Scotland Deanery
Quality Management Visit Report

Date of visit	26th April 2019	Level(s)	FY/GP/Core
Type of visit	Scheduled	Hospital	Borders General Hospital
Specialty(s)	Mental Health	Board	NHS Borders

Visit panel	
Amjad Khan	Visit Chair – Lead Dean Director Mental health
Wai Lan Imrie	Training Programme Director
Jan Lyell	Lay Representative
Dawn Mann	Quality Improvement Manager
Eleanor Davidson	Trainee Associate
In attendance	
Patriche McGuire	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	4	
Trainers in attendance	8	Inc Medical Director and Operational Managers
Trainees in attendance	5	FY/GP/Core
Feedback session: Managers in attendance	DME, Medical Director and Operational Managers	
Date report approved by Lead Visitor	21 May 2019	

1. Principal issues arising from pre-visit review

This is a scheduled visit as part of the Deanery's five-year plan to visit each unit delivering training within the quality cycle. The visit team will take the opportunity to gain a broad picture of how training is carried out within the department and to identify any areas of innovation or good practice for sharing more widely. The visit provides an opportunity for trainees and staff within the unit/department to tell the Deanery what is working well in relation to training; and also, to highlight any challenges or issues, the resolution of which could be supported by the Deanery.

The 2018 NTS data was positive for Borders General Hospital with the site receiving letters of good practice from the Foundation, GP and Mental Health Specialty Quality Management Groups (SQMGs).

Following a review of the data and pre-visit questionnaires the visit panel's main areas of focus were clinical supervision, induction and handover.

2.1 Induction (R1.13)

Trainers: The panel were advised that a corporate induction program runs at regular intervals during the year when trainees change over. This induction program includes sessions where the trainees meet the DME and Medical Director, information from HR and a session on the mental health act. The trainees will also have an opportunity to complete eLearning modules. The trainers advised there is also a local induction meeting hosted by the ADME for mental health which includes information on the history of the site, the different teams and wards, roles and responsibilities, the on-call system, the teaching program and role timetables. We were advised trainees are asked for feedback on the induction programmes and appropriate changes were made.

Trainees: Trainees advised they had all received a corporate and local induction. Trainees advised that they did not receive EMIS training or violence and aggression training until several weeks into the placement and felt this would be beneficial at the start of their placement.

Non-Medical Staff: Staff felt the induction was fairly good at preparing the trainees for the wards. It was felt the induction training could be improved for the completion of risk assessments and care cards for discharge. It was felt there is an opportunity for more MDT involvement at induction.

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

Trainers: The panel were advised that local teaching takes place on Mondays during term time and comprises of a one-hour journal club and a one-hour educational slot. We were told external speakers are invited to the educational slot. Trainers advised local teaching is not bleep free however it is rare for a trainee to have to leave during the training sessions. Trainees have protected time to attend grade appropriate regional teaching.

Trainees: Trainees confirmed they are encouraged to attend local teaching sessions on a Monday during term time. It was reported that one trainee will be on call, but the nurses are aware of the training sessions and it is rare to miss teaching due to service commitments. We were advised that the consultant who normally organises the teaching program is currently on maternity leave, so it has felt a little less structured this term however there have still been regular sessions and external speakers. All trainees advised they receive protected time to attend regional teaching but will miss some due to rest days.

Non-Medical Staff: Nursing staff advised they are aware when teaching is on and will try not to bleep trainees at this time if avoidable.

2.3 Study Leave (R3.12)

Trainers: The panel were informed there are no issues with trainees accessing study leave.

Trainees: Trainees advised they had no problems gaining study leave.

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

Trainers: It was reported that as the site has a relatively small consultant body it is expected that they take on training roles. Trainees are allocated depending on their preferences be that

geographical area or speciality. The panel were told that often trainees have trained within NHS Borders previously so local information would be passed on regarding the trainees. The educational supervisor attends regular meetings for the South East where information would be shared if there are known concerns. Trainers all advised they have time within their job plans to allow them to undertake their educational role and they have access to training. Trainers told us that their training role would be discussed at appraisal.

Trainees: Trainees advised they all receive weekly supervision sessions.

Non-Medical Staff: Staff felt trainees can access senior support when required, albeit on some wards it is easier than others.

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

Trainers: The educational supervisor for Core advised that she attends meetings in Edinburgh where changes in the curriculum are discussed and she would pass this information onto trainers. Trainers told us they would also rely on trainees to advise them of their curricular needs. Trainers felt the competencies were easily achievable for trainees. We were told there is a focus on training at the site and they are conscious of maintaining a balance between training and service needs. Trainers will check in with trainees at weekly supervision to ensure they remain on track to completing their competencies and ensure a balanced caseload.

Trainees: Trainees felt they received a good mix of inpatient and outpatient experience. They all felt they would have no difficulty in achieving their competencies. Trainees described feeling well supported by the site, receiving adequate time for CPD and having a good balance between service and learning. One trainee described the placement as ‘awesome’. The panel were advised that due to small numbers of trainees it can require a ‘bit of juggling; to cover service during annual leave etc.

Non-Medical Staff: The panel were told that nursing staff on Huntley burn ward run observation teaching for trainees.

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

Trainers: Trainers felt the trainees have no difficulties in achieving their portfolio assessments and trainers are made aware of the relevant assessments from Deanery updates and from trainees. Trainers have not attended formal training on how to undertake workplace-based assessments. It was discussed that trainers meet regularly and can discuss assessments with other trainers if they would like guidance.

Trainees: Trainees advised there is normally a consultant available for supervision, but they may not be of that specialty. Trainees felt the assessments were fair and consistent.

Non-Medical Staff: Staff confirmed they are asked to complete multi source feedback for the trainees.

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

Trainers: It was felt by the group that trainees have lots of opportunities for multi professional learning due to the nature of mental health training.

Trainees: Trainees informed the panel they attend weekly team meetings with MDT professionals including social workers, occupational therapists and support workers. They told us they have the opportunity to shadow the psychologist and the pharmacist is helpful.

Non-Medical Staff: Staff felt the ward rounds were a good opportunity for joint learning and confirmed nursing staff are invited to local teaching sessions, but workload often prevents them from attending.

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

Trainers: It was reported that audits are discussed with trainees at induction. There are some rolling audits for example Lithium monitoring, it was felt by the trainers that audits could be logged in a more formal fashion.

Trainees: Trainees advised consultants are supportive of audit projects however it can take 4-6 weeks to gain board approval for audit projects, as trainee placements are only a few months this can impact on their ability to complete audit projects.

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

Trainers: The panel were advised trainees all wear coloured badges to allow staff to identify their level of competence and it was felt nursing staff were aware of the different grades. The panel were informed that the on-call procedures were discussed at induction including who trainees should contact for support. As there are no specialty trainees', trainees contact consultants directly during the night, but we were told they are encouraged to do so. There is also a calendar that advises who is covering on call when a consultant is on annual leave. Trainers were not aware of any instances where trainees had to cope with problems beyond their experience. All level of trainees receives an hour's weekly supervision. Trainers told us that GP trainees will spend their first few weeks shadowing a consultant at clinics and when it is deemed they are ready they will attend outpatient clinics without onsite supervision. Supervision can be accessed via phone if required and treatment plans will be discussed with consultants retrospectively. The cases given to trainees will have been through a triage system.

Trainees: Trainees advised that during day to day working and whilst on call they know who to contact for supervision. We were told that if a consultant is on annual leave trainees are told who will cover supervision duties. GP trainees told the panel that several weeks into their placement they are seeing patients in GP practices without consultant supervision on site, due to annual leave and rest days this could mean they have not received much training to prepare them for solo clinics. We were told patient appointments are either for medication reviews or are returning, it was highlighted that some patients have only been seen by different trainees and not a consultant. Core trainees have access to onsite consultant support at outpatient clinics. Trainees felt their senior colleagues were very accessible and approachable.

Non-Medical Staff: Staff were unaware of the coloured badge system which is used to identify the grade of doctor and their competency level. It was discussed that there may have been posters, but they are not sure where they were displayed. Nursing staff would rely on the trainees to advise them of their grade and competency level.

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: The panel were informed that due to the small size of the site trainees work directly with the consultants and receive immediate feedback whilst on wards and on call. Trainees also receive feedback at weekly supervision sessions.

Trainees: Trainees advised they receive formal feedback at weekly supervision sessions and due to the small team receive informal feedback on a daily basis. They find the feedback constructive and meaningful.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: Trainees can provide feedback at weekly supervision sessions. We were told that trainees are encouraged to complete the NTS and STS to provide feedback on their placement. Trainees are also invited to the medical committee meetings.

Trainees: Trainees felt they have opportunities to provide feedback to trainers on the experience of their training.

2.12 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Trainers advised that HR produce the rotas to ensure they are compliant. Trainees arrange their own swaps for annual leave etc. We were told the on call demands in mental health has increased in recent years and the rota was changed to reflect this, trainees now work a 24-hr shift with a 4-hour protected rest period and a rest day proceeding the shift. The site is aware that this rota pattern especially at times of increased annual leave can have an impact on trainees attending teaching sessions etc but after a review it is felt this is the best system for trainees. The panel were told that a nurse will monitor all calls during the night and will contact the consultant direct to protect trainees rest period. It was felt the rota concerns would not impact on patient safety.

Trainees: The panel were told that HR oversee producing the rota but as they are not aware of all the trainee’s clinical commitments trainees organise swaps to cover training and leave. It was felt this

system and the rota were not ideal but was the 'least worst option'; trainees felt if they had suggestions to improve the system the site would listen to them and be open to change.

Non- Medical Staff: Nursing staff advised they try to ensure trainees get 4 hours uninterrupted rest overnight, on rare occasions this may not be possible.

2.13 Handover (R1.14)

Trainers: Trainers advised daily handover is by email between trainees and at weekends a call is made to the duty consultant to advise of admissions and workload expectations. There is also an online system which allows staff to task teams where relevant.

Trainees: Trainees advised they introduced the current email handover process as there was nothing in place. An email is sent between trainees with no senior involvement. Trainees advised it is difficult to carry out a face to face handover due to differing locations but felt the current system relies on an element of trust. Trainees attend a face to face handover at weekends with nursing staff and members of the crisis team.

Non-Medical Staff: It was confirmed that trainees would be involved in the weekend ward handovers.

2.14 Educational Resources (R1.19)

Trainers: The panel were advised there is a good library on site and all trainees have adequate access to computers. There are known issues with the WIFI signal in all areas, but this is being tackled and it is hoped all areas will have coverage by the end of the summer.

Trainees: Trainees felt the library was a good resource and liked having access to a workspace away from clinical areas. Due to hot desking it could sometimes be challenging to access a computer, but this was not felt to be a regular problem.

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 trainee concerns would be fed through the educational supervisor. We were told trainees are offered individual careers guidance as part of supervision sessions. The site has a good recruitment record and have attracted trainees who have worked in the site as part of a different specialty.

Trainees: Trainees felt staff were supportive and the panel were given recent examples where the site had made reasonable adjustments for trainees.

Non-Medical Staff: The panel were advised staff would raise any concerns regarding a trainee with the appropriate consultant.

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: The panel were told that the DME office have a good relationship with the site and play an active role in managing the quality of education provided at the site.

Trainees: Trainees were unsure who was responsible for the quality of education at the site. They were aware who the DME was and confirmed they attended an induction session but were unclear as to the specific role.

2.17 Raising concerns (R1.1, 2.7)

Trainers: It was reported that trainees are actively encouraged to discus patient safety concerns with consultants and management and there are policies in place to support this. All staff are encouraged to use the Datix system. It was felt that trainers' model high quality of care. We were told the site develop a culture of awareness around patient safety and it is discussed at team meetings. It was felt trainers are supported with their training needs through appraisal, CPD peer groups and the DME advising on RoT processes.

Trainees: Trainees advised they would raise patient safety concerns with consultants in the first instance and felt these would be taken seriously. They would also report via Datix. If trainees had

concerns regarding their education, they would feel comfortable speaking to their clinical or educational supervisor.

Non-Medical Staff: It was reported that patient safety is talked about regularly and there are regular safety huddles and safety briefings.

2.18 Patient safety (R1.2)

Trainers: Trainers felt the environment was safe for patients and trainees. There is limited boarding of patients at the site, rarely a patient will be placed in a ward that is not specific to their needs but the site work hard to minimise this and staff have appropriate training. There are routine systems in place to monitor the safety of patients including daily safety huddles, safety brief on every ward and regular risk assessments by the health and safety team.

Trainees: Trainees told us they would have no concerns regarding the care of friends or family members if they were admitted to the site. We were told patients are rarely boarded and as it is a small team everyone would be aware of the patient's needs if it did occur.

Non-Medical Staff: The panel were told that there are some mental health facilities which are lacking in appropriate facilities which can impact on patient safety but does not compromise the care patients receive. We were told that trainees are not involved in the safety huddles, but each ward has a safety briefing print out that any staff member can review.

2.19 Adverse incidents (R1.3)

Trainers: It was reported that trainees are encouraged to discuss adverse incidents with consultants and report through Datix. Everyone involved in the incident will receive feedback. Adverse incident reviews are included in a regular newsletter and discussed at team meetings. Themes of adverse incidents are discussed in an education slot at local training.

Trainees: Trainees felt comfortable using the Datix system to report adverse incidents and felt they would receive feedback following an incident. The panel were informed there is a regular newsletter

all staff receive which includes details which could be used as learning from adverse incidents and there has been an adverse incident review session at local teaching.

2.20 Duty of candour (R1.4)

Trainers: The trainers felt the culture fostered at the site and flat hierarchy system fosters good relationships among the trainees and senior staff which in turn encourages trainees to be open and honest when things go wrong. The panel were given an example where a mistake had occurred, and the trainee had received support to talk with the family and received feedback.

Trainees: Trainees reported they would feel well supported if they were involved in an incident when something went wrong and would feel comfortable being open about it with senior staff.

2.21 Culture & undermining (R3.3)

Trainers: The panel were informed a bullying and undermining session forms part of induction and there are policies in place. Trainees would be encouraged to speak to their supervisors or the medical director who is visible at the site.

Trainees: Trainees reported they had not witnessed undermining or bullying behaviour at any level during their placement. The panel were advised there is a bullying and undermining module as part of the virtual induction pathway and the Medical Director advised them at induction that ‘his door is always open’.

Non-Medical Staff: Staff were unaware of any incidences of undermining or bullying behaviour and felt there is a positive team culture at the site.

2.22 Other

Trainees were asked to score their training experience from 0-10, the average score was 8 with a range from 7 to 9.

3. Summary

Is a revisit required?	Yes	No	Highly Likely	Highly unlikely

We would like to thank the site for their assistance in organising the visit and good attendance on the day. Please find below a list of positive and less positive aspects from the visit:

Positive:

- Supportive and approachable senior team; strong on pastoral care and career support
- Cohesive consultant team with high standards of role modelling
- Strong focus on training for trainees and trainers
- Regular, valued local teaching which all trainees are supported to attend
- Positive team culture with emphasis on flat hierarchy
- Shared learning from adverse incidents including adverse incident briefings and regular newsletter

Less than positive:

- Outpatient clinics: GP trainees have no onsite supervision at clinics and there is a chance of patients seeing only trainees and trainees having limited experience of new patients.
- Although the trainees wear coloured badges, staff were unaware of the meanings and differing levels of supervision required.
- Induction: We were advised it took several weeks for some sessions including the new IT system and violence and aggression training. There could also be more detail on risk assessment and care cards and greater trainee involvement in induction.
- Handover: There is no formalised system in place for handover and no management involvement in the current email system.
- Audit: trainees are encouraged to undertake audit projects, but it can take some time to gain audit board approval for projects.

5. Areas for Improvement

Ref	Item	Action
6.1		It would be beneficial for to trainees to receive violence and aggression training at the start of placement.
6.2		Audit sign off process should be reviewed to allow trainees to begin in a timely manner.
6.3		It would be beneficial for patients to be seen by a consultant and not just passed between trainees. Trainees should also have access to experience new patient reviews.

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
7.1	Trainees must not undertake outpatient clinics without access to on-site, in-clinic consultant supervision.	9 Months	All
7.2	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.	9 Months	All
7.3	All trainees must have timely access to IT passwords and system training through their induction programme.	9 Months	All
7.4	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 must be introduced.	9 Months	All