Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	14th/17th December 2020	**Level(s)**	FY/GP/Core/Higher
Type of visit	Enhanced Monitoring Revisit	**Hospital**	Pan Tayside
Specialty(s)	Mental Health	**Board**	NHS Tayside

Visit panel	
Clare McKenzie	Visit Chair - Lead Dean Director Mental Health
Robin Benstead	GMC Visits & Monitoring Manager
Rosie Lusznat	GMC Enhanced Monitoring Associate
Stuart Holmes	Lay Representative
Wai Lan Imrie	Training Programme Director
Claire Langridge	Associate Postgraduate Dean – Quality
Rhona McMillan	GP Training Programme Director
Dawn Mann	Quality Improvement Manager
Timothy Jagelman	Trainee Associate
In attendance	
Susan Muir	Quality Improvement Administrator
Gaynor MacFarlane	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	17	
Trainees in attendance	8 FY/GP, 15 Core, 7 Higher	

Feedback session: Managers in attendance	Chief Executive		DME Yes		ADME Yes		Medical Director Yes		27 including Director for Mental Health,NHS Board executive MD and AMD for Mental Health and LD	

Date report approved by Lead Visitor	25th January 2021

1. Principal issues arising from pre-visit review:

Following four visits to Murray Royal Hospital where it was identified that concerns were not localised to that site, the first Pan Tayside visit took place in November 2017. At this visit we wrestled with the decision about whether to escalate the level of scrutiny to the GMC's Enhanced Monitoring arrangements. However, we were encouraged by the improvements that had been reported by the more junior trainees and by the attendance at, and engagement in the consultant session of the visit (24 consultants). Also, this was our first visit to general psychiatry services across Tayside and we decided against escalation at that point in order to provide an opportunity for improvement to take place. Following a subsequent visit in May 2018 General Adult Services across Tayside was placed on enhanced monitoring. An enhanced monitoring revisit took place on 23rd January 2019 with another on 9th October 2019. Please see below the summaries from the October visit:

Positive aspects of the visit:

- Supportive consultant body, who we were told are going above and beyond in challenging circumstances.
- No patient safety concerns raised.
- Regional teaching is protected, and Thursday morning teaching is an expectation.
- GP/FY groups were mainly happy with the training they receive.
- Annual Training meeting for trainers.

Less positive aspects from the visit:

- Higher GAP teaching programme is not formalised and has little consultant support
- As no Liaison services in Perth there is some confusion as to who should be contacted for cover and who can be contacted for support.
- Undermining of trainees and fear of raising concerns due to perceived repercussions
- No formal process for learning from adverse events or providing feedback.
- A high percentage of consultants have no formal job plan and no SPA time for training
- Induction could be improved with further information on IT, passwords prior to post and aformal process for catch up sessions for those out of synch or absent.

- No consultant oversight of trainee rotas, rotas still have 24hr shifts and higher rota running on8 instead of 14, trainees are unaware if rota is compliant or how to check.
- Imbalance between non educational tasks i.e. phlebotomy and ECG and those of educational benefit.
- Shortage of substantive consultants putting pressure on clinics, supervision and workplace-based assessments.

On the day of the October 2019 visit the panel were told of a service under pressure from a lack of substantive consultants which is impacting on both trainers and trainees. We were told most of the consultants are supportive and many go above and beyond to limit the impact on trainees' teaching. Following finalisation of the report, a discussion was held between the deanery and GMC to explore whether conditions should be placed on the continued approval of ongoing training in Tayside in General Adult Psychiatry, to help drive the required improvements, and it was agreed that a decision on conditions would be postponed until the June 2020 revisit.

An enhanced monitoring revisit was planned for June 2020 but was postponed due to the impacts of COVID-19. The GMC wrote to the DME to advise that any decision on conditions would now be deferred until the next visit. After review of the 3 monthly updates, it was agreed an enhanced monitoring revisit should be timetabled to take place virtually on 14th and 17th December 2020.
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.

We would like to thank the department and DME office for helping us arrange this virtual visit and for the large attendance especially at the site presentation and feedback session.
On the day the panel attended a session with service leads who provided a useful update on Mental Health across Tayside since our last visit in 2019. This included short talks from Mike Winter, Kate Bell, David Rooke and a Core Trainee Representative and provided information on investment in senior staff roles and appointments, work of Strategic Partnership, the collaborative development of Tayside Mental Health Strategy, management/trainee engagement and ongoing work on the previous requirements.

2.1 Induction (R1.13):

Trainers: Due to COVID-19, induction now consists of a day online and then some time individually or in small groups on their wards. We were informed that videos are available to view online covering the induction content which allows trainees to view them who were not able to attend on the day. It is expected that trainees' clinical supervisors provided a summary catch up at the meeting at beginning of the placement. The panel were advised that feedback is requested from trainees after induction sessions with highlights of the most recent including 80% of trainees say it increased their confidence and 90% reporting induction was relevant to the role. Trainers advised that trainees shadow consultants at the beginning of their placement and are heavily supported for approximately the first month of training. Trainers felt there was now more opportunity for peer support as there is a full complement of core trainees.

FY/GP Trainees: Trainees advised they had all received online induction which included information on who to contact for support, how the rota works and how to raise concerns. All trainees had IT passwords at the start of placement and had been emailed their rota previous to commencing placement. The panel were given an example of a trainee who was due to be on call for the induction session, but this shift was rearranged by their supervisor to allow attendance. Trainees advised that the ward induction was less formal, and most trainees were shown around by another trainee.

Core Trainees: Trainees advised they had all received induction. The panel were told that following trainee feedback the content has now changed to include information on the day to day work of trainees, core trainees were involved in delivering this content. Also, a section regarding the rota which was created by a core trainee. Trainees all had IT passwords prior to post although most had been within NHS Tayside in previous posts so were already set up. Trainees felt induction prepared them for their role.

Higher Trainees: Most trainees had attended an induction session but felt it was not particularly focused on senior trainee needs. We were given an example of a trainee who rotated placement and was not expected so had no formal induction. It was felt it would be useful to have more information regarding OOH work and who to contact for support.

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

Trainers: The panel were provided access to the MS Teams channel now used for local teaching. This allows trainees to attend weekly teaching sessions online or catch up on content if missed. Teaching is led by a senior staff member and a trainee. It was felt the department try to make it varied and suitable for all trainee levels. Trainers advised that some clinical teams specifically timetable teaching for trainees, but in other teams' trainees are expected to attend and take turns with the duty bleep. It was felt trainees have protected time to attend regional teaching.

FY/GP Trainees: Trainees advised there is a two-hour weekly teaching session they can attend and reported it as helpful and relevant to the curriculum. Several GP trainees advised the short notice of the regional GP teaching can lead to problems attending as it allows little time to source cover. This was especially pertinent to a trainee who is currently the sole trainee on the ward.

Core Trainees: Trainees advised they attended a two-hour weekly local teaching session and most had no problems attending although those on wards without GP trainees had to take turns at covering the bleep. It was felt by trainees that the department had worked hard to improve trainees' ability to attend local teaching and the teaching was highly valued. Trainees also attend regional teaching and as they join the South East regional sessions, they felt it was beneficial this was now online which made it easier for them to attend. The panel were informed there are also a weekly virtual Balint group, psychotherapy case discussions and monthly CASC sessions.

Higher Trainees: Trainees advised they attend a two-hour weekly local teaching session which comprises of a case journal and a talk from a consultant on that topic. This teaching is now on MS Teams. The panel were advised a higher trainee has set up monthly higher GAP teaching. This teaching was valued by the higher trainees and they expressed their thanks to the trainee organiser. The panel were told there are national teaching sessions for CAMHS, Psychotherapy and Forensic psychiatry via MS Teams. Trainees reported no problems being able to attend teaching.

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

Trainers: Trainers advised the panel they all now had time in their job plans for supervision. An example was relayed regarding a trainer having difficulty getting allocated time, this was raised with

Mike Winter and resolved.

FY/GP Trainees: Trainees advised they were aware from Turas of who their clinical and educational supervisors were and most met with them on their first day of placement. All trainees had met with their educational supervisors and had a personal learning plan in place.

Core Trainees: N/A

Higher Trainees: N/A

2.4 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 that there is always a consultant on call and that they cover the OOH, without a trainee, between 3am and 8am. The on-call consultant can be contacted via the switchboard. The process outlining who to contact for supervision is covered with trainees at induction and it was felt trainees were aware of the process. Trainers advised they would also reiterate the process at supervision sessions. There is a known concern regarding the availability of CAMHs out of hours support. This was highlighted and a meeting has been set up to proactively address concerns. It was highlighted that it is now normal practice that junior doctor clinics do not run if there is not a consultant available to provide supervision.

FY/GP Trainees: Trainees were aware of who to contact for support both out of hours and during the day. It was felt that OOH can be daunting especially at the beginning of placement. We were told there is helpful support available by phone but there is no registrar on site during the night. Several trainees highlighted CAMHs assessments can be particularly challenging OOH when they have little experience and direct support is not available (CAMHs is included in induction for this reason).

Core Trainees: Trainees advised that during the day they had supervision pathways in place and out of hours they were provided with a rota describing who will provide support. The panel were told of several occasions where trainees were allocated educational supervisors who were on long term sick leave meaning they had no supervisor in place until they escalated this and it was rectified.

Higher Trainees: Trainees advised they were not always aware who to contact for support out of

hours. The panel were given several examples of recent instances where trainees have been unable to contact consultants for support during OOH shifts. This included a time where a consultant was on sick leave and no one was aware and times where there was no answer.

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

Trainers: Trainers advised they are generally given the same training grade of trainees which makes it easier to keep up to date with curricular requirements. Before COVID-19 some trainers attended sessions from the university which included information on conducting workplace-based assessments etc. For national programmes some trainers had attended virtual trainer days and committee meetings where any curriculum changes would be discussed. The department are advertising for new consultants with special interests which will offer greater training opportunities matched to the curricula. Trainees can take up the offer to attend special interest sessions.

FY/GP Trainees: Trainees did not feel there were specific competencies that would be difficult to achieve but had to actively seek out opportunities due to a lack of substantive consultants. Locum consultants are not able to undertake assessments. The panel were advised that outpatient clinics were reduced due to COVID-19 and some were run by locum consultants who cannot formally supervise, meaning there were not many opportunities for trainees to get outpatient clinic experience. Some trainees had not attended any clinics. GP trainees advised they can spend a high percentage of their time (75-80%) carrying out duties which are of little educational benefit including taking bloods, ECGs and administration work. GP trainees in Carseview Hospital unable to attend outpatient clinics.

Core Trainees: Trainees raised no concerns regarding achieving their competencies. Some trainees had not attended any outpatient clinics. It was agreed trainee experience regarding outpatient experience varies. It was felt trainees would be able to complete their competencies. Trainees reported the amount of time spent carrying out non educational tasks have reduced but they still spend time carrying out tasks such as ECGs and taking bloods.

Higher Trainees: The panel were told there is a lack of substantive consultants and this can lead to difficulties getting experience in certain specialty areas as there is no consultant available to supervise. For some curricular requirements, trainees have to go to other geographical areas to

achieve their competencies. Trainees raised no concerns regarding the amount of time spent carrying out non educational tasks.

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

Trainers: It was felt trainees can achieve their portfolio assessments. It was raised that due to a large number of consultant vacancies it can lead to cancellation of clinics or a reduction of supervision opportunities.

FY/GP Trainees: Trainees advised that due to lack of substantive consultants on their wards it canbe difficult to get work placed based assessments however it was felt these would be achieved as consultants were supportive. It was felt assessments are fair and consistent.

Core Trainees: Trainees felt it was easy to obtain workplace-based assessments apart from at outpatient clinics and that these were fair and consistent. The panel were advised there is a new TPD in place who has been trying to ensure core trainees are not placed in posts where they have no access to clinics. We were assured trainee clinics no longer run if there is no substantive consultant to supervise.

Higher Trainees: Trainees advised that due to a lack of substantive consultants it can be challenging to achieve work place-based assessments. It was felt the consultants available are supportive of trainees achieving these but are very busy and short staffed especially in general adult wards. It was reported that locum consultants do not have time to do assessments and this was particularly an issue in GAP.

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

Trainers: Trainers advised there are various opportunities for trainees to learn with multi-professional colleagues including working with nursing staff and psychologists and attending MDT meetings.

FY/GP Trainees: Trainees felt there were limited opportunities to learn with other allied health professionals. Ward rounds with MDT colleagues are not used as a learning opportunity.

Core Trainees: Trainees felt they had opportunities to learn with multi-professional colleagues such as crisis nurses, psychologists and the intervention team.

Higher Trainees: Trainees reported opportunities to learn with multi professional colleagues vary depending on post. For example, some general adult inpatient wards, staffed by locum consultants have no MDT meetings or ward rounds leading to very little opportunities to learn whereas CAMHS and Forensic trainees felt they have opportunities to learn with MDT professionals. The panel were advised there used to be reflective practice groups, but these are no longer running.

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

Trainers: N/A

FY/GP Trainees: N/A

Core Trainees: Trainees advised the panel they had the opportunity to attend and present at an annual audit symposium and we were given examples of quality improvement projects trainees had been involved in. It was felt the Quality Improvement lead was supportive once trainees identified projects.

Higher Trainees: N/A

2.9 Feedback to trainees (R1.15, 3.13)

Trainers: It was felt weekly supervision sessions are a good opportunity for the trainees to receive feedback. We were advised there is a consultant on call during OOH who can provide support and feedback, or trainees can seek feedback the following day.

FY/GP Trainees: Trainees felt feedback was available at their weekly supervision sessions regarding OOH cases however did advise that at Foundation and GP level they make very few psychiatry clinical decisions as these are normally made by senior psychiatry staff. GP trainees reported this limits learning.

Core Trainees: Trainees felt weekly supervision sessions provided a formal setting for feedback and that informal feedback was available during ward rounds or by contacting consultants regarding OOH cases. It was highlighted that at junior doctor level there is limited clinical decisions made by trainees.

Higher Trainees: Trainees felt they did not receive feedback from out of hours work.

2.10 Feedback from trainees (R1.5, 2.3)

Trainers: The panel were advised that trainee feedback was sought following the August induction sessions and after the new format training sessions. Feedback was also sought through peer group input to TTMG.

FY/GP Trainees: Trainees were unaware of active trainee forums for FY/GP trainees but were aware of a Core trainee representative. They were not aware if FY and GP issues were taken forward. Trainees had not heard of TTMG.

Core Trainees: Trainees advised they would feel comfortable providing feedback through their supervisors, Core representatives or enthusiastic and approachable TPD.

Higher Trainees: N/A

2.11 Culture & undermining (R3.3)

Trainers: The panel were told there has been ongoing work into improving the culture in the department and it was felt this is starting to improve and trust is beginning to be built. Trainers advised they ensure trainees know they can approach them with concerns and take the time to ask trainees how they feel things are. It was felt the formal structures in place for support can be complicated, but we were advised these are being streamlined albeit this was delayed due to COVID-19. Trainers were unaware of any trainees having received any comments felt to be undermining or less than supportive within the department. We were given an example of a concern raised by a trainee relating to a department out with mental health Tayside, this concern has been escalated and was in the process of resolution.

FY/GP Trainees: Trainees felt the senior staff and nursing staff were supportive and would be comfortable raising concerns. Trainees had not experienced any behaviour that had undermined their confidence, performance or self-esteem.

Core Trainees: Trainees advised there had been a number of changes in senior leadership since our last visit which has been beneficial to the culture. Trainees felt the new Training Programme Director (TPD) was very supportive and helpful. Trainees reported no new concerns regarding undermining behaviour and would now feel more comfortable raising concerns with their supervisors or TPD.

Higher Trainees: It was felt the attitude of senior staff could vary and be unpredictable with sometimes the culture being supportive but at other times not. Trainees felt that concerns they raise are not always taken onboard and there is a lack of communication from senior management when approached.

2.12 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: The panel were told there is not a consultant in charge of the rota at present. There has been investment in administration support for the rota and it is hoped that with the better infrastructure in place they can recruit a consultant for the role. Trainers advised there are current gaps in the rota and trainees were given financial payment if they step up to fill them. Consultants cover between 3 and 8 am to ensure trainees' rest period is protected. Trainers advised trainees are involved in rota design and a new process for short term gaps has been developed following trainee suggestions whereby HR have a rotating list of trainees to call for cover.

FY/GP Trainees: Trainees did not believe there were current rota gaps at their level. The panel were told trainees had to arrange rota cover for their own leave which could sometimes be difficult, it was felt this process could be made easier and streamlined. Trainees advised they did not yet have a copy of their new rota which will come into effect early February.

Core Trainees: The rota is currently created by a core trainee but looking for someone else to take over. There are more trainees covering this rota since the last Deanery visit and there are currently no gaps, it is felt there is some flexibility now to cover short term gaps. It was highlighted that there is currently no dedicated doctor cover at Strathmartine Hospital and trainees are being asked to carry

out tasks without clear guidelines of what their role is and with no direct supervision on site. Trainees did not feel the rota was compromising their wellbeing or patient safety overall.

Higher Trainees: The panel were advised there were significant rota gaps, trainees raised concerns sometime in advance of changeover and provided several options for solutions. Trainees felt disappointed at the length of time this took to be addressed and the lack of support from management to engage with trainees and resolve in a timely manner. Trainees felt rota issues impacted on their wellbeing.

2.13 Handover (R1.14)

Trainers: The panel were advised there are various handover processes in place across the different locations. It was mentioned that MS Teams is being used in Liaison Psychiatry for handover purposes and this may be useful for other areas.

FY/GP Trainees: Trainees advised handover occurs via email between trainees and consultants are not involved however it was felt this process is adequate but not used as a learning opportunity. Trainees raised a suggestion that it would be helpful for daytime admissions to arrive earlier in theday so can be clerked in dayshift with no need to handover information or additional work be undertaken by OOH on call.

Core Trainees: Trainees advised handover is undertaken through email between trainees only. It was felt that due to the nature of the work and geography of sites it would be difficult to change the handover and trainees thought it was fit for purpose. There are no consultants involved in handover and it is not used as a learning opportunity.

Higher Trainees: N/A

2.14 Educational Resources (R1.19)

Trainers: Trainers highlighted that with the move to online learning and virtual clinics it would be helpful if trainees were issued with a personal set of headphones and a webcam as on occasions trainees have to share computers due to limited access.

FY/GP Trainees: Trainees advised there is a lack of access to on site computers, webcams and headsets and access to private space to carry out online teaching or consultations. It was noted by the panel that at this virtual visit a majority of trainees did not have access to webcams, headphones and some did not have microphones to participate. It was also highlighted that some sites have difficulty accessing Wi-Fi or mobile signal which makes it difficult for trainees to use their personal devices. It was raised that some wards have a shortage of personal alarms for trainees.

Core Trainees: The panel were advised that due to COVID-19 the library at Caresview Hospital is now the Crisis team office however trainees have access to online resources. The panel were told there is a lack of access to computers, headsets, webcams and quiet space for online learning.

Higher Trainees: N/A

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

Trainers: It was felt that governance processes were now embedded with regular Teaching and Training Management Group (TTMG) meetings taking place with representation from both core and higher trainee forums. We were advised an enhanced monitoring group has also been established to allow interaction with the board regarding broader issues including culture. It was felt the relationship has also been strengthened between the department, DME office and Deanery.

FY/GP Trainees: Trainees advised they would raise concerns with their supervisors. Trainees were unaware of active trainee forums for FY/GP trainees but were aware of an approachable core trainee representative. They were uncertain why there was no FY/GP trainee representative. Trainees were unaware of the TTMG nor had they received updates following these meetings.

Core Trainees: Trainees advised they would raise concerns through supervisors or their TPD. Trainees advised they met as a group to discuss concerns, the core trainee reps would feedback concerns to TTMG or STC and bring answers back to trainees if action has been taken. We were given an example of a concern raised and progress through this process.

Higher Trainees: Trainees advised they would raise concerns with their supervisors and TPD if required. We were told of times when concerns had been raised to senior management regarding the

quality of education and trainees had not received a response. Trainees advised there was a trainee forum in place which fed into TTMG, but it was felt this is a large formal meeting and they did not always feel comfortable raising concerns there and do not always get feedback from concerns that have been raised. It was highlighted that sometimes trainees are wary of raising concerns regarding the quality of their education as this may lead to them having to complete training in another geography due to lack of trainers in the region.

2.16 Raising concerns (R1.1, 2.7)

Trainers: It was felt there are various signposted routes to encourage trainees to raise patient safety concerns which are outlined during induction and included in the trainee handbook. Trainees are also supported to raise concerns during weekly supervision. It was felt the environment is now more encouraging for trainees to raise concerns regarding patient safety or their education. The panel were advised there are peer groups in place for trainees to feedback concerns regarding their training and escalation processes in place and that concerns could also be raised through the Specialty Training Committees (STC).

FY/GP Trainees: Trainees had no specific examples of raising concerns but felt able to raise them with supervisors, senior charge nurses, senior clinicians or Training Programme Director, they felt they would be addressed.

Core Trainees: Trainees advised they would raise patient safety concerns with nurses orconsultants.

Higher Trainees: Trainees felt that a lack of substantive consultants and other staff especially in general adult psychiatry was impacting on the consistency of care provided.

2.17 Patient safety (R1.2)

Trainers: Trainers raised no concerns regarding patient safety and felt the substantive consultants made efforts to ensure a good level of supervision was provided considering the current staff shortages. Trainers did not feel boarding was a concern as the site will take ownership of a patient even if boarded.

FY/GP Trainees: Trainees had no specific patient safety concerns but did highlight there has been a recent shortage of beds on some wards and a shortage of staff over most locations. Trainees felt making crisis assessments with limited psychiatry experience can be daunting, on occasions OOH workload can be high and the use of patient initials instead of full name can be confusing.

Core Trainees: Trainees highlighted teething issues with the new pager system which it was felt is causing some confusion (having both a pager and mobile system for contacting) and switchboard not following the process of who to contact which can cause delays in patient care. It was felt it would be helpful to have more than one phoneline at certain sites to ensure pagers always work.

Higher Trainees: N/A

2.18 Adverse incidents (R1.3)

Trainers: Trainers advised that if trainees raise a Datix they will receive feedback and will be invited to the incident review, however sometimes trainees have already moved onto another post. It was felt a more robust and formal process for learning from shared incidents would be beneficial and we were advised there is an ongoing quality improvement project involving trainees looking at this which was stalled by COVID-19. It is hoped that meetings will be set up similar to morbidity and mortality reviews to provide shared learning from adverse incidents.

FY/GP Trainees: Trainees were aware of the function of Datix but had no experience of using it to document adverse incidents. Trainees were unaware of any shared learning that occurred following adverse incidents.

Core Trainees: Trainees were aware of the use of Datix to report adverse incidents. We were given examples of trainees who had reported adverse incidents and did not receive feedback. The panel were advised trainees were invited to attend the first meeting to discuss shared learning from adverse incidents that morning and it was reported to be beneficial.

Higher Trainees: Trainees were all aware of how to report adverse incidents through Datix. The panel were given several examples where adverse incidents had been reported and some trainees had received feedback while others hadn’t so there is no consistent approach in place. Most trainees

did report receiving support from supervisors and consultants following adverse incidents. It was reported that as part of a quality improvement project with trainee input there had been a red event group meeting where an MDT approach was used to review an incident. It was felt this was educational and run in a supportive manner and would be keen to circulate to the wider group.

2.19 Other

FY/GP Trainees: It was felt it would be beneficial to training to have more involvement in psychiatric decisions during daytime work. It was highlighted that the division of trainees is not always even among wards which can affect trainee workload.

3. Summary

Is a revisit required?	Yes	No	Highly Likely	Highly unlikely

Positive aspects of the visit:

- Improvement in the culture experienced by some groups of trainees
- New leadership structures in place with clear roles are starting to have an effect
- Very supportive consultants and core programme TPD, who we were told are going above and beyond in challenging circumstances.
- Trainee representation and inclusion at meetings like TTMG is helping; although limited engagement at FY and GP levels
- Positive feedback regarding the local teaching programme which is running successfully virtually
- Positive feedback regarding the GAP local teaching which is organised and run by a higher trainee, although this will require succession planning to sustain

Less positive aspects from the visit:

- Concern around supervision particularly in-patient locum provided services where it is not possible to undertake WBA and there is little feedback for trainee learning. For junior level trainees there is limited psychiatry specific training in these environments.
- There is still no regular process for learning from adverse events or consistently providing

feedback.

- Shortage of substantive consultants and consultants off sick putting pressure on providing educational supervision of all trainees
- Several instances were reported where higher trainees could not access the on-call consultant
- There is still no consultant responsible for rotas. The importance of this was highlightedrecently with the pressures on the higher trainee rota and the lengthy process to find a workable solution.
- Wide-spread lack of access to IT resources including webcams, headphones, computers as well as a lack of private space. This affects trainees' ability to deliver clinical care and to engage in teaching.
- Less positive training experience at GP level
- Concern around sustainability of the higher training programmes secondary to the number of consultant trainers available and poor trainee recruitment

Requirements from previous visit on 19th October 2019 and assessment following Dec 2020 visit:

- A regional teaching programme for the General Adult Psychiatry training programme must be established and supported by a Consultant/Training Programme Director – **Partially Met**
- The culture of blame, fear of raising concerns and undermining must continue to beaddressed – **Partially Met**
- The department must work with the Board in implementing changes to improvethe educational environment for all grades of doctors in training – **Partially Met**
- There must be consultant oversight of trainee Rota's, including a Rota with named duty consultants for all sites with a working process to cover unexpected leave – **Not Met**
- Review of the workload for trainees within General Adult Psychiatry programme to improve educational experience -**Partially Met**
- Trainees must receive feedback on incidents that they raise and there must be a forum for learning from adverse events. -**Not Met**

- A process must be put in place to ensure that any trainee who misses their induction session is identified and provided with an induction. **Met**
- Handover must be formalised and happen consistently in all areas for all levels to ensure safe handover and continuity of care. **Met**
- All Consultants who are trainers must have time within their job plans for their roles to meet GMC Recognition of Trainers requirements. **Met**
- All trainees must have timely access to IT passwords and system training through their induction programme. **Met**
- Tasks that do not support educational and professional development and that compromise access to formal learning opportunities for all cohorts of doctors should be reduced. **Not Met**
- Trainers within the department must provide more regular informal 'on the job' feedback, particularly in regard to trainee decisions and care planning. **Partially met (varied by grade)**
- Clarity on who to contact for Liaison services at Perth Murray Royal should be given and timely support available. **Met**

On the day the panel were told of a service under pressure from a lack of substantive consultants which is impacting on both trainers and trainees. We were told most of the consultants are supportive and many go above and beyond to limit the impact on trainees' teaching. The panel were pleased to see a more established and accessible department leadership structure in place and hear of the start in a shift in culture however there are a number of previous requirements which have still not progressed. Following finalisation of the report, a discussion will be held between the deanery and GMC to explore whether conditions around the continued approval of ongoing training in Tayside in General Adult Psychiatry should be attached to help drive the required improvements. The GMC will write to Tayside with the outcome of these discussion on conditions. We will propose a Pan Tayside revisit takes place in 2021 to look at the progress that has been made across the sites. Regular updates on progress against the action plan will be required.

4. Areas of Good Practice

Ref	Item	Action
4.1	Use of MS Teams to provide weekly local teaching sessions. The channel provides trainees easier access to teaching and an ability to catch up with sessions missed including induction.	

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 requireany further information in regard to these items.

Ref	Item	Action
5.1	For junior level trainees there is limited psychiatryspecific training in these environments.	
5.2	Concern around sustainability of the higher training programmes secondary to the number of consultant trainers available and poor trainee recruitment	
5.3	The regional teaching programme for the General Adult Psychiatry training programme should be supported by aConsultant/Training Programme Director to ensure sustainability.	
5.4	A shortage of consultants and a high turnover of locums is impacting on the training experience of trainees with inconsistent support, more of a challenge to arrange WBAand supervision and a reduction in exposure to different specialties of psychiatry. Available consultants are supportive but overstretched.	
5.5	Greater awareness of access to training forums at FY/GP level and the work of TTMG including involvement ofthese trainee groups.	
5.6	Handover must be formalised and happen consistently inall areas for all levels to ensure safe handover and continuity of care.	

6. Requirements - Issues to be Addressed

Ref	Issue	By When	Trainee cohorts in scope
6.1	There must be an increase in relevant training opportunities for GP trainees.	6 Months	GP
6.2	The department must build on the current work to improve the culture and promote raising and addressing concerns	6 Months	All
6.3	The department must work with the Board on implementing changes to improve the educational environment for all grades of doctors in training	6 Months	All
6.4	There must be consultant oversight of trainee Rotas to ensure supervision at all times including a Rota with named duty consultants for all sites and with a working process to cover unexpected leave of any grade	6 Months	All
6.5	Trainees must receive feedback on incidents that they raise and there must be a forum for learning from adverse events	6 Months	All
6.6	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
6.7	Trainers within the department must provide more regular informal ‘on the job’ feedback to facilitate learning, particularly in regard to trainee decisions and care planning. This applies particularly to In Patient areas and is separate to “supervisions”	6 Months	All
6.8	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. This must include computers, headsets and cameras in all sites.	6 Months	All