Scotland Deanery
Quality Management Visit Report

Date of visit	16th January 2020	Level(s)	FY/GP/Core/Specialty
Type of visit	Triggered	**Hospital**	Dykebar Hospital
Specialty(s)	Mental Health	**Board**	Greater Glasgow & Clyde

Visit panel	
Alastair Campbell	Visit Chair - Associate Post Graduate Dean for Quality
Norman Nuttall	Training Programme Director
Jack Kirby	Trainee Associate
Marion McLeod	Lay Representative
Dawn Mann	Quality Improvement Manager
In attendance	
Janice Jenkins	Quality Improvement Administrator

Specialty Group Information		
Specialty Group	Mental Health	
Lead Dean/Director	Amjad Khan	
Quality Lead(s)	Claire Langridge and Alastair Campbell	
Quality Improvement Manager(s)	Dawn Mann	
Unit/Site Information		
Non-medical staff in attendance	9 including senior nursing staff, IHTT rep and inpatient manger	
Trainers in attendance	9 trainers including the clinical director and educational supervisor	
Trainees in attendance	0 FY2, 1 GP, 5 Core and 1 Higher	

Feedback session: Managers in attendance	Chief Executive		DME		ADME Yes		Medical Director		7 including the clinical director and educational supervisor.	

Date report approved by Lead Visitor	14th February 2020

1. Principal issues arising from pre-visit review:

Following the mental health QRP where all available data was triangulated, and local information provided it was decided that a triggered visit should be planned for Dykebar Hospital. Data and local information raised concerns regarding rota gaps impacting on trainee's experience.
A summary of the discussions has been compiled under the headings in section 2 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.

2.1 Induction (R1.13)

Trainers: Trainers felt the induction programme prepared trainees reasonably well for their role. It was felt it can be daunting starting a placement in mental health especially if it is trainees first experience of psychiatry. The panel were advised that if a trainee starts out of sync, they would receive a one on one catch up, aimed to replicate the main induction as much as possible, including the involvement of a trainee mentor. We were advised the induction handbook is currently being updated by the higher trainee and once this is complete it is hoped this can be uploaded to the intranet for better trainee access. Trainers thought the induction could be improved by introducing a face to face induction element between the IHTT (Intensive Home Treatment Team) and trainees as this may be a step to improving relationships.

All Trainees: Trainees advised they had all received a structured**,** formal site induction at the start of placement apart from one who was on leave, who had a one to one catch up with their consultant. Trainees were aware of instances where trainees and a locum who started out of synch did not receive all the relevant induction information. Trainees felt it was useful that a previous trainee was involved in the induction and advised they also attended sessions provided by pharmacy, library services, IHTT and the educational supervisor. Trainees were also shown the ward they will be working on and introduced to consultants and nursing staff. The panel were advised the higher trainee is currently working on updating the induction handbook and trainees felt this would be a welcome improvement. It was also raised induction could be improved by including more information regarding the on-call duties, the expected role of trainees within the IHTT and including a tour of all wards covered as part of on call duties.

Non-Medical Staff: The panel were advised that the IHTT are involved with the induction and give a brief overview of what they expect from trainees, it was felt it would be helpful for trainees to spend some time with IHTT during their placement. Overall the non-medical staff felt the induction prepared the trainees for their placement.

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

Trainers: The panel were advised that local teaching takes place on alternate Thursday mornings at Paisley and is organised by the educational supervisor. The training includes a case of interest presented by a trainee and a journal club facilitated by a consultant. All trainees and consultants are invited to attend. Trainers advised teaching is bleep free apart from one trainee covering duty doctor responsibilities. Regional teaching takes place on the other Thursday and all trainees are able to attend unless they are on call or post nights.

All Trainees: Trainees confirmed local teaching takes place during term time on alternate Thursday mornings and is attended by all levels of trainees and consultants. Trainees told us they appreciate having opportunities for case presentation. Trainees advised they also attend regional teaching the duration varying depending on the level of trainee. Trainees told us they can all attend teaching unless they are on call as the teaching is spread over sites. We were informed that for core trainees working within Old Age Psychiatry they could be on call more often on a Thursday as this is the only day they are scheduled for on call duties.

Non-Medical Staff: Non-medical staff advised there was an embedded culture that teaching occurred on Thursday mornings.

2.3 Study Leave (R3.12)

Trainers: Trainers raised no concerns regarding trainees obtaining study leave and advised priority was given to those sitting exams.

All Trainees: All trainees advised they had no problems obtaining study leave.

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

Trainers: The educational supervisor advised she creates the trainee's rotation and places them with clinical supervisors depending on their training needs, stage of training and any given preferences. The panel were told that the educational supervisor attends quarterly meetings where she would be given information regarding core/higher trainees where there are known concerns in advance of placement, information is not always provided prior to placement for FY or GP trainees with known concerns. The panel were advised that training is available to supervisors as part of their RoT (Recognition of Trainers) requirements although trainers felt it would be helpful if these were available more frequently. Trainers advised they all had time within their job plan to undertake their educational role.

All Trainees: All trainees had met with their educational supervisor. The panel were told there is one educational supervisor for core trainees who was described as very approachable. All trainees had a personal development plan in place. Trainees were told before the start of placement who their clinical supervisor was, and some had the opportunity to meet them on the first day.

Non-Medical Staff: Staff felt there was always support available for trainees and advised that consultants and senior nursing staff were approachable, and trainees would be encouraged to contact them.

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: The panel were informed that the use of colour coded badges to differentiate between different stages of doctors were not in use, but the site were looking into these. It was felt trainees are always aware of who to contact for support, during the day it will be within their own team and out of hours there is a clear process in place with a 2nd on call and a consultant on call for support. Trainers were not aware of any incidents where trainees felt they had to deal with situations beyond their level of competence and encouraged trainees to contact them for support or raise concerns through Balint group or through trainee representatives at division meetings.

All Trainees: Trainees advised they have clear guidance on who to contact for support both during the day and out of hours. They felt they had not faced problems that were out with their competency without having support and felt senior staff were approachable and easily contacted.

Non-Medical Staff: The panel were advised that the colour coded badges used in many units to identify doctors of different training grades were not yet in use at the site. Non-medical staff advised they were aware of the structure of different training grades of trainees and the different supervision levels required.

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

Trainers: The panel were advised that some trainee posts were purely outpatient and some inpatient which could prove a barrier to trainees attending clinics. Clinics are not timetabled for trainees however they are encouraged to be proactive to arrange and attend them. It was felt this can prove tricky when wards are busy, and we were given an example of trainees being called away from clinics to cover the wards.

All Trainees: Trainees advised there were no particular competencies they felt were difficult to achieve. The panel were told that not all rotations have specific clinics as are inpatient only and it can be challenging to get to other clinics as their role is busy. It was suggested it would be beneficial to have timetabled clinics. It was felt that on call duties can include a higher percentage of time carrying out tasks such as ECGs or blood taking but that this is balanced with psychiatry work during their normal roles.

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

Trainers: Trainers advised that work placed based assessments are covered in the RoT training, annual training and they all received specific training when the new workplace-based assessments were introduced.

All Trainees: Most trainees had no difficulty completing workplace-based assessments and it was felt assessments are fair and consistent.

Non-Medical Staff: The panel were advised nursing staff are asked to carry out multi source feedback for trainees and trainees carry out joint assessments with the IHTT.

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

Trainers: Trainers advised that trainees have opportunities for multi professional learning through community work, especially trainees within Old Age Psychiatry who work closely with CPNs (Clinical Nurse Practitioners).

All Trainees: Trainees felt they had opportunities for multi professional learning including working with physiotherapists and occupational therapists on the wards, helpful pharmacists and regular MDT meetings.

Non-Medical Staff: The panel were advised there are some training sessions that are open to all multidisciplinary staff for example medical emergency training and extended awareness sessions.

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

Trainers: It was felt the department are supportive of trainees undertaking audit and quality improvement projects and trainees have the opportunity to present at the annual audit morning. There is not a specific audit co-ordinator however the clinical director and academic consultant are approachable. We were informed there are also opportunities available for higher trainees to supervise projects.

All Trainees: Trainees advised there were opportunities available if they wanted to undertake quality improvement projects and felt they would be supported during these.

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: Trainers advised they would provide direct feedback to trainees on a day to day basis and there are opportunities for trainees to receive feedback during weekly supervision sessions, from IHTT, following clinical incidents and at Monday morning handover.

All Trainees: Trainees advised that all admissions would be discussed with a registrar or consultant and felt this was a good opportunity for feedback. It was felt feedback received was meaningful and constructive.

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

Trainers: The educational supervisor advised she meets with all trainees at the midpoint and end of training providing an opportunity for trainees to feedback concerns. It was felt that due to the smaller size of the site trainees have more direct contact with trainers to be able to provide feedback. The panel were advised there is a trainee representative who attends regular directive meetings.

All Trainees: The panel were told there is a trainee management committee meeting every six months which provides an opportunity for trainees to give feedback and raise concerns and a trainee representative attends regular senior meetings. Trainees advised that the junior doctor committee meetings have stalled but it is hoped to get these started again monthly after local teaching.

2.12 Culture & undermining (R3.3)

Trainers: Trainers felt all areas tried to include trainees from day one to make them feel part of the team. It was felt there are various avenues available for trainees to provide feedback regarding undermining and bullying behaviour including escalation to the educational supervisor and through the training management group rep. The trainers were aware of some difficulties with the interface between the IHTT and the trainees and they are looking into ways to improve this.

All Trainees: Trainees advised the clinical team and nursing staff are supportive and trainees would know the channels of raising undermining and bullying concerns if required. It was discussed that interaction with the IHTT can be variable and it is felt there can be a lack of understanding from IHTT regarding the trainee's roles and ability to assist IHTT due to other demands, especially during the day. The panel were told concerns have been raised with senior staff.

Non-Medical Staff: Non-medical staff felt that a team culture was encouraged at the site and trainees were absorbed into the teams. We were told that trainees are invited to management meetings to

allow them to provide feedback and that there was formal dignity at work policies in place. Non-medical staff were unaware of any incidents of bullying or undermining.

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

Trainers: The panel were advised there are ongoing rota gaps with the rota currently running at 10.6 instead of 12. The panel were told trainees are asked if they would like to cover gaps as an internal locum and if not, external locums are sourced. Trainers advised the other implication of the rota gaps are that trainees will be picking up more daytime on call shifts and this is shared out among the trainees. The panel were told a trainee drafts the rota and then sends it to the clinical director and an admin staff member who will check it is compliant.

All Trainees: Trainees advised the rota was compiled by a core trainee and it was felt this can be a confusing and time intensive task as there are not standard templates set up or set processes on how to run the rota with current gaps. The rota for February has not been agreed o released yet as there was some uncertainty if it should run with rota gaps or the slots should be left as unfilled on the template. The rota is overseen by the clinical director with admin assistance. We were told there is currently rota monitoring occurring. It was felt the site are proactive in trying to source locums to fill gaps. Trainees advised there were more rota gaps in the last training year with the rota running on 8.5, it was felt this did impact on trainee's education and could have impacted patient safety, but this year has been better. It was also raised that clinics are not scheduled in the timetable and that there is a discrepancy in the amount of on call duties expected from trainees across Dykebar Hospital, Leverndale Hospital and Inverclyde Hospital which could be viewed as unfair.

Non-Medical Staff: Non-medical staff were unaware of any rota concerns that would impact trainees training or wellbeing.

2.14. Handover (R1.14)

Trainers: Trainers advised there is a Monday morning handover which will be attended by those on call over the weekend where trainees and consultants are invited to attend. The panel were told on a day to day basis trainees would handover between themselves. Some trainers felt it may be beneficial to investigate a written element or electronic handover and the panel were advised of an

instance where the IHTT were not given handover information from a patient admitted over the weekend.

All Trainees: Trainees advised that handover takes place in the duty doctor room at changeover times between trainees with no formal structure. We were told there is a more formal handover on a Monday morning where the weekend on call doctors attend and trainees and consultants are invited, however there is poor consultant attendance. There is no written element to any of the handovers and they are not used as learning opportunities. It was felt handover is effective, but it would be beneficial to have some structure and a written record.

Non-Medical Staff: Nursing staff advised they are not involved in the doctor's handover but would have a nursing handover. We were told there is no written record of handover, but it was felt this may be useful. It was raised there have been occasions when details of a community patient assessment taken place after 7pm didn't get handed over via the duty day doctor in the morning.

2.15. Educational Resources (R1.19)

Trainers: N/A

All Trainees: Trainees felt there are enough computers, but they are very slow.

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

Trainers: Trainers advised if they became aware of a struggling trainee, they would contact the educational supervisor, who would investigate the best course of action and involve occupational health or the Peer Support Unit if required. It was felt career support is given to trainees during supervision sessions.

All Trainees: Trainees felt support was available for trainees who were struggling, and the panel were given an example where reasonable adjustments were made for a trainee. The panel were informed the site are supportive of less than full time working (LTFT).

Non-Medical Staff: We were advised that if non- medical staff had concerns regarding a trainee's performance in relation to patient care they would speak to the trainee or raise with the consultant.

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

Trainers: The panel were told the educational supervisor manages the quality of education and training at the site.

All Trainees: Trainees were unaware who the Director of Medical Education (DME) was. The panel were informed there are regular meetings with a trainee representative where they could raise concerns regarding the quality of their training.

2.18 Raising concerns (R1.1, 2.7)

Trainers: Trainers advised trainees are encouraged to raise patient safety concerns with the senior nurse or on call supervisor and any concerns regarding their education would be directed to their clinical or educational supervisors.

All Trainees: Trainees advised they would raise any concerns about patient safety with their clinical supervisor, but nobody had experienced this.

2.19 Patient safety (R1.2)

Trainers: Trainers felt the environment was safe for trainees and patients. Trainers acknowledged that boarding can pose a risk to patient safety, but the panel were told there are regular discussions to control the risks.

All Trainees: Trainees would be less happy for family and friends being admitted to ward 3B due to known concerns and advised there are nursing staff shortages on Old Age wards. Trainees advised that there is boarding of patients at the site with patients in alternative wards at Dykebar Hospital or when no beds are available nursing staff have to find beds at other sites.

Non-Medical Staff: It was felt the site was a safe environment for patients. The panel were informed that boarding does have an impact on patient safety here as patients can be in wards not designed for their needs but there is a tracking process in place to minimise the risks. We were told there are nursing handovers between shifts and patient safety briefs, these do not currently involve trainee doctors but we were advised they are currently exploring the viability of developing a daily huddle involving all levels of medical staff utilising VC so it can be across the sites.

2.20 Adverse incidents (R1.3)

Trainers: The panel were told that all trainees are aware that adverse incidents should be reported through Datix, any events would be discussed during supervision and trainees would receive feedback. Trainers advised shared learning from adverse incidents is part of the local teaching programme with a session timetabled later in the year.

All Trainees: Trainees advised adverse incidents would be raised through Datix**.** Trainees advised they are supported if an adverse incident occurs and invited to the debriefing. Trainees were not aware how learning is shared from adverse incidents.

Non-Medical Staff: Non-medical staff advised they would raise adverse incidents using Datix. We were told actions from adverse incidents are shared among the team and regular meetings are held to discuss shared learning from adverse incidents, including a sky red meeting(?) where incidents for all over GG&C are discussed.

2.21 Other

Trainees: Trainees felt the rule for not allowing 3 people have annual leave at one time should not include staff working in outpatient roles as this would not affect the ward staffing levels.

When trainees were asked to score their ‘overall satisfaction’ with their training in their current post, with ‘0’ being ‘lowest level possible for overall satisfaction’ and 10 being the ‘highest level of satisfaction possible’, the following scores were recorded:

All Trainees: Trainees scored between 6 and 9 with an average of 8

3. Summary

- Put the table below at the start of the section and only highlight one option from yes, no, highly unlikely, highly likely.

Is a revisit required?	Yes	No	Highly Likely	Highly unlikely

Positive aspects of the visit:

- It was evident the site has responded to trainee feedback and tried to implement positive changes
- Supportive and approachable senior staff who encourage a team culture and have education as a core value
- Trainees are always able to access supervision within hours and out of hours and trainees get regular weekly supervision sessions
- Local teaching program is ingrained, structured and of a good standard
- Department is open to trainee feedback with a regular trainee/management forum in place. We would encourage the junior trainee forum to be restarted as proposed.

Less positive aspects from the visit:

- We were told induction was adequate however it would be beneficial to include greater detail regarding the on-call duties and responsibilities and we would encourage the proposed update to the handbook
- There is some strain in the interface between trainees and the IHT team at times which requires attention. It may be beneficial if both teams have clear guidance of their roles and responsibilities to manage expectations.
- Handover would benefit from more structure, a written element and possible consultant involvement, particularly at weekends.

- It would be beneficial for trainees to have more structured access to clinics, especially for GP trainees who are at the site for a shorter duration.
- Rota gaps have proved challenging, it would be helpful for the trainees creating the rota to have more senior support.

The panel were left with an impression of a supportive and approachable senior staff and a new educational supervisor who has worked hard to ensure trainees achieve their competencies throughout a time of diminished trainee numbers. A number of requirements follow. The panel will suggest to the mental health sQMG that Dykebar Hospital remains on the 5-year quality management cycle with appropriate monitoring.

4. Areas of Good Practice

Ref	Item	Action
4.1	Supportive and accessible senior team, who are responsive to trainee feedback and promote a culture of education.	

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 beneficial for trainees to have more structured access to clinics.	
5.2	It would be beneficial to include greater detail on the on-call duties and responsibilities of the IHTT in induction. We would encourage the proposed update to the handbook.	

5.3	There should be a greater awareness of educational governance processes and the role of the DME office.	
5.4	Rota gaps have proved challenging, it would be helpful for the trainees creating the rota to have more senior support.	

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	Handover processes must be improved to ensure there is a safe, robust handover of patient care with adequate documentation of patient issues, senior leadership and involvement of all trainee groups who would be managing each case.	9 months	All
6.2	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 must be introduced.	9 months	All
6.3	Rotas must be issued well in advance, usually 6 weeks, of trainees taking up their post, in keeping with national agreements.	9 months	All
6.4	Relationships at the trainee – IHTT interface must be improved.	9 months	All