. The trainers advised all trainees should now have access to personal alarms and don't feel there are any remaining safety concerns for trainees. The morning huddle allows the safety of patients to be discussed, trainee doctors are involved with the huddles.

Non-medical Staff: Staff felt the site was a safe environment for patients and trainees. They advised there is a morning safety huddle where safety concerns can be raised and a 4 weekly SPSP meeting.

Trainees: Trainees would have no concerns for the safety or care of a friend or relative who was admitted to the site. We were advised there have been some logistical problems with boarding patients due to a reduction in beds in the ward. On the whole trainees felt patients who are boarded receive the same quality of care.

3.19 Adverse incidents (R1.3)

Trainers: The panel were advised adverse incidents were reported through Datix and the allocated consultant is responsible for providing the trainee who raised it with feedback. The clinical governance board will decide if a serious adverse event review (SAER) should be carried out. All staff involved in the incident should be involved in this and feedback provided.

Non-medical staff: We were advised adverse incidents would be reported through the Datix system and adverse incident review meetings take place occasionally where feedback would be given.

Trainees: Trainees advised they would raise adverse incidents through the Datix system. We were given an example of a trainee who had raised an incident with support from nursing staff. Trainees had not received feedback from incidents and were not involved in incident reviews. Some trainees were aware of SPSP meetings but had not attended.

3.20 Duty of candour (R1.4)

Trainers: Trainers felt trainees were encouraged to be open and honest when talking to staff and patients and that consultants model this behaviour. It was felt that Balint group would also provide a confidential environment to discuss incidents that went wrong. Consultants have not received formal duty of candour training.

All Trainees: All trainee groups advised they felt they would be supported if an incident occurred and were encouraged to raise Datix's.

3.21 Culture & undermining (R3.3)

Trainers: The panel was advised that there were no known concerns of bullying or undermining. Trainers felt that due to the small site there is a positive team culture, and this is encouraged with a bi-annual loch swim. As trainees work closely with senior medical staff it is felt they are comfortable raising concerns and we were given examples of junior doctors raising concerns directly with the clinical lead which were acted upon.

Non-medical Staff: The non-medical staff advised they had not witnessed undermining or bullying towards the trainees and if they had concerns there is an independent complaints procedure in place. It was felt that the site fosters a small, close knit team and encourages good working environments.

Trainees: The trainees had no concerns regarding undermining or bullying behaviour towards the trainees in the workplace. Trainees felt there had been significant changes since the last Deanery visit, with a positive impact. Trainees advised they felt valued and supported at the site.

3.22 Other

Trainees: Trainees raised concerns regarding the unlit walk from the residence to the Hospital.

4. Summary

This was a revisit following a triggered visit to the site in January 2018. At our visit we met with an engaged and enthusiastic group of consultants, with representatives of the nursing staff and MDT professionals and with a mixed group of learners, including two core trainees, one GP Specialty Trainee and one Foundation Trainee.

When trainees were asked to score their overall satisfaction with their post, with 0 being very dissatisfied and 10 very satisfied, the following scores were recorded between 7 and 8 with an average of 8.

The following is a record of the requirements highlighted at the previous visit and any action that has been taken:

- Trainees told us of differing management approaches amongst the senior staff, including variation in adherence to referral pathways that had put a trainee in a position of personal risk on more than one occasion. Trainees can feel 'caught in the middle' of decision making. These issues must be addressed as a matter of priority.

Action: There has been a change in senior medical staff which appears to have alleviated this concern.

- There has been a pattern of over-filling trainees' clinics, both in terms of numbers and case-mix. There is an awareness of this issue and it has been addressed with some change in approach. The trainees that we talked to confirmed that this change has occurred. This change must be maintained.

Action: Trainees confirmed the changes had been maintained.

- Induction was described as 'pretty bad', 'not good' or 'non-existent' depending on which group we talked to. This must change, and we were pleased to hear of the detailed plans and programme for the coming trainee change-over. There is an opportunity to

include the wider team in this process and in particular, we would encourage the involvement of the senior nurses in ensuring the proper implementation of personal alarms (R1.13)

Action: It was evident changes have been made to the induction programme, however there are still areas that could be improved as trainees did not feel it adequately prepared them for their role.

- The Core Trainees that rotate through the Argyll and Bute Hospital are in the first year of their psychiatry training and their experience must be foundational and address curricular needs rather than supervisors' special interests. There is an awareness of this issue and it has been addressed with some resulting change in approach. The trainees that we talked to confirmed that this change has occurred. This change must be maintained. (R1.15)

Action: Changes were evident which addressed this concern.

- There has been a pattern of distant supervision for very junior trainees with those trainees feeling exposed. This has been recognised and working patterns have changed since the changes in educational leadership, with a policy now that '*lone working has been absolutely stopped*'. The trainees that we talked to confirmed that this change has occurred. This change must be maintained. (R1.8)

Action: These changes have been maintained and there was no evidence of lone working.

- Doctors in training must receive feedback on incidents that they raise and there must be a forum for learning from adverse events (R1.4)

Action: There was still no evidence of shared learning for trainees following adverse incidents.

There were also several areas for improvement highlighted at the last visit which are listed below along with an update from this visit.

- Trainees carry the load of medical management of in-patients who are now situated in the Mid Argyll Hospital. Medical support has historically been provided from the Lorn and the Isles Hospital in Oban which is one hour away, despite there being a staffed intermediate care facility onsite. We would urge the Health Board to put in place the

necessary arrangements/ agreements to ensure that trainees are better supported in managing medical issues by enabling them to access this on-site support

Action: A new process has been successfully introduced which supports trainees in seeking access to medical care for patients on site if required.

- The on-call Rota is described as a 'feast or a famine'. The trainee group could not however come up with a better model than is currently in place but we heard of a pattern of clinics being booked after a night on-call and would ask that this be revisited

Action: Trainees confirmed they now have the option of cancelling a clinic to allow a rest day if they have been called out during the night.

- We heard of training needs for the senior staff in terms of their approaches to workplace assessment and their approaches to providing feedback. We would encourage the use of the academic programme sessions as an ideal time to learn together with the trainee group

Action: There appears to be greater consistency of approach among the substantive consultants, although the position in relation to locum staff was not clear

- We heard of plans to establish a trainee forum and would strongly encourage this development

Action: There is still no formal trainee forum, however a trainee attends the senior medical staff meetings

- Trainees reported to us that there is a lack of available computer access for them in the ward and we would ask that this be addressed

Action: An additional computer has been provided to trainees in the weeks prior to the current visit

We were pleased to see a number of positive changes implemented or maintained since our previous visit and hope to put Argyll and Bute Hospital back on the Deanery's scheduled visiting plan.

Is a revisit required?	Yes	No	Highly Likely	Highly unlikely
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We wish to share both some positive findings and some less positive areas below:

Positives

- Consultant staff who are supportive, engaged and promote a team culture.
- There have been clear positive changes in the provision for medical support on site.
- Changes to the Rota have been implemented to add a flexi rest day following night time on call.
- Improvements to the teaching programme and support for trainees to attend.
- There are no longer lone trainee clinics occurring and clinic workload has been reviewed.
- Safety concerns have been addressed and trainees have access to alarms.
- The maintenance of the morning huddle which encourages a safe training environment and provides an opportunity for feedback and learning.
- The breadth of training opportunities due to the diverse patient group and consultant staff expertise.
- High level of satisfaction among trainees.
- Use of VC facilities to allow attendance of rural staff for MDT meetings.
- Supportive and capable nursing staff.

Less Positive Areas

- GMC have recommended the introduction of colour coded badges to help identify the trainee's level of competence.
- The required 1-hour supervision is inconsistent and not formalised for some trainees.
- It was unclear if non-substantive consultants providing supervision meet the GMC requirements for Recognition of Trainers.

- There has been some improvement to the induction but the programme is still not adequate for trainees needs.
- A lack of shared learning from adverse incidents.
- Trainees should not be carrying out bed management duties.
- Inadequate access to IT support including passwords.

5. Areas of Good Practice

Ref	Item	Action
5.1	The introduction of VC facilities on wards and in the community, which allow a regular MDT meeting which includes trainees and is used as a learning opportunity.	

6. Areas for Improvement

Ref	Item	Action
6.1	Induction	Involvement of Senior Nursing/AHP/SW staff to support induction of doctors in training
6.2	Duty of Candour	Duty of candour training for senior medical staff involved in the supervision of doctors in training
6.3	Supervision	Consistent 1 hour weekly supervision with an appropriately trained supervisor for FY and GP trainees

7. Requirements

Ref	Issue	By when	Trainee cohorts in scope

7.1	All trainees must have timely access to IT passwords and systems training through their induction programme.	immediate	All
7.2	Bed Management tasks that do not support educational and professional development and that compromise access to formal learning opportunities for all cohorts of doctors should be reduced.	Immediate	All
7.3	Departmental induction must be provided which ensures trainees are aware of all of their roles and responsibilities. The induction booklet or online equivalent should be sent to all grades of trainees before commencing in post.	9 months	All
7.4	Formal, consistent weekly supervision should in place for trainees.	9 months	Core
7.5	There must be a process that ensures trainees understand, and are able to articulate, arrangements regarding Educational Governance at both site and board level.	9 months	All
7.6	The level of competence of trainees must be evident to those that they come in contact with. The use and promotion of colour coded badges as part of the GMC recommendations should be introduced.	9 months	All
7.7	Provide routine team-based opportunities for trainee learning from clinical incidents/DATIX.	9 months	All