Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	21st January 2021	**Level(s)**	FY,GP,Core
Type of visit	Triggered	**Hospital**	Inverclyde Royal Hospital
Specialty(s)	Mental Health	**Board**	NHS GG&C

Visit panel	
Alastair Campbell	Visit Chair - Associate Post Graduate Dean for Quality
Norman Nuttall	Training Programme Director
Neil Logue	Lay Representative
David MacPherson	Trainee Associate
Dawn Mann	Quality Improvement Manager
In attendance	
Susan Muir	Quality Improvement Administrator

Specialty Group Information		
Specialty Group	Mental Health	
Lead Dean/Director	Clare McKenzie	
Quality Lead(s)	Claire Langridge and Alastair Campbell	
Quality Improvement Manager(s)	Dawn Mann	
Unit/Site Information		
Trainers in attendance	5	
Trainees in attendance	5 and Locum who recently finished core training at site	

Feedback session: Managers in attendance	Chief Executive		DME Yes		ADME		Associate Medical Director Yes		14		

Date report approved by Lead Visitor	 11.02.21

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. It was felt important to reschedule the visit due to ongoing local concerns.

2.1 Induction (R1.13):

Trainers: The panel were advised the department induction has now been moved online following COVID-19. This induction is run by the educational supervisor (ES) and an existing trainee and includes information regarding what to expect from the role, who to contact for support and escalation procedures. We were informed that the administration team send trainees information before starting which includes IT passwords, security access and dates for violence reduction training. It was felt it may be useful to update induction to include information regarding the role of Community Mental Health Teams (CMHT). Feedback is requested from trainees following induction which has been positive. In previous years there has also been a site induction providing details of labs, trakcare and a clinical induction but this was cancelled this year. We were also informed that new trainees should have access to the west of Scotland induction providing an overview of life in psychiatry training. If a trainee misses induction a catch-up session will be arranged with the educational supervisor or experienced trainee.

All Trainees: Trainees advised they had all received a departmental induction which was led by the educational supervisor with input from current trainees. It was felt this induction was good and prepared trainees for their role. Trainees advised they had not received a site induction and felt it would have been helpful to have more information regarding the hospital and board.

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

Trainers: Trainers advised that a trainee is required to carry the on-call bleep during local teaching, but it was thought this doesn't cause too much disruption as ward staff are aware when training takes

place and try to minimise calls. It was felt that now there are two locums in place to assist with the junior rota it provides more cover to allow trainees to attend regional teaching sessions, but no training is fully bleep free. It was highlighted attending training was now easier for trainees as much of it is delivered on a virtual platform.

All Trainees: Trainees advised there is a two-hour local teaching session on alternate Thursday mornings. This takes the form of a trainee led case presentation followed by a discussion on the topic by a consultant. It was felt the local teaching is helpful however the panel were advised there have been several occasions recently where there was no consultant available to talk at the session. A trainee is required to be on call at all times including during local and regional teaching sessions. It was felt that the appointment of two locums onto the trainee rota was beneficial to allow trainees to attend teaching as they will cover if possible. Trainees highlighted they cover a high number of nightshifts due to their rota and the panel were advised it is the highest number across the GG&C mental health departments. It was felt this impacted trainee's ability to attend teaching, but they are currently managing up to 70% of regional teaching due to the locum cover.

2.3 Study Leave (R3.12)

Trainers: Trainers were not aware of any concerns regarding trainees obtaining study leave. They did comment that there is limited study leave budget for core trainees due to teaching costs and due to small trainee numbers, there may be problems obtaining cover.

All Trainees: The trainees were unaware of any study leave being refused however felt it could be difficult arranging study leave as they had to organise their own cover which with the limited trainee cohort could prove difficult. It was felt that the trainee who currently manages the rota is very helpful in assisting trainees to arrange 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 he was responsible for allocating trainers to trainees. This normally followed the process of a trainee in year one being allocated to a general adult psychiatry post and then moving on to a developmental post taking into consideration the trainees' areas of interest. The educational supervisor advised he was new in post last year and has found the

ES meetings a useful source of information and the training programme director has been supportive. Trainers felt it would be helpful to have more information available regarding changes to the curriculum and that they have access to GG&C recognition of trainer courses when these are available. The panel were informed that trainers have time in their job plans for weekly supervision but don't feel this is happening every week but maybe every second week due to annual leave, on call duties etc. It was also raised they were unsure whether weekly supervision was an expectation or a requirement. Trainers advised their role as supervisors is discussed at appraisal.

All Trainees: All trainees had met with their educational supervisor and advised meetings normally occur at the start, midway and at the end of placement.

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 advised the colour coded badge system is well established to allow staff to differentiate between training grades. Trainers advised there is a consultant roster detailing who is available for support during on call shifts day and night and trainees are informed of the process at induction. Trainers were aware of a recent incident where the rota hadn't been circulated and a new locum had not received an induction so did not know how to help leading trainees to phone the Glasgow wide contact. The educational supervisor told the panel he has an open-door policy and trainers felt trainees would come to them for support.

All Trainees: Trainees advised there is a process and rota in place advising who to contact for support however it is not always possible to contact them. The panel were given several recent examples when trainees were unable to contact the on-call consultant as they were on annual leave or offsite which has made the trainees doubt the accuracy of the rota and often, they go looking for a consultant instead. We were told they do have access to the main GG&C on call consultant via switchboard if necessary. Trainees advised they are not always aware when their consultant has scheduled annual leave or who will cover during this time. Trainees felt when they do contact them the consultants are helpful. Most trainees were not receiving weekly supervision sessions and that these sessions were happening on average every fortnight

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

Trainers: It was felt trainees have a good range of opportunities in the department but highlighted there are not many research opportunities for trainees.

All Trainees: The panel were advised that due to a lack of consultant cover there are no opportunities to access ECT experience. We were told an arrangement was discussed to allow trainees to go to Leverndale Hospital, but this was impacted by COVID-19. Trainees felt that following the introduction of a centralised Liaison service there were fewer opportunities for initial assessments and decision-making. The panel were told there is no support for tasks such as taking blood and ECGs and a large percentage of their time is occupied with non-educational tasks and medical work which limits access to psychiatry experience.

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

Trainers: N/A

All Trainees: Trainees advised they have opportunities to complete work placed based assessments at supervised clinics and all felt assessments were consistent.

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

Trainers: The panel were advised trainees had opportunities to be involved in audit and other quality improvement (QI) projects. The ES advised that he checks trainees are getting involved in quality improvement activity. It was thought it is however dependent on the motivation of individual trainees to come up with ideas and undertake projects.

All Trainees: Trainees advised they have been involved with audits and QI, but they need to use their own initiative to seek out opportunities and there is no consultant involvement in QI projects.

2.9 Feedback to trainees (R1.15, 3.13)

Trainers: Trainers felt there were sources of regular formal and informal feedback for trainees including weekly supervision, on call activity and feedback from nurses and MDT staff.

All Trainees: Trainees felt there were limited opportunities to receive feedback especially as weekly supervision was not always taking place. It was felt it would be helpful to get more consultant constructive feedback.

2.10 Feedback from trainees (R1.5, 2.3)

Trainers: The educational supervisor advised the panel that he encouraged trainees to provide feedback on their training and sends out a feedback form at the end of placement. We were told regular trainee management meetings take place with representation of senior staff and trainee representatives. Trainers advised there is a west of Scotland junior doctor committee that trainees can feed into.

All Trainees: Trainees were unaware of formal processes to allow them to feedback to trainers and the management team on the quality of their training but would discuss with the educational supervisor.

2.11 Culture & undermining (R3.3)

Trainers: It was felt that everyone works well as a team due to the smaller nature of the department. Trainers highlighted that COVID-19 had impacted on team culture as activities such as coffee breaks, lunch and onsite training cannot take place. It was felt consultant presence at the Monday morning catch up had slipped recently. Trainers advised processes for reporting bullying and undermining are covered with trainees at induction and they are also encouraged to speak to their educational supervisor, TPD or escalate to the clinical director if required. The panel were told of a recent incident where a trainee had raised concerns regarding supervision and were placed with a different supervisor. It was felt the trainees also offer a high level of support to each other and discuss concerns amongst the group.

All Trainees: Trainees told the panel Dr Cochrane their current educational supervisor is very approachable and supportive. It was felt some other senior staff were not as approachable leading trainees to sometimes feel unsupported and on occasion inadequate. Trainees advised they tend to help each other and discuss things together.

2.12 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: It was felt the rota design takes teaching and clinics into account and no clinics take place unsupervised. The panel were told currently the rota is fully organised by a trainee representative, but this is under review as part of a whole south Glasgow and Renfrewshire rota review with trainee input. Trainers advised that due to a small number of trainees there is little flexibility in the rota, but two long term gaps have been filled by locums. Trainers were not aware of any aspects of this post that is compromising trainee's wellbeing.

All Trainees: Trainees advised there are two permanent gaps in the rota which for this year have been filled by locums. It was raised there would be an additional gap following change over in February and some trainees work less than fulltime (LTFT). The panel were told the rota is managed by a core trainee with secretarial support but no consultant input or support. Trainees were grateful for the time and effort given to the rota by the trainee co-ordinator and felt this was a difficult task due to limited trainee numbers. There is little flexibility in the rota, and it can be difficult to cover short notice gaps. We were given an example of an occasion where senior support was sought to help cover sickness leave but this was not forthcoming and the trainee on shift had to leave the page unmanned and ask the next duty doctor to come in early in the knowledge that they would likely breach working hours. Trainees felt the rota could lead to patient safety concerns and impacts on their wellbeing. Trainees advised the rota does not officially schedule in clinics and teaching but the rota co-ordinator tries hard to factor in trainees' learning opportunities to the on-call rota.

2.13 Handover (R1.14)

Trainers: Trainers felt the handover process was robust and it was always known who was taking over the page. We were told there is a written diary documenting any duties requiring handover and a new admission checklist has been developed by a core trainee. It was highlighted that handover is

mainly trainee led and not utilised as a training opportunity, but the Monday morning handover could be developed for this if better attended by consultants.

All Trainees: Trainees informed the panel that handover happens 4 times a day at changeover times and is trainee led and organised. The panel were told there used to be a Monday morning handover with consultant representation, but this had not been taking place recently. Due to lack of consultant support handover is not used as a learning opportunity.

2.14 Educational Resources (R1.19)

Trainers: Trainers advised there is a lack of laptops and work space for trainees.

All Trainees: It was felt there is limited access to computers which was more of a problem following a move to online learning and meetings from COVID-19. The panel were advised the department had made a bid for laptops, but things have not changed to date. Trainees are all currently working on site with no access to work from home.

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

Trainers: N/A

All Trainees: It was felt there was support available for struggling trainees and they could access occupational health help if required. It was felt not all staff were supportive of LTFT working.

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: We were advised the Deanery and APGD for the west oversee the quality of postgraduate medical education and training at the site. The educational supervisor advised he has regular contact with the TPD and discusses concerns. It was felt that due to the small size of department quality of education was discussed regularly but on an informal basis.

All Trainees: Trainees advised they would raise concerns regarding the quality of their education through their educational supervisor who they felt was very supportive. It was felt some concerns are

difficult to get help with due to a divide between departments leading to difficulty in agreeing who is responsible for the issue. The panel were told there are regular training management group meetings with representation of a junior doctor. There is no formal junior doctor forum in place to discuss matters together but it was felt that due to small numbers they communicated well as a group.

2.17 Raising concerns (R1.1, 2.7)

Trainers: Trainers advised the processes for raising concerns are covered with trainees at induction and it was felt they are aware to raise any patient safety concerns with senior nursing staff or consultants. The ES advised trainees have raised concerns regarding achieving psychotherapy competences and felt they would be comfortable discussing others they may have.

All Trainees: Trainees informed the panel that there is a degree of separation between the old age site and the general adult wards, leading to a lack of confidence concerns raised regarding old age will be acted upon.

2.18 Patient safety (R1.2)

Trainers: Trainers felt the environment was safe for patients and trainees with patient safety being paramount. The panel were advised boarding of patients happens infrequently and if patients are boarded in, they are treated the same as other patients and monitored accordingly.

All Trainees: Trainees advised they would have concerns regarding the quality or safety of care of a friend or relation who was admitted to Old Age unit but not the General Adult unit. It was discussed that there is a lack of substantive consultant presence on the Intensive Psychiatric Care Unit (IPCU) ward with only consultant presence being one morning a week. New patients are assessed by the trainee who has access to support on the phone, but patients are only reviewed by the consultant at the weekly ward round. This situation was felt to be a patient safety concern especially due to the complex nature of the care needs in this ward. The trainee currently in this placement is experienced and is an approved mental health professional registered to detain patients under the mental health act but this will not always be the case due to the rotation of trainees. It was felt boarding is not an issue at the site and when patients are occasionally boarded there are adequate processes in place to track them.

2.19 Adverse incidents (R1.3)

Trainers: The panel were informed that adverse incidents are reported using Datix which trainees are encouraged to submit. It was felt trainees would receive feedback on incidents through sessions with their clinical supervisor and that learning from incidents takes place.

All Trainees: Trainees were aware of the use of Datix for reporting adverse incidents. Trainees had limited experience of reporting adverse incidents but felt their educational supervisor would be supportive. They were not aware of formal processes in place following a Datix report including feedback and shared learning from incidents.

2.20 Other

Trainers: The panel were informed that the current educational supervisor has recently resigned, and steps will be taken to ensure there is no gap in support for trainees.

Trainees: The panel were told the foundation trainee from the department was redeployed during the first phase of COVID-19 and they have not had one since. There are currently no other trainees redeployed.

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 4 and 7 with an average of 6

3. Summary

Is a revisit required?	**Yes**	**No**	**Highly Likely**	**Highly unlikely**

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.

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 useful information 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. 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 not signs of improvement at a subsequent visit, we would have to consider recommending escalation to enhanced monitoring. A number of requirements follow.

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	Trainees should have access to a site induction as well as departmental induction.	
5.2	There should be consultant involvement and support for quality improvement projects and audits.	
5.3	Handovers take place but it would be beneficial to have formal processes and consultant involvement which would provide opportunity for learning.	
5.4	Access to ECT training for trainees should be available.	
5.5	A more cohesive relationship between department staff for example Old Age and General Adult.	

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	There must be a process that ensures trainees understand, and are able to articulate, arrangements regarding Educational Governance at both site and board level.	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. The department must ensure that there are clear systems in place to provide formal and informal feedback to trainees.	6 months	All
6.8	Measures must be implemented to address the ongoing patient safety concerns described in this report especially within the IPCU.	Immediate	All

6.9	There must be consultant responsibility for trainee Rotas with a working process to cover unexpected leave of any grade.	6 months	All
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.	6 months	All
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.	6 months	All