Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	10th March 2023	**Level(s)**	FY, GPST, CT & ST
Type of visit	Triggered	**Hospital**	Royal Edinburgh Hospital
Specialty(s)	Old Age Psychiatry	**Board**	NHS Lothian

Visit panel	
Dr Claire Langridge	Visit Lead - Associate Postgraduate Dean (Quality)
Dr Wai Imrie	Training Programme Director
Dr Chris Haxton	Foundation Programme Director
Dr Charlotte Soulsby	Trainee Associate
Mrs Natalie Bain	Quality Improvement Manager
Mr David Soden	Lay Representative
In attendance	
Mrs Susan Muir	Quality Improvement Administrator

Specialty Group Information		
Specialty Group	Mental Health	
Lead Dean/Director	Professor Clare McKenzie	
Quality Lead(s)	Dr Alastair Campbell & Dr Claire Langridge	
Quality Improvement Manager(s)	Mrs Natalie Bain	
Unit/Site Information		
Non-medical staff in attendance	2	
Trainers in attendance	2	
Trainees in attendance	3 x FY2, 1 CT, 1 GPST, 1 ST	

Feedback session: Managers in attendance	Chief Executive		DME		ADME	x	Deputy Medical Director	x	Other	x

Date report approved by Lead Visitor	12th April 2023

1. Principal issues arising from pre-visit review:

The Mental Health Quality team at Scotland Deanery triggered a visit in view of survey data relating to Old Age Psychiatry at Royal Edinburgh Hospital, NHS Lothian. The visit team planned to investigate the red flags at All trainee levels in the 2022 National Training Survey. These were for educational governance, handover, local teaching and reporting systems, as well as pick flags in relation to clinical supervision, clinical supervision OOH, rota design and supportive environment. The Scottish Training Survey also highlighted red flags at ST level for Handover and a pink flag for Teaching. There was also a negative freetext comment at FY level in the STS survey. The visit team planned also to use 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.

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: The trainers reported that there was a comprehensive induction that covered all aspects of training. The trainees are given 3 days of induction specific to their training level. For example, the FY and Core trainees get specific sessions on risk assessments and detaining patients under the Mental Health Act. All trainees get ID badges and access to TRAK. Trainees also attend violence and aggression training and also active bystander training.

Trainees: The trainees reported receiving a good hospital induction, with a clear induction timetable sent out in advance of starting. They had ring fenced time with useful information provided, a SIM session (which was very beneficial), violence and aggression training and a guided site tour of the hospital site. However, the trainees reported a poor departmental induction, with some trainees having no induction at all. They said they were emailed several versions of a departmental handbook and found information it contained was out of date or incorrect. The trainees said they relied on peer support from those already in the department for induction type information. OOH was covered well by the hospital induction but they were unsure about the structure and processes of their day-to-day ward duties and which wards they should be on. The trainees stated that induction would be

improved if a consultant took ownership of it and created a more formal structure to it along with for example assigning them wards ahead of beginning in post.

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

Trainers: The trainers reported that trainees have access to weekly departmental teaching that provides opportunities to present cases as well as having taught sessions. There is protected time for releasing each trainee group to their specific teaching, for example, on a Wednesday morning for MRCPsych for core trainees. There is also a clinical conference chaired by a consultant that all trainees are actively involved in. The trainers ensure that the wards are aware of the teaching timetable and it has been embedded as part of the ward routine that trainees will not be available during their teaching time.

Trainees: Trainees reported being able to attend up to 4 hours of teaching weekly, including case conferences and Balint groups. Teaching that is attended is relevant to all curriculums of trainees in post. Teaching is described as not formally bleep free; however, trainees are not usually interrupted during it. All trainees are able to attend both departmental and regional teaching when available.

2.3 Study Leave (R3.12)

Trainers: Not formally asked

Trainees: Not formally asked

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

Trainers: The trainers reported that the supervisor roles are discussed among the trainers and it is agreed who will be supervising each trainee cohort. They tend to supervise the same grade of doctor each time so they are aware of their particular curriculum needs. The trainers do not have any barriers to fulfilling their supervisory roles, however they believe there could be more robust discussions relating to their job plan. All trainers have time allocated in their job plan for their role. The trainers attend a monthly peer group with trainers across Scotland and find these meetings useful in creating a culture that supports training. The trainers have no awareness of a formal transfer of

information process if there are known issues with a trainee, usually the trainers would be made aware of this by default or by the candidness of the trainee.

Trainees: The trainees reported that they are able to meet with the supervisor on a weekly basis for their supervision session. It was noted there was a brief time when there was no supervisor in post, however this was quickly rectified and supervision was reinstated with the trainees.

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 trainers stated that the term SHO is not used by staff members and that colour coded ID badges are used to differentiate between training grades. The trainers emphasised that the wards in general have a good awareness of who everyone is. It was noted that escalation pathways are explained at induction. They said that there was always clear supervision during the day and OOH. During the day there was a senior colleague on the ward, either a consultant or specialty doctor. If there are sickness it was always highlighted and communicated to the trainees who was overseeing the wards.

Trainees: The trainees reported that they are mostly aware of who is providing clinical supervision during the day. The trainees stated that there have been various issues previously that do seem to be resolved, however specifically on a Friday, the only person to escalate any concerns to is the clinical director. The trainees are thankful that there is a named person, however, it is common for the responsible person to not be aware of the patient's management plans. They felt that the consultants were overstretched and overworked due to the number of patients they were looking after. Due to the nature of the Old Age Psychiatry wards the patients often have complex medical issues that the FY and GP trainees have to manage on a daily basis. They feel the Hospital at Home team do provide a very useful means of support and attend fortnightly ward meetings to discuss cases. They are able to call them for advice and email them but they are not always immediately available. Otherwise for sicker patients needing transfer to Edinburgh Royal Infirmary they need to speak to the Medical Registrar on call. They often feel under pressure to look after the physical needs of the patients on a daily basis with no one more senior than themselves as FY2s seeing them and they do not feel as supported when these discussions to consultant psychiatrists take place over the telephone. The trainees commented that there is no middle step for escalation as there is often no Old Age Psychiatry registrar on site. The trainees noted that OOH the on-call consultants are accessible and

approachable with no issues. Rota watch will hopefully help direct trainees to the correct person for specific issues.

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

Trainers: The trainers reported that due to the nature of the specialty, there is always a pressure to ensure that the trainees are exposed to the sufficient psychiatry training as patients do present with physical health issues. The trainers noted that it is partly about the mindset of the trainees to look out for the psychiatry opportunities by reviewing the patients mental state as they evolve over time. The trainers believe that the service would be improved with the provision of an ECG technician and phlebotomist and more input from the Hospital at Home team (HAH) and Medicine for the Elderly team.

Trainees: The trainees reported that they do not feel like they have witnessed much psychiatry and some have seen only a few mental state examination reviews by consultants. The trainees highlighted that they spend more time doing physical reviews and very little in psychiatry. The on-calls are good for psychiatry reviews when trainees are on Rota B, but all trainees do not get the same opportunity as some are allocated to rota A and on this rota, they see the medical problems of patients across the site rather than psychiatric issues.

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

Trainers: The trainers reported that the trainees are able to complete their assessments without many issues, but they recognise that ACEs (Assessment of Clinical Expertise) are more challenging to complete. Although there is no formal benchmarking process against other trainers, the trainers report that being part of the higher training committee allows for an informal sense of how others provide and complete assessments.

Trainees: The trainees reported that there is plenty of opportunity to complete WBA's through the protected supervision time and they are all consistent and fair. However, there is a concern that outside supervision there may not be as much opportunity. It was noted that trainees can be relying on one consultant to complete ACEs and these were more challenging and only completed within the inpatient setting.

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

Trainers: The trainers reported that there are no formal sessions together with the wider healthcare team, but there are MDT meetings that everyone regularly attends along with any QI sessions.

Trainers: The trainees reported that there are regular MDT meetings. There are no formal teaching opportunities, but the trainees spend a good portion of time with the wider MDT and learn with one another.

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

Trainers: The trainers reported that the trainees are supported to undertake quality improvement work. There is a QI lead and a forum that supports and develops the projects with the trainees.

Trainers: The trainees noted that there is a QI team that trainees have met with, however trainees do have to seek this out. The trainees state they are helpful and will support the trainees. It was also highlighted that although trainees can seek out time to complete a QI project, there is not always enough time to do it and it is not felt a priority for training.

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: The trainers reported that clinical staff would routinely give informal feedback to the trainees during the day. The trainers operate an open-door policy for trainees to ask questions, trainees are also encouraged to bring any issues to their weekly supervision sessions. The site also uses the Greatix system to give positive feedback to trainees but this is probably underused.

Trainees: The trainees report that there is no feedback OOH, but during the day if trainees request feedback, it is given, but usually feedback is given through supervision time. Any feedback given is constructive and meaningful.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: The trainers noted that there is a confidential survey that the trainees are asked to complete at the end of the post, the trainees are encouraged to be as candid as possible to improve training. The trainers highlight that there is an active junior doctor forum and a trainee representative who attends the Specialty Training Committee (STC).

Trainees: The trainees noted that they felt this Deanery quality visit was a good vehicle for feedback. There were aware of the surveys about the post but felt that the freetext comments was limited to 250 characters and was too short. Trainees were not aware of any forums to feedback any concerns. Trainees have raised induction concerns with their supervisor at their weekly sessions. Trainees emphasised that they felt that management were aware of staffing issues, but the immediate management had little control over how to fix things and they did not always have concrete plans in place to ensure appropriate cover was in place. The trainees felt that information filters through and there is an expectation that people will just pick up the slack and therefore put further pressure on those who are there. The trainees state that meetings were held to discuss these issues, but the trainees felt that the meetings held were demoralising.

2.12 Culture & undermining (R3.3)

Trainers: The trainers report that there is positive culture that has been embedded into the hospital. All staff are encouraged to attend active bystander and whistleblowing training. It is emphasised to trainees at induction what is expected of them within the hospital. The trainers encourage trainees to discuss any concerns at their weekly supervision and find this session to be very supportive. However, if there are any immediate concerns that require to be raised, trainees are aware of how to escalate and to who.

Trainees: The trainees report that the site is a supportive and professional environment. There is no undermining behaviour. The trainees comment that despite the pressure the senior colleagues are under, they are always supportive. The trainees feel that there is not a strong Datix culture in the department and sometimes Datix can be treated as an inconvenience.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: The trainers reported that the rota is comprehensive and is shared with the trainee at the start of their training via email. The current staff numbers presently do not give trainees adequate access to clinics; however, the trainers are working on ringfencing a day a week (in the community) but trainees are not routinely given access to outpatient clinics. The trainers emphasise that this remains one of the more challenging issues currently on site. There are occasional rota gaps but they are managed through the locum process. There is always an awareness of the gaps and discussions are had about how best to cover the gap.

Trainees: The trainees reported that there is a comprehensive OOH rota however for their weekday 9-5pm work there is no Old Age Psychiatry rota which tells them which ward they should be on each day. This means that the trainees have made up their own spreadsheet and have to work out who is currently available on site each week (from the OOH rota), who covers which ward, if there are any gaps that need filled and decide if someone is able to take annual or study leave. There is no consultant oversight of the spreadsheet that the trainees have made up and no allocated person responsible for approving annual/study leave or a formal process for trainees to follow. Due to the trainees managing their rota and only receiving a part rota when beginning in post, there is no awareness of who is starting in the department at changeover times. Therefore, this has affected when trainees are able to take their leave, and they have now found that they all need to take annual leave in the last 2 months of the block. The junior trainees noted that they feel overwhelmingly pressured to manage the workload and also manage the nursing staff's anxiety around patient care and escalation of care. It was stated that there are patients who have not been reviewed by a senior colleague for as long as a month, which leaves the junior trainees managing family queries and medication reviews.

2.14 Handover (R1.14)

Trainers: The trainers reported that there is a formal structure for handover in place at the weekend. The trainers recognise that there are issues with the handover during the week. Presently there is no mechanism to handover in an electronic format, there is no generic mailbox and TRAK is not used consistently.

The trainers reported that there is a rapid run down that take place on each ward, however they are all in agreement that there needs to be an easier way for the doctor at night to hand over to the doctor during the day.

Trainees: The trainees reported that there is only a formal handover at weekends that is safe and fit for purpose. The trainees raised concerns about the handover during the week. There is no consistent approach to how it is done and it is not safe. In particular the handover from night-time to daytime is not safe, as there is little way of knowing who to approach for a handover or give a handover to. Trainees do not use a central system to handover information and found that there is no consistency when using TRAK for handover. The trainees also reported that they have patient safety concerns relating to handover. There are times when information has not been handed over or no awareness of patients that have been clerked in overnight, therefore leading to issues with patients not being assessed in the appropriate timeframes or other pertinent information being communicated. The trainees feel anxious and demoralised because of this, for the fear of missing vital information, which leads to the trainees having patient safety concerns.

2.15 Educational Resources (R1.19)

Trainers: Not formally asked

Trainees: There are no issues with the educational resources.

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

Trainers: The trainers note that support is given to the trainees through their supervision lines. If there are specific concerns raised it would be discussed with the trainee and directed appropriately.

Trainees: Most trainees have no experience with requiring specific support for the job, however they felt that some trainees who are less than fulltime training can feel more pressure and expectation on them as they are not on site every day.

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 trainers stated that there is a training committee for both Core and Higher training, which has overlap with the DME with trainer involvement. During these meetings both trainees and posts are discussed explicitly, especially if there are noted concerns.

Trainers: The trainees reported that they would raise issues with their training with their supervisors and through Deanery quality visits. Some trainees have raised concerns regarding the amount of psychiatry in the post, although the supervisor was sympathetic to it, it was felt that little could be done to resolve the issue. The trainees also noted that there is a trainee representative that would attend meetings, but trainees are not always aware of who they are and what they attend.

2.18 Raising concerns (R1.1, 2.7)

Trainers: The trainers reported that any issues with patient safety can be raised with the clinical supervisor or during the weekly supervision meetings. Trainees are also encouraged to use the Datix system.

Trainees: The trainees report that they can raise concerns via the Datix system but noted that you cannot Datix ‘a system.’ Trainees feel that there is not consistent communication when Datix’s are submitted.

2.19 Patient safety (R1.2)

Trainers: Not formally asked in this question but trainers reported they had no patient safety concerns in relation to workload and rotas.

Trainees: The trainees reported that the believe the nursing care is suitable and they would have no issues with this, but the medical care is not adequate and there needs to be more staff available.

2.20 Adverse incidents & Duty of Candour (R1.3 & R1.4)

Trainers: The trainers reported that trainees would use Datix to report any incidents and the trainers are informed when they do so. Following the incident, the trainee would be supported and anything concerning could be further discussed during supervision sessions, feedback would be given after an SAE review. A senior colleague would always be the person to communicate to patients if anything has gone wrong with the patient care and that junior staff could accompany them for learning.

Trainees: The trainees noted that when they have submitted a Datix that their supervisor is informed that their trainee has submitted a Datix, but it is anonymised. There is no culture of immediate de-briefing following any adverse event. The trainees felt like they would benefit from more support from the medical teams to manage the physical issues that patients present with. The trainees state they have no seniors to support them at the weekend and this is where it would be useful to get the input from the medical teams. Trainees feel disheartened whilst in post.

2.21 Other

3. Summary.

Is a revisit required?	**Yes**	**No**	**Dependent on outcome of action plan review**

Positive aspects of the visit

- The panel were pleased to see that the trainers are engaged and keen to provide good supervision to trainees.
- It was happy to hear that funding has been approved for an ANP, ECG technician and Phlebotomist.
- The panel were pleased to hear about the input from the Hospital at Home and Medicine for the Elderly team.
- Trainees were able to attend most if not all teaching and found the teaching to be useful towards their curriculum competencies.
- Overall hospital induction was good and prepared the trainees for working on site and OOH.

Less positive aspects from the visit:

- Two patient safety issues were raised to the panel:
    - There were staffing issues that have led to patients on the acute dementia wards not being reviewed on a regular basis leading to concerns being raised by family members.
    - Handover, although there is a good weekend handover in place, weekday handover has safety issues particularly relating to the night to daytime handover. Handover at times is not happening, which is creating anxiety in the trainee group over missed tasks.
- It was noted that the trainee group as a whole felt demoralised but they also recognised that the entire unit was stressed and overstretched.
- Overall, the induction to the department is poor. There is no formal structure for this, the handbook that is given to trainees contains out of date information. The trainees are also not aware of the ward allocation when beginning in post.
- The OOH rota was not provided to the trainees in the allotted time before beginning in post. The trainee's weekday rota is self-managed and would benefit from more oversight from either a senior staff member or administrator to ensure consistency across the trainee levels.
- It was noted there is considerable lack of access to clinics. This is due to the trainees having to manage their rota timetable and they are not able to rota in reasonable time to attend clinics.
- Again, due to senior staffing issues, it was highlighted that Friday's are a day of particular concern among the trainee group. Although there is a named consultant the trainees are not able to escalate any issues in a timely manner to anyone on site and are left feeling exposed.

The deanery and GMC will review the content of this report and following this the GMC will write to the Health Board regarding the status of enhanced monitoring.

4. Areas of Good Practice

Ref	Item	Action
4.1	n/a	

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	n/a	

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	Measures must be implemented to address the patient safety concerns on the acute dementia ward in relation to the review of patients	10th July 2023	All trainees
6.2	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.	10th July 2023	All trainees
6.3	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	11th December 2023	All trainees
6.4	The unit handbook must be kept up to date to reflect changes to departmental processes.	11th December 2023	All trainees
6.5	The unit should actively seek administrative resource to take on rota and leave management and all items relating to it.	11th December 2023	All trainees

6.6	The trainee rota must be issued to trainees with a minimum of 6-weeks' notice	11th December 2023	
6.7	There must be provision on the rota to ensure CT & GPST's can attend clinics relevant to their training needs.	11th December 2023	CT & GPST