<table>
<thead>
<tr>
<th>Date of visit</th>
<th>23 January 2019</th>
<th>Level(s)</th>
<th>FY, GP, Core and Higher</th>
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</thead>
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<tr>
<td>Type of visit</td>
<td>Enhanced Monitoring Revisit</td>
<td>Hospital</td>
<td>Pan Tayside</td>
</tr>
<tr>
<td>Specialty(s)</td>
<td>General Adult Psychiatry Services</td>
<td>Board</td>
<td>NHS Tayside</td>
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**Visit panel**

- Clare McKenzie: Visit Chair – Regional Postgraduate Dean
- Chris Lawler: GMC Visits & Monitoring Manager
- Rosie Lusznat: GMC Enhanced Monitoring Associate
- Stuart Holmes: Lay Representative
- Claire Langridge: Associate Postgraduate Dean – Quality
- Dawn Mann: Quality Improvement Manager
- Wai Lan Imrie: Training Programme Director
- Ken Lee: Assistant Director GP
- Rekhe Hedge: Foundation Programme Director
- Hannah Austin: Trainee Associate

**In attendance**

- Gayle Hunter: 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: 6 Senior Nursing Staff
- Trainers in attendance: 18 Including ADME and TPD
- Trainees in attendance: 3 FY, 2GP, 9 CT and 11 ST
- Feedback session: Managers in attendance: 23 including Chief Executive, ADME’s Medical Education Manager

**Date report approved by Lead Visitor**

- 25 February 2019
1. **Principal issues arising from pre-visit review**

The recommendation was made to place General Adult Services across Tayside onto enhanced monitoring at the previous visit on 3rd May 2018, following a number of visits to Murray Royal Hospital and Pan Tayside. This visit was an enhanced monitoring visit in conjunction with GMC.

2. **Introduction**

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 below includes numeric reference to specific requirements listed within the standards.

The panel met with Trainers and Non-Medical staff as well as the following trainee groups:
- Foundation Trainees
- GP Trainees
- Core Trainees
- Specialty Trainees

The visit team also took the opportunity to gain a broader picture of how training is carried out within the department and to identify any points of good practice for sharing more widely.

An update was provided by the management team at the visit, including the following information:

- A new AMD has been appointed
- The Teaching and Training Management Group (TTMG) which has a recurring agenda point to review the visit requirements and has trainee representation.
- They feel that they have set positive foundations to effect change but recognise that further work is required
3.1 Induction (R1.13)

**Trainers:** The panel were advised a comprehensive two-day induction is in place for trainees across Tayside. This includes sessions on the Mental Health act, roles and responsibilities and tours of the hospital. Since our last visit a junior and higher trainee handbook is in place. If trainees are unable to attend on the day the expectation is their educational supervisor (ES) would provide the information they need to prepare them for their role. Passwords should be issued by administrators prior to the trainees starting, we were told it has proved challenging to provide onsite IT support.

**Non-medical staff:** Senior nursing staff advised they are involved in the trainee’s induction programme and provide sessions including personal safety and the Datix system. They feel it is helpful for sessions to be carried out by someone with personal experience however this is not always the case. We were advised they felt that overall the induction prepares the trainees for their role.

**FY and GP Trainees:** Trainees confirmed they had received an induction. When the induction took place not all trainees knew the ward they would be based on so didn’t receive specific ward information. Most trainees felt the induction was good and the topics helpful. It was felt it would be useful to have more information of the on-call system at induction. Several trainees did not have IT access prior to starting their role and had to wait several days for this to be set up, this was particularly problematic if trainees were scheduled for on call. Trainees advised they had received a handbook which they felt was useful and thorough, however there are known discrepancies between the junior and higher trainee handbook.

**Core Trainees:** Trainees advised they had all received inductions sessions, including ward inductions and they felt the sessions met their needs. Trainees told us they are all able to attend as existing trainees are asked to cover on call duty at this time. Some trainees did not have IT access at the start of their placement.

**Higher Trainees:** Most higher trainees had not had induction since our last visit. Those who had advised it was mainly run by trainees and felt it would be good to have consultant involvement. The panel were told there is now a higher trainee handbook in place however
there are discrepancies between the higher and junior handbooks. The trainees advised clarity is needed to confirm if Liaison assessments should be carried out by Core or Higher trainees. Trainees have tried to seek clarity on this and not had confirmation. We were told this is causing daily problems and has become a ‘flash point’ between the trainee groups.

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

Training: Since our last visit a new teaching program has been established on a Thursday morning for all psychiatry trainees and consultants, which we were told has been well attended. We were advised the service has carried out two surveys and received positive feedback on the sessions from trainees. The panel were made aware there are still some practical difficulties, but these are being worked on.

Non-medical staff: Nursing staff were aware of the new teaching programme and advised they support trainees to attend.

FY and GP Trainees: Trainees felt the Thursday teaching sessions were good however felt that sometimes the discussions were high level and it would be helpful to have some more basic topics aimed at FY/GP level. Trainees also felt it would be helpful to be able to attend via VC sometimes.

Core Trainees: Trainees advised the Thursday morning teaching sessions are well established and consist of a 45-minute trainee led session and a 45-minute consultant led session. They liked that all levels attended and felt the teaching was of a good standard. Some trainees had difficulty attending the sessions as they had clinics at this time. If the trainee was leading a session, they were permitted to cancel their clinic. They felt VC could be helpful to allow attendance if you had clinics or meetings to attend and couldn’t travel. Trainees advised they sometimes have monthly clinical skills training but felt this was ad hoc.

Higher Trainees: The higher trainees felt the Thursday sessions were of a good standard. Most were able to go but sometimes they were too busy to attend. It was felt VC facilities would help them to attend more consistently. The panel were told there is a General Adult Psychiatry (GAP) teaching program in its infancy. This was set up previously but fell into abeyance
following the previous Deanery visit. Efforts have been made to re-establish this and a session has taken place with several more scheduled albeit some without confirmed topics/speakers.

3.3 Study Leave (R3.12)

N/A

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

**Trainers:** The core training programme director explained that core trainees are asked to rank their top three placements, and this is used to allocate trainees with clinical and educational supervisors. There has been a recent half day training event for trainers which received positive feedback. The panel were advised there have been challenges in the past getting supervisors due to a lack of substantive consultants, it is felt this is improving. We were advised there can be difficulty in getting Foundation supervisors as trainers feel they do not have adequate time for the role. There has recently been a GP lead appointed.

**Foundation and GP Trainees:** Trainees had an appointed educational supervisor however we were advised there was no process to provide cover for supervisor sick leave.

**Core Trainees:** Trainees confirmed they all had an appointed educational supervisor.

**Higher Trainees:** Trainees confirmed they all had an appointed educational supervisor. We were advised that some trainees have the same person as their clinical supervisor, educational supervisor and training programme director. It was felt this could be problematic if they required a second opinion or wanted to raise a concern regarding their supervision.

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

**Trainers:** We were advised that on occasion trainees have asked consultants to carry out workplace-based assessments during OOH and consultants have not felt able to support this due to work demands.
**Foundation and GP Trainees:** The GP trainees felt on the whole they have access to a range of opportunities and felt the outpatient clinics provided good training experience. Foundation trainees had varied views of the benefit of their role. Some trainees gain from the opportunity to be in the wards and with their consultants in clinics/community. For others their workload was unstructured resulting in difficulty gaining competences and developing as a doctor in the psychiatry placement and consequently feeling similar to a medical student.

**Core Trainees:** It was felt that OOH work allowed good access to emergency assessments but can be very busy. Trainees felt that General Adult Psychiatry and Old Age ward roles in particular are very busy with service demands which can limit their educational opportunities. We were given examples of trainees having to sideline educational tasks in order to meet service demands. The panel were advised they have raised these concerns and made a suggestion of appointing a physician’s assistant which would relieve them of some non-educational tasks, but they have been advised there are no available resources to support this.

**Higher Trainees:** It was felt the balance between education and service requirement was better for higher trainees than at core level.

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

**Foundation and GP Trainees:** GP trainees felt they were able to achieve their competencies. As above, some Foundation trainees felt the limited workload during the day impacted their ability to achieve competencies. This had been raised with supervisors with mixed responses.

**Core Trainees:** Trainees advised it could prove challenging to complete ACES as the consultants run clinics at the same time as the trainee clinics meaning they are not available for joint sessions. They felt it would be beneficial if consultants had some time blocked off to facilitate these.

**Higher Trainees:** We were advised that work place-based assessments were achievable although not always possible to complete during OOH work.
3.7. Adequate Experience (multi-professional learning) (R1.17)

**Foundation and GP Trainees:** The panel were advised that on occasion nursing staff cannot carry out joint assessments due to work demands.

**Higher Trainees:** Trainees felt there were regular opportunities for multi professional working and learning.

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

**Trainers:** We were advised that since the previous Deanery visit there is a new process in place to engage trainees in audit processes. Processes to improve access to research is still a work in progress.

**Foundation and GP Trainees:** Some trainees were involved in audit projects.

**Core Trainees:** Not all trainees were getting access to audit projects.

**Higher Trainees:** Some trainees had problems accessing research opportunities and felt there was no real structure to allow them to access 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:** The panel were advised coloured lanyards have been introduced across Tayside to ensure staff can identify the level of trainees. There are also posters explaining this system displayed. We were advised there are lists available for trainees to identify who to contact for support whilst on call. It was confirmed that at trainee led clinics, consultants do not see patients jointly with core trainees however there is a contactable consultant on site. We were advised there has been a process introduced to prevent patients solely being seen at trainee led clinics however it is felt this is not always being adhered to with reports that some admin staff/stakeholders are not aware of the new process resulting in persistence of the trainee led clinics.
**Non-medical Staff:** Staff were aware of the coloured lanyard system to identify the competence level of trainees and consultants.

**Foundation and GP Trainees:** There is a long-standing problem with the phone signal in Murray Royal Hospital which can make it hard to contact people. Trainees are aware who to contact for emergency advice. We were told the process of who to contact in the community, following initial patient assessments, is complex.

**Core Trainees:** The panel were told of concerns regarding what were referred to as ‘SHO clinics’. Consultants run separate clinics at the same time as trainee led clinics so there is no opportunity for joint assessments. We were told they would always be able to get advice but there is no designated named contact and trainees would need to wait until a consultant was free. Patients are allocated to consultants based on the geography of the GP practice with patients at the trainee led clinics having a different consultant to the one the trainee is able to contact resulting in less continuity. There continue to be instances of trainees seeing patients for emergency assessment at these clinics without consultant supervision as these patients are being added to the trainee led clinic list by the admin/managers. At previous visits the concern was highlighted that patients could be seen by solely trainees for years. Trainees recognised attempts had been taken to improve this but, in most clinics, it was still occurring. It was felt part of the problem was that there were a large number of patients on the trainee led clinics which will take some time to move over to consultant clinics and there is difficulty facilitating this process.

**Higher Trainees:** Trainees advised they are aware who to contact but due to issues with the phone and wifi signal in certain sites it can be difficult and time consuming. We were told there is an excellent secretary who is helpful in finding people during the day.

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

**Trainers: N/A**

**Foundation and GP Trainees:** Trainees advised they would receive regular feedback from the consultants they worked with during the day. They felt it was more difficult to receive feedback OOH as consultants were at different locations.
Core Trainees: Trainees advised they receive feedback at weekly supervision sessions however this is retrospective and not always from the consultant involved. They felt it was difficult to get feedback on cases worked OOH and in clinic for the reasons noted above.

Higher Trainees: Trainees advised they can discuss cases at weekly feedback sessions, but they don’t receive feedback at the time from the consultant involved.

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

Trainers: The panel were informed that trainee forums have recently been set up. Guidance was sought from the Royal College on how best to set up the trainee forums. The service lead is aware that some trainees are having difficulty in attending these meetings and are looking for ways to assist.

Foundation and GP Trainees: Most trainees felt able to provide feedback at weekly supervision sessions. There has been a junior doctor forum established recently although not all trainees were aware of its existence. The panel were advised that through concerns raised by trainees they had recently secured an on-call bleep for those based at the Caresview Centre.

Core Trainees: Most trainees felt they could raise concerns regarding their education at weekly supervision sessions. Since the previous Deanery visit there has been a junior doctors forum established which feeds into the TTMG group however trainees felt that they have not received any feedback from concerns raised as yet. Some trainees had faced difficulty attending this meeting due to work demands.

Higher Trainees: Trainees advised they can provide feedback regarding the quality of education through the National Training Survey. They do have a monthly trainee group meeting however this is not minuted.
3.12. Workload/ Rota (1.7, 1.12, 2.19)

**Trainers:** Trainers advised there have been a great deal of changes made to the rota in the last 18 months to try and improve the trainees experience. It is a challenge to balance service provision with educational needs and there were trainees involved in the redesign. Trainees have raised concerns about cross site cover and rota monitoring is ongoing. There is currently no consultant in charge of the trainee or consultant rotas.

**Foundation and GP Trainees:** The trainees felt the rota did not impact on patient safety but advised that due to the cross-site cover model it could occasionally be challenging to provide timeous review. Not all Foundation trainees received a rota for their day to day duties.

**Core Trainees:** Trainees advised the rota is produced by trainees with no consultant support. We were told following our previous visit there was a process put in place to provide OOH sickness cover, but in a recent example this was not followed, leading to the process being dropped. Trainees felt the way they are asked to cover was not equitable.

**Higher Trainees:** Trainees felt that due to higher numbers of trainees at present the rota has improved but have concerns about the future if staffing changes. They also raised concerns regarding no formal process followed to provide sickness cover.

3.13. Handover (R1.14)

**Trainers:** N/A

**Non- Medical Staff:** Senior nursing staff advised us that there are different handovers in place for different sites and days including a 10am rapid rundown, a weekend morning handover that includes trainees and email communication. They felt when handovers occurred they were used as a learning experience for trainees.
**Foundation and GP Trainees:** Trainees advised that handover emails are sent to a centralised mailbox. There was a concern that due to limited wifi at sites this inbox could only be accessed whilst logged on to a mainframe computer.

**Core Trainees:** N/A

**Higher Trainees:** Trainees advised that during the week an informal handover would occur between them but if they had specific concerns they would find the relevant people to relay the information to. At weekends there is now a safety huddle in place for GAP which trainees attend. There is no formal process for handover for Old Age patients.

### 3.14. Educational Resources (R1.19)

**Trainers:** N/A

**Foundation and GP Trainees:** Trainees advised there is a functional library at both Caresview Centre and Murray Royal Hospital. Due to different locations there were varying responses regarding IT facilities with some trainees having limited computer access on wards as no designated doctors’ room.

**Core Trainees:** N/A

**Higher Trainees:** Trainees advised there are limited computers for trainee use and no printing facilities within the libraries.

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

**Trainers:** We were advised that since our previous visit junior and senior trainee forums have been established. The Teaching and Training Management Group (TTMG) now meets regularly with a trainee representative and a rolling agenda point for training updates. The panel were advised if there were concerns there would be local discussions involving the educational supervisor and training programme director and support could be sought via the Performance Support Unit (PSU) at the Deanery. We were given details of recent careers
events including: an event aimed at Foundation trainees which was attended by Core and Higher trainees to encourage training in mental health and an active undergraduate recruitment programme. These have been successful with Tayside having high recruitment from Dundee University and a fully subscribed Core training programme.

**Non-Medical Staff:** Senior nursing staff advised there are escalation procedures in place if they have concerns regarding a trainee that can not be overcome by talking with the trainee.

**Foundation and Core Trainees:** There were no Foundation or GP trainees present that worked less than full time or had required reasonable adjustments. They would feel comfortable raising issues with their supervisors.

**Core Trainees:** N/A

**Higher Trainees:** Trainees felt there was some flexibility regarding working patterns and would feel comfortable discussing with their supervisors. The panel were given an example of a trainee who received reasonable adjustments and support.

### 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:** N/A

**Foundation and GP Trainees:** Trainees were unaware who was responsible for the quality of education within Tayside.

**Core Trainees:** N/a

**Higher Trainees:** One trainee suggested the Medical Director was responsible for the quality of education in sites, but other trainees were unaware. We were advised that since our last visit trainees have been invited to attend various management meetings including the TTMG.
3.17 Raising concerns (R1.1, 2.7)

**Trainers:** Trainers advised there are details of how to raise concerns at induction and in the trainee handbooks. It was felt trainees are encouraged and supported to raise concerns in various ways including daily ward rundowns and discussions at supervision sessions. If trainees wish to raise concerns regarding their education and training they are encouraged to talk to their supervisor or TPD.

**Non-Medical Staff:** The panel were advised that concerns regarding staffing/systems and buildings would be raised through line management or at the daily meetings, they felt concerns were listened to by management.

**Foundation and GP Trainees:** Trainees felt comfortable raising patient safety concerns with their supervisor or consultants. GP trainees advised there has been a lack of clarity regarding who the GP lead is to raise educational concerns.

**Core Trainees:** Trainees advised they would raise patient safety concerns with their supervisor or through the DATIX system. It was felt it would depend on the issue how it was dealt with, but they would get a timely response. If trainees had concerns regarding their education they advised they would raise them with their clinical supervisor, educational supervisor or discuss at the monthly peer group meeting. Trainees felt there was less response from concerns raised regarding their education.

**Higher Trainees:** Trainees advised they felt comfortable raising patient safety concerns with their clinical supervisor or through the Datix system. We were given an example of a concern raised where the trainee had received feedback. Trainees advised they would raise concerns regarding their education and training with their clinical or educational supervisor.

3.18 Patient safety (R1.2)

**Trainers:** The service advised they were disappointed to learn from our previous visit that some trainees felt unsafe when working with patients. They have used guidance from the Royal College to carry out an audit and found a problem with the perception of safety and the use of
alarms. A new safety lead has been appointed to implement changes. A training DVD has been
obtained from the college for trainees to watch and discuss and there has been a review of
alarms. There is also a session at induction on aggression and safety management. Some
wards have implemented safety huddles.

**Non-Medical Staff:** The panel were advised there has been a recent ward move which has led
to some safety issues due to lack of appropriate facilities. These were being raised with
management. Senior nursing staff advised there are regular safety audits carried out and safety
huddles have been introduced to some wards.

**Foundation and GP Trainees:** Some trainees would have concerns if a relative or friend were
admitted to wards in particular if it was a Friday afternoon as it was felt patients would only be
seen by trainees until Monday.

**Core Trainees:** Some trainees would have concerns if a friend or relative was admitted to
wards. Concerns included mixed use wards, occasional reduced cover meaning delays in
patients being seen and a resistance to transferring patients with medical needs to suitable
facilities.

**Higher Trainees:** Some trainees would have concerns if relations were admitted to wards. We
were advised General Adult wards feel strained however staff go above and beyond to
maintain services. There were also concerns raised regarding consultant gaps and turnover of
staff leading to an inconsistency of consultant care.

### 3.19 Adverse incidents (R1.3)

**Trainers:** Trainers advised adverse incidents are reported using the Datix system. There is
now a system in place to review adverse incidents which will provide feedback to all those
involved in a supportive manner. Initial feedback is positive on the adverse incident reviews.

**Non- medical Staff:** The panel were advised that local adverse event review meetings now
take place. This includes everyone that was involved in the incident and offers help and
support. These occur following a near miss as well as a reported event and are used as a learning experience.

**Foundation and GP Trainees:** Trainees felt the Datix system was straight forward to use although there could be confusion regarding which consultant to attribute it to, leading to delays in receiving feedback. We were given an example of a concern raised by a trainee who had received feedback within a week and felt that it had been proactively dealt with. GP trainees advised they had asked to attend an adverse incident review and found it a very useful process. All trainees felt it could be used as a wider learning experience and would like to be included in any learning identified.

**Core Trainees:** Trainees advised only those who were involved in the incident are invited to the local adverse incident reviews and there are currently no mortality and morbidity meetings to allow shared learning. Trainees who had attended review meetings felt supported and benefited their learning.

**Higher Trainees:** Trainees advised they would raise adverse incidents through the Datix system. They provided positive feedback on the local adverse incident reviews.

### 3.20 Duty of candour (R1.4)

**Trainers:** The panel were advised that trainers are encouraged to sit down with trainees to discuss difficult shifts and provide support. They advised of the intention to start morbidity and mortality meetings.

**Foundation and GP Trainees:** Trainees advised they felt they could go to registrars or senior nursing staff for support if required.

**Core Trainees:** N/A

**Higher Trainees:** Trainees feel most supervisors would be supportive if they were involved in an incident. They would also be happy to discuss at peer group meetings.
3.21 Culture & undermining (R3.3)

Trainers: Trainers felt the new Thursday teaching sessions were a valuable opportunity for all levels to get together. Since the previous Deanery visit the TTMG group has been implemented and trainee representatives are invited to attend. Trainee forums have recently been established and trainee representatives at other meetings are now encouraged.

Foundation and GP Trainees: Trainees have not witnessed any undermining incidents.

Core Trainees: The panel were told that morale amongst trainees is low which has not been helped by recent negative publicity. We were given examples where trainees had witnessed or experienced undermining behaviour from both within and out with the department.

Higher Trainees: Trainees advised the lack of clarity of roles for core and higher trainees especially regarding Liaison assessments can cause difficulties between the trainees. Trainees felt there is the beginnings of a positive cultural change including better communication.

3. Summary

This return visit was arranged to assess whether the required improvements had occurred. Overall it was pleasing to see some positive steps toward change including:

- The establishment of working groups such as the TTMG with trainee representation.
- The new programme of Thursday morning teaching sessions received positive feedback.
- The Local Adverse Incident Reviews are viewed more positively and provide feedback in a supportive manner to those involved in an incident.
- The creation of the senior trainee’s handbook, although there are some discrepancies between this and the junior trainee’s handbook which require to be addressed.
- Careers events and a commitment to recruitment which has led to full recruitment to Core training.
The visit identified specific aspects that require to be addressed (in addition to requirements from previous visit):

- A clear decision is required regarding who is responsible for Liaison out of hours assessments as there is confusion regarding if this lies within the role of Core or Higher trainees, regularly creating a flash point during shifts. This can then be included in both induction handbooks.
- There is not a named duty consultant for all sites during the day.
- Difficulty contacting the duty doctor both in and out of hours due to problems with phone and wifi signal, causing a significant amount of wasted time spent looking for the correct individual. This is a recognised long standing problem which has not been addressed.
- There is no consultant oversight of any rotas and trainees note the written process to cover unexpected leave is not working.
- Concerns raised regarding the workload mainly within General Adult programme impacting on trainee’s education due to service requirements.

In relation to the requirements that were requested following the previous visit in May 2018 listed below, commentary on what progress has been observed is noted.

A regional teaching programme for the General Adult Psychiatry training programme must be established and supported by a Consultant/Training Programme Director.

- Action: A regional psychiatry teaching programme is in place for all level of trainees which is also attended by consultants. We were advised that a General Adult Psychiatry teaching programme was set up but faltered. This has very recently been restarted but we were told there is a lack of consultant support for running sessions leading to a lack of formality to the timetable.

Consultant involvement with local regional teaching/learning meetings is required at both Carseview Centre, Dundee and Murray Royal Hospital, Perth.

- Action: We were pleased to hear there is a good level of consultant involvement with the Thursday teaching sessions but less so with the GAP teaching programme.
Clarity of roles and responsibilities for each grade of trainee is required. This will include: the new out-of-hours system, junior trainees being asked to undertake inappropriate tasks by Community Mental Health Teams, and in liaison services.

- Action: There is a new document in place outlining the trainee’s roles and responsibilities however this was due to get approval at TTMG on 11th January so has not had time to bed in. We were told by trainees there is still a lack of clarity for some roles particularly Liaison out of hours assessments.

Appropriate on-site clinical support must be available to FY2 trainees at all times in all sites as laid down by the GMC.

- Action: The on-call rota has been revised so FY2s are only now at Murray Royal Hospital and we were not made aware of any concerns from Foundation trainees regarding clinical support.

There is a need to reconsider the role of the FY1 trainees to ensure a valuable learning experience.

- Action: Although these roles have been reviewed we were given examples from trainees who felt their day to day roles provided limited educational value.

The allocation of personal alarms to trainees is required to ensure their safety.

- Action: We were pleased to see that changes have been implemented to improve trainees’ access to personal alarms.

A trainee forum should be established and supported so trainees can safely raise concerns and provide feedback.

- Action: A junior forum has now been established and the minutes are fed back to the TTMG. There are some trainees who are unable to attend this meeting due to service
requirements and some trainees who were not aware of them. Although there is a higher
trainees monthly peer group meeting this is not formalised and does not appear to feed into management.

Clarity and availability of supervision and support for trainees at out-patient clinics is required.

- Action: Although there have been steps taken to try and improve this the trainees told us there was no named consultant available for advice and no jointly run clinics. Trainees advised there is also a concern that patients are seen only by trainees and they are being asked to carry out inappropriate assessments by community teams.

A culture of blame, fear of raising concerns and undermining must be addressed.

- Action: Although some higher level trainees felt there was the beginnings of change occurring in the culture there were some trainees who have a fear of raising concerns.

The level of competence of trainees must be evident to those that they come into contact with.

- Action: We were encouraged to see the coloured lanyard system is now in place across Tayside.

Unit induction must be available to all trainees and must include training on relevant IT systems to support their role (MIDIS).

- Action: We were informed all trainees had a good induction however there still appears to be concerns regarding IT support and availability of passwords. The creation of the senior trainee’s handbook is positive, although there are some discrepancies between this and the junior trainee’s handbook which require to be addressed.

Handover arrangements need to be formalised and streamlined to ensure that confidential information is shared amongst only relevant staff who need to receive it.
• Action: There have been some changes to the handover arrangements including the introduction of safety huddles in some wards however trainees still had some concerns that information could be lost.

The department must work with the Board in implementing changes to improve the educational environment for all grades of doctors in training.

• Action: It was reassuring to the panel that there was involvement by senior management and clinicians in the health board. There is early evidence in change of attitude of the culture and training experience in Tayside, we would encourage this momentum to continue.

In some of these actions there are moves in the desired direction, however, there are persisting concerns, both related to specific elements of the training process and to the educational environment leading us to recommend an enhanced monitoring revisit in 6 to 9 months.

Overall Satisfaction:

Foundation and GP Trainees: Ranged from 2 to 7 with an average score of 5
Core Trainees: Ranged from 5 to 7 with an average score of 6
Higher Trainees: Ranged from 4 to 8 with an average score of 6

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<th>Is a revisit required?</th>
<th>Yes</th>
<th>No</th>
<th>Highly Likely</th>
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6. Areas for Improvement

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<th>Ref</th>
<th>Item</th>
<th>Action</th>
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<tr>
<td>6.1</td>
<td>Review trainee’s ability to access research opportunities</td>
<td></td>
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<tr>
<td>6.2</td>
<td>Trainees should have access to IT support and passwords in place at the start of post.</td>
<td></td>
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<tr>
<td>6.3</td>
<td>A trainee forum should be maintained so trainees can safely raise concerns and provide feedback</td>
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6.4 The learning from adverse incidents reviews were viewed positively and there is an opportunity to utilise for shared learning.

7. Requirements - Issues to be Addressed

<table>
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<th>Ref.</th>
<th>Issue</th>
<th>By when</th>
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<td>7.1</td>
<td>A regional teaching programme for the General Adult Psychiatry training programme must continue and be supported by a Consultant/Training Programme Director.</td>
<td>6 months</td>
<td>Higher</td>
</tr>
<tr>
<td>7.2</td>
<td>Clarity of roles and responsibilities regarding Liaison assessments out of hours. This can then be confirmed in both trainee handbooks to limit discrepancies.</td>
<td>Immediate</td>
<td>Core and Higher</td>
</tr>
<tr>
<td>7.3</td>
<td>There is a need to reconsider the role of all FY1 trainees to ensure a valuable learning experience.</td>
<td>6 months</td>
<td>Foundation</td>
</tr>
<tr>
<td>7.4</td>
<td>Difficulty contacting the duty doctor both in and out of hours due to problems with phone and wifi signal, causing a significant amount of wasted time spent looking for the correct individual. New solutions must be identified.</td>
<td>6 months</td>
<td>All</td>
</tr>
<tr>
<td>7.5</td>
<td>The culture of blame, fear of raising concerns and undermining must continue to be addressed.</td>
<td>6 months</td>
<td>All</td>
</tr>
<tr>
<td>7.6</td>
<td>The department must work with the Board in implementing changes to improve the educational environment for all grades of doctors in training.</td>
<td>6 months</td>
<td>All</td>
</tr>
<tr>
<td>7.7</td>
<td>Trainees must be able to complete educational assessments at out-patient clinics</td>
<td>6 months</td>
<td>All</td>
</tr>
<tr>
<td>7.8</td>
<td>There must be consultant oversight of trainees Rota’s, including a Rota with named duty consultants for all sites with a working process to cover unexpected leave.</td>
<td>6 months</td>
<td>All</td>
</tr>
<tr>
<td>7.9</td>
<td>The practice of trainee led clinics should be addressed to ensure patients have proper and consistent consultant involvement in their care.</td>
<td>Immediate</td>
<td>Core</td>
</tr>
<tr>
<td>7.10</td>
<td>Review of the workload for trainees within General Adult Psychiatry programme to improve educational experience.</td>
<td>6 months</td>
<td>Core and Higher</td>
</tr>
</tbody>
</table>