Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	5th October 2021	**Level(s)**	FY, GP, Core
Type of visit	Triggered	**Hospital**	Inverclyde Royal Hospital
Specialty(s)	Mental Health	**Board**	NHS Greater Glasgow &Clyde

Visit panel	
Clare McKenzie	Visit Chair – Lead Dean Director Mental Health
Alastair Campbell	Associate Post Graduate Dean for Quality
Peter MacDonald	Associate Post Graduate Dean for Quality
Norman Nuttall	Training Programme Director
Neil Logue	Lay Representative
Manjit Cartlidge	Trainee Associate
Dawn Mann	Quality Improvement Manager
In attendance	
Susan Muir	Quality Improvement Administrator
Kelly McBride	Lay Representative - Shadowing

Specialty Group Information		
Specialty Group	Mental Health	
Lead Dean/Director	Clare McKenzie	
Quality Lead(s)	Alastair Campbell and Peter MacDonald	
Quality Improvement Manager(s)	Dawn Mann	
Unit/Site Information		
Trainers in attendance	5	
Trainees in attendance	7	

Feedback session: Managers in attendance	Chief Executive		DME Yes		ADME		Associate Medical Director		Service Lead, Service Manager, Consultant	

Date report approved by Lead Visitor	12th October 2021

1. Principal issues arising from pre-visit review:

At the 2019 QRP it was highlighted that there had been a significant deterioration in NTS/STS data and local concerns were raised regarding the staffing levels and rota gaps leading to reduced training opportunities and increased workload for trainees. A visit was scheduled for 5th December 2019 however at the request of the DME office this visit was postponed. A subsequent visit was scheduled for 24th March 2020 which was unfortunately postponed due to COVID-19. A virtual triggered visit was carried out on 21st January 2021. There were serious concerns raised at the visit including patient safety concerns.

Positive aspects of the visit:

- Comprehensive departmental Induction
- Diligent, approachable and enthusiastic Educational Supervisor
- Highly engaged, cohesive and proactive group of trainees

Less positive aspects from the visit:

- We were advised the IPCU only has consultant presence once a week for several hours which leaves a high degree of responsibility to the trainee, little supervision or feedback on complex cases and is a patient safety concern.
- We were told that the rota is challenging, it was reassuring to hear there are now two locums included on the trainee rota to fill gaps. However, the amount of on call duties the trainees have is impacting on their ability to spend time on tasks of educational benefit. Trainees are fully responsible for the management of the rota with no consultant involvement including covering short notice absences. This is impacting on trainee wellbeing and is felt could be a patient safety concern.
- There seems to be a degree of disconnect between the trainee and trainer views on how the site is performing, the access to and quality of education available for trainees.
- Although there is a document in place advising which consultant is on call during the day, it seems that this is not always accurate as there have been occasions when trainees have experienced challenges contacting the consultant for support and advice as they are on leave or offsite.

- The panel were given the impression that consultants were individually supportive but there was a lack of working as a cohesive team in relation to training and we felt a more structured approach to training by the consultant body would be beneficial.
- Weekly supervision sessions are not happening consistently for all trainees which is a GMC requirement for mental health trainees.
- We were pleased to hear that the local teaching has moved online and is consistent but is not always supported by consultants and trainees can't always attend due to on call duties or workload.
- Handover is happening several times a day however this is trainee led and would benefit from consultant involvement and there is potential for it to be used as a learning opportunity.
- There is a lack of formal feedback and shared learning opportunities following the reporting of adverse incidents.

The panel were left with an impression of a site under pressure due to a lack of substantive consultants and small trainee numbers. It was apparent the current Educational Supervisor is very supportive, and the trainees work as a supportive and highly engaged group. Due to a number of patient safety and trainee wellbeing concerns we will recommend a revisit in approximately six months. If there are no signs of improvement at a subsequent visit, we would have to consider recommending escalation to enhanced monitoring.

2.1 Induction (R1.13):

Trainers: The panel were told that induction took place in August and was led by experienced core trainees with no consultant presence. The Educational Supervisor explained that unfortunately he was not able to attend on the day but would hope to in future. He had given advice to the core trainee regarding induction. The ES advised that as he was new in post and not based at the site, he had to source site specific information which was pulled together in an induction booklet.

All Trainees: Trainees confirmed they had all received an induction to the site and department. The induction was run by current core trainees and it was reported that although it was helpful to get guidance from those already in post, the induction was lacking formalisation and governance information for example position crash trolleys etc. It was highlighted to the panel there was no consultant presence nor was the Educational Supervisor (ES) present. The core trainees running the

session had not been given a pro forma to follow. Trainees did not feel that the induction fully prepared them for their role. Not all trainees met their supervisors at the start of placement, due to leave, and reported that they were lacking some departmental information.

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

Trainers: Trainers advised a virtual fortnightly teaching programme is in place and it is felt to be functioning well, with good trainee attendance. A journal club is in the process of being finalised in addition to teaching sessions. It was mentioned it would be beneficial to have greater consultant attendance at teaching and we were told consultants are being encouraged to prioritise attending sessions.

All Trainees: Trainees confirmed they are able to attend local and regional teaching sessions unless on call or occasionally if a clinic was concurrent. Local teaching includes a trainee session followed by discussion with a consultant. The panel were told consultant attendance at teaching is very limited and is normally only the consultant attached to the trainee presenting. It was felt this limits the opportunities for case-based discussions and it would be more educational if more consultants were present. No MDT staff are involved in teaching. Trainees advised they had not been involved in any form of simulation training whilst in post.

2.3 Study Leave (R3.12)

Trainers: N/A

All Trainees: N/A

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

Trainers: The panel were told there are a limited number of substantive consultants in post to provide formal supervision but recently two experienced locums were approved as trainers which was felt to be beneficial. We were advised all supervisors had time within their job plan for 1-hour weekly supervision sessions and it was believed these were occurring regularly. The Educational Supervisor

confirmed they are attached to all trainees and had met with them virtually approximately 3 weeks after they started in post.

All Trainees: The panel were informed a new Educational Supervisor has been in post since May but is not based on site and has never visited the site in person. Most trainees had met the Educational Supervisor once via MS teams but advised this was 3 weeks into their placement. Trainees advised they received an email confirming their clinical supervisor before placement, but this did not include any contact details. Most core trainees received weekly supervision sessions although these were not timetabled and carried out on an ad hoc basis depending on workload. The panel were advised it could be difficult fitting in supervision sessions due to on call duties and the availability of consultants.

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

Trainers: It was felt trainees are aware off who to contact for supervision both during the day and OOH. It was confirmed there is a dedicated consultant two days per week for Intensive Psychiatric Care Unit (IPCU) on site and the consultant is always happy and available for trainees to contact when based at Leverndale Hospital. We were told cover is in place for IPCU when the attached consultant is on leave. Trainers advised it was difficult to always be available whilst on call (if attending a tribunal) but felt there would always be a consultant available for trainees to contact. Trainers believed that support was available for trainees if they encountered problems out with their level of competence.

All Trainees: Trainees advised there are processes in place, so they know who to contact for support both during the day and out of hours (OOH). The panel were given several examples where the named consultant was not contactable using the phone number given both during the day and out of hours. We were told of one incidence when the second on call advised the trainee the case would need to be discussed with the consultant, but they could not be contacted. Trainees felt the consultants were helpful and approachable once contacted, the difficulty lay in easily getting in contact with an appropriate person on all occasions.

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

Trainers: The Educational Supervisor advised he tried to keep up to date with curriculum changes. Trainers advised they would expect to be led by the trainees regarding their required competencies and educational needs. They were not aware of the detail of different trainee curricula. They felt that COVID-19 restrictions had made it a challenging time for trainees to experience adequate outpatient work. The panel were advised that sometimes it was challenging for trainees to complete audit work within a 6-month placement. Trainers advised there was not a phlebotomist in place at the site and felt it would be advantageous for nursing staff to be trained to assist with ECGs however the panel were advised that trainers felt that all tasks are educational for trainees and they have enough time for education.

All Trainees: Core trainees advised they currently have no access to ECT training, although they have been advised that they will be offered this on another site soon. This will likely include travelling to a different Glasgow site which trainees felt will be challenging due to the additional strain this will place on the day-time rota. It was felt that it can be difficult to gain Mental Health assessment experience in this placement as most new admissions are assessed by the Mental Health Acute Unit (MHAU) or are boarded from other hospitals where the patients have already been assessed. This is especially a concern for trainees who spend most of their 3 year programme at the Inverclyde site as it can be difficult to achieve the 55 cases required to complete training requirements. The panel were advised that it is normal to spend up to four placements (2 years) at the site which, due to the lack of substantive consultants in some departments, limited the breadth of educational opportunities in certain subspecialties. All trainees reported spending an excessive amount of time carrying out tasks of non-educational value with the percentage mentioned being approximately 80-90% of their time. The panel were told there is limited mental health training exposure in the roles with no additional support available for bloods, ECGs and physical examinations. Some trainees felt the majority of their tasks were not relevant to their level of training. Trainees advised there has recently been a Balint group established which is beneficial for psychotherapy training. The panel were told that trainees have access to psychotherapy cases however as all trainees need to achieve these it is an additional strain on the already tight rota. It was felt the Liaison post offered more educational value to trainees.

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

Trainers: Trainers were not aware of any problems with trainees completing work placed based assessments.

All Trainees: Trainees felt it was challenging to get work placed based assessments (WBA) completed due to limited consultant availability. The panel were advised that consultant workload is high, and trainees felt their training was not a priority.

2.8 Adequate Experience (multi-professional learning) (R1.22)

Trainers: N/A

All Trainees: Trainees advised they have no formal opportunities to learn with multi professional staff however do learn through informal contact. We were told that nursing and pharmacy staff are very supportive with trainees highlighting that they valued this.

2.9 Feedback to trainees (R1.15, 3.13)

Trainers: It was felt weekly supervision sessions were a good opportunity to provide trainees with feedback and discuss cases they have encountered during OOH work. The panel were told some inpatient placements will include a ward round and provides an opportunity for patient care to be discussed. Trainers felt that trainees should reach out for feedback if they desired it.

All Trainees: Trainees advised they would only receive feedback when they sought it for example at weekly supervision sessions. The panel were advised trainees did not receive feedback on on-call daytime and OOH work. Trainees indicated there were cases where they had seen from patient notes that their decision had been altered but had not received feedback on it. The panel were told that the pharmacist does provide trainees feedback which is valued.

2.10 Feedback from trainees (R1.5, 2.3)

Trainers: It was felt weekly supervision sessions provided trainees with an opportunity to provide feedback. The panel were also told about the implementation of the Trainee Management meeting which is attended by senior staff, consultants and trainees and provides an opportunity for trainees to feedback concerns. The panel were advised there is good admin in place for the meeting so all should be aware when they are taking place and we were advised it was a non-confrontational meeting and trainees were encouraged to talk.

All Trainees: Some trainees had attended the Trainee Management meetings and advised they had raised service issues at these. Trainees did not feel that it was an appropriate forum to raise other concerns. Trainees advised there was some confusion regarding who should attend the meetings as they had not been mentioned at Induction. Trainees advised they have, in the past, raised concerns regarding their education and training but have not seen actions arise. They do not have confidence that the group will address issues.

2.11 Culture & undermining (R3.3)

Trainers: N/A

All Trainees: N/A

2.12 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Trainers advised there was an awareness of training needs and felt the rota allowed flexibility to attend clinics and psychotherapy training. Trainers acknowledged the rota is tight and understood it may impact on training requirements. They are trying to fill gaps using locums but struggle to recruit.

All Trainees: The panel were told there are currently 2 gaps in the rota. During the day trainees are expected to cover the gaps and OOH the unit tries to employ locums, but we were told this is often difficult, so trainees cover the shifts. One specialty doctor does provide cover but has limited availability during the day as works within the community. Rota gaps are long term and not likely to

change in the immediate future. The limited trainee numbers working on the rota makes it difficult to cover for unpredictable gaps for example sickness. Trainees advised they work more OOH shifts than other sites across GG&C and the demands of the rota left them feeling overworked with less training opportunities in comparison to their peers. The rota is managed by a core trainee with admin support for managing gaps but no consultant support or oversight. Due to the small number of trainees on the rota it is split into 4 shifts daily and changes on a monthly basis to allow trainees to attend educational activity. Trainees were aware there had been discussions regarding merging the rotas across sites and they were open to this suggestion.

2.13 Handover (R1.14)

Trainers: Trainers confirmed handover is carried out at shift change between duty doctors. We were advised that following the last deanery visit the department tried to implement consultant attendance at handover so it could be a learning opportunity but due to consultant workload this was not achievable.

All Trainees: Handover happens four times a day during the week and is peer to peer. The panel were advised there is no formalised pro-forma, no written element and no consultant involvement meaning it provides no learning opportunities. While there is a more formal handover on a Monday morning, we were advised there is no consultant presence.

2.14 Educational Resources (R1.19)

Trainers: The panel were advised new laptops have been acquired but they are still working out protocols before these can be issued to trainees. Trainers advised there was an in-house library where trainees can access resources.

All Trainees: Trainees felt they did not have adequate access to computers. They had been advised for some time they would receive personal laptops, but this has not transpired. The panel were told there is limited space for trainees to work especially following the introduction of virtual patient appointments.

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

Trainers: It was felt trainees have access to informal support from very experienced staff at different levels and that the small size of the site nurtures a supportive environment. The panel were advised that the trainee group are very supportive of each other.

All Trainees: Trainees felt they supported each other well and are a close group. They were not aware of the available avenues to access support if needed and felt there was a lack of pastural support. Trainees advised they had a developed relationship with the previous Educational Supervisor but did not feel this had been built with the new ES as yet.

2.16 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

All Trainees: N/A

2.17 Raising concerns (R1.1, 2.7)

Trainers: The panel were told trainees had raised concerns through the Educational Supervisor to highlight the lack of access to ECT training. This has been taken forward and alternatives investigated. Trainers felt the Training Management Meeting offered an opportunity to raise concerns.

All Trainees: Trainees have raised concerns in the past regarding their education and had not seen positive changes.

2.18 Patient safety (R1.2)

Trainers: It was felt the environment was safe for patients and trainees. The panel were told the Intensive Psychiatric Care Unit (IPCU) unit now has a consultant present two days per week who is available by phone the rest of the week, arrangements have been made for adequate cover when the consultant is not available. Trainers highlighted that there had been recent assaults on nursing staff in

IPCU which were allegedly due to inappropriate patient placement as a result of a national shortage of forensic psychiatry beds. Trainers confirmed patients were reviewed within timescales and normally within 24 hours.

All Trainees: The panel were advised that the consultant is now present in the IPCU ward twice a week and is readily available to contact via mobile. Arrangements are in place for cover to be accessed via other consultants on site if required or if the named consultant is on leave. When asked if trainees would have concerns if a friend or family member were admitted we were advised that due to the lack of consultants, trainees would be a little concerned regarding the length of time taken to review patients which can be more than 24 hours. It was felt there is a lack of cover arrangements when consultants are on leave.

2.19 Adverse incidents (R1.3)

Trainers: The panel were advised that Datix is used as standard across GG&C to raise incidents and trainees were aware of how to use this system. Trainers advised adverse incidents were a standing agenda item at the Training Management meeting for discussion. The example provided was still not resolved hence departmental learning was awaited.

All Trainees: Trainees advised there are no opportunities for team learning following adverse incidents. Trainees advised in other posts they have attended M and M meetings but there is no equivalent at this site. It was felt there have been recent opportunities of cases that could have been reviewed as a learning opportunity. The panel were provided with details of an incident which had been escalated however they were unaware of any follow-on actions or changes to practice.

2.20 Other

Trainees: Trainees advised they had seen little improvement since the previous deanery visit and reported that things had actually deteriorated.

3. Summary

Is a revisit required?	Yes	No	Highly Likely	Highly unlikely

Positive aspects of the visit:

- Valued and very supportive nursing and pharmacy staff.
- Consultants are considered approachable.
- There have been improvements in the IPCU accessibility of consultant supervision and support.
- Cohesive cohort of trainees.
- Liaison psychiatry placement highlighted

Less positive aspects from the visit:

- The departmental induction lacks consultant leadership and involvement and is not adequately preparing new doctors for working on the site.
- The rota design results in the trainees covering a large amount of on call shifts during the day and OOH. This significantly impacts their access to educational opportunities. Radical redesign will be required to move the emphasis towards supporting training.
- Trainees report a high proportion (up to 90%) of their time is spent undertaking non educational tasks which affects their ability to access psychiatry focused training.
- The length of placement at Inverclyde Royal Hospital as a core trainee should be reviewed by the TPD to ensure that the programme delivers the required curricular training opportunities.
- There is a significant disconnect between the views of trainees and trainers particularly around: receiving feedback on clinical case management, time spent undertaking non educational tasks, completion of workplace-based assessments, awareness of curricular requirements (Foundation and GP).
- While the development of the Training Management Group is a positive step, the lack of progress on addressing issues is adversely affecting trainees' views of it.
- We were pleased to hear there is a new Educational Supervisor in post however feel there is a need for some role development taking account that the Supervisor is not based on site.

- There is a lack of evidence of team learning from adverse incidents.
- Handover has no pro-forma, no written element and no consultant involvement which limits its educational value.
- Although trainees are aware of who to contact for supervision, we were given several examples where the consultant on all was non contactable via phone.
- The panel found poor progression on requirements from the previous Deanery visit, with the trainee feedback being that the situation has actually declined.

We would like to thank the DME office and department administration teams for help setting up this virtual visit and to the site for engagement on the day. The panel were provided with a useful update from the last deanery visit at the site presentation session. The panel were left with an impression of a site under pressure due to a lack of substantive consultants and small trainee numbers. There are significant differences in perception of the training environment between trainers and trainees. It was apparent the trainees work as a supportive and highly engaged group. The panel are extremely concerned at the lack of progress to address the action plan and propose that Enhanced Monitoring should be considered. This will be discussed with the GMC.

Previous Requirements:

- 6.1 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. – **NOT MET**
- 6.2 There must be clear and explicit understanding around the arrangements for clinical supervision at all times and consultants must be contactable. – **NOT MET**
- 6.3 Trainees must receive consistent weekly sessions with their appointed supervisor. – **PARTIALLY MET**
- 6.4 Trainees must receive feedback on incidents that they raise and there must be a forum for shared learning from adverse events. - **NOT MET**
- 6.5 There must be a process that ensures trainees understand, and are able to articulate, arrangements regarding Educational Governance at both site and board level. - **PARTIALLY MET**
- 6.6 The Board must provide sufficient IT resources to enable doctors in training to fulfil their duties at work efficiently and to support their learning needs. - **NOT MET**

- 6.7 The department must ensure that there are clear systems in place to provide formal and informal feedback to trainees. - **NOT MET**
- 6.8 Measures must be implemented to address the ongoing patient safety concerns described in this report especially within the IPCU**. - MET**
- 6.9 There must be consultant responsibility for trainee Rotas with a working process to cover unexpected leave of any grade. -**NOT MET**
- 6.10 There must be access to study leave for all eligible trainees and this must not be dependent on trainees arranging their own service cover**. - MET**
- 6.11 There must be active planning of attendance of doctors in training at teaching events to ensure that workload does not prevent attendance. This includes bleep-free teaching attendance. - **PARTIALLY MET**

4. Areas of Good Practice

Ref	Item	Action

5. Areas for Improvement

Areas for Improvement are not explicitly linked to GMC standards but are shared to encourage ongoing improvement and excellence within the training environment. The Deanery do not require any further information in regard to these items.

Ref	Item	Action
5.1	It would be educationally valuable to have consultant presence at teaching.	
5.2	Trainees should have access to and support for quality and audit projects.	
5.3	There is a disconnect between trainers and trainees understanding and perceptions of training which should be reviewed.	
5.4	Access to ECT training for trainees should be available.	

5.5	Role development for the new Educational Supervisor would be beneficial including some presence on site.	
5.6	Education is not the focus of the culture within the department.	
5.7	Trainees must have easy access to regular and fair work placed based assessments.	

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	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.	6 months	All
6.2	There must be clear and explicit understanding around the arrangements for clinical supervision at all times and consultants must be contactable.	6 months	All
6.3	Trainees must receive consistent weekly sessions with their appointed supervisor.	6 months	All
6.4	Trainees must receive feedback on incidents that they raise and there must be a forum for shared learning from adverse events.	6 months	All
6.5	The department must ensure that there are clear systems in place to provide formal and informal feedback to trainees.	6 months	All
6.6	The Board must provide sufficient IT resources to enable doctors in training to fulfil their duties at work efficiently and to support their learning needs.	6 months	All
6.7	There must be consultant responsibility for trainee Rotas with a working process to cover unexpected leave of any grade.		All

6.8	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 or online equivalent may be useful in aiding this process but are not sufficient in isolation.	6 months	All
6.9	The Board must design rotas to provide learning opportunities that allow doctors in training to meet the requirements of their curriculum and training programme.	6 months	All
6.10	Alternatives to doctors in training must be explored and employed to address the chronic gaps in the junior rota that are impacting on training.	6 months	All
6.11	The length of placement should be reviewed by the TPD due to lack of access to emergency assessments and breadth of training opportunities.	6 months	All
6.12	Handover processes must be improved to ensure there is a safe, robust handover of patient care with adequate documentation and senior leadership to allow for learning opportunities.	6 months	All
6.13	Educational Supervisors must understand curriculum and portfolio requirements for their trainee groups.	6 months	All