Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	29th June, 5th July 2022	**Level(s)**	Foundation, Core and GP
Type of visit	Triggered	**Hospital**	Queen Margaret Hospital
Specialty(s)	Psychiatry	**Board**	NHS Fife

Visit panel	
Geraldine Brennan	Visit Chair – Associate Postgraduate Dean Quality (Foundation)
Jane Dymott	Programme Director - Foundation
Laura Sutherland	Programme Director – Core Psychiatry
Aaron Taylor	Trainee Associate
Hazel Stewart	Quality Improvement Manager
Helen Adamson & Dorothy Wright	Lay Representative
In attendance	
Gaynor MacFarlane	Quality Improvement Administrator

Specialty Group Information		
Specialty Group	Foundation	
Lead Dean/Director	Prof Clare McKenzie	
Quality Lead(s)	Dr Geraldine Brennan, Dr Marie Mathers	
Quality Improvement Manager(s)	Jennifer Duncan	
Unit/Site Information		
Trainers in attendance	2	
Trainees in attendance	4: Core, Foundation, GP	

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

Date report approved by Lead Visitor	1st September 2022

1. Principal issues arising from pre-visit review:

Queen Margaret Hospital was last visited in January 2020 as part of a Fife-wide mental health re-visit. 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.

At the start of the visit the panel met with Clinical Director Dr Marie Boilson, who gave a presentation highlighting some challenges the department has faced over the past two years and the improvements that have been implemented and continue to be made. This presentation showed significant improvements that had been made in relation to induction and teaching.

2.1 Induction (R1.13):

Trainers: Trainers reported there is an effective induction in place as significant work had been undertaken following poor feedback on past inductions. A short life working group was set up with input from the chief residents. Part of the induction package, covering roles and responsibilities is updated by the outgoing trainees. Trainers also reported that trainees are signposted to resources to help carry out their role out of hours. Trainers reported that rotas are co-ordinated to ensure trainees are able to attend induction. However, if this is not possible or a trainee starts their post out of sync, all information is sent to the trainees, and they have the opportunity to meet a site co-ordinator for a in-person induction. Part of the induction includes breakaway training to aide trainees if a patient makes physical contact. Trainers felt that increasing online resources and videos, especially for the corporate induction allows trainees to take information onboard at their own pace and can be referred back to as and when required.

Trainees: Trainees reported they received a corporate and departmental induction. All felt that they understood their roles and responsibilities within their post. Trainees within General Adult Psychiatry (GAP) are provided with a rolling induction document which is updated by trainees that have just been in post to ensure information is up to date. This was found to be helpful for trainees to refer to as the volume of information provided at inductions can be overwhelming. It was suggested that a

similar document for Older Age Psychiatry would be of benefit to help cement trainees' understanding of how the department works.

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

Trainers: Trainers reported that core psychiatry trainees (CPTs) have programme specific teaching on Wednesdays and trainees are taken off the rota to attend these sessions. Teaching for Foundation and General Practice trainees is protected by having whoever holds the duty phone leave this in the office with another member of the team. In addition to programme specific teaching, trainers reported that there is Fife-wide postgraduate teaching, covering a wide range of topic for trainees of all levels, as well as a journal club which is trainee led and gives them the opportunity to present and deliver critical appraisal. Within mental health, trainees are provided with 1 hour weekly clinical supervision time which offers trainees the opportunity to raise any areas for development that they would want more teaching to be provided on.

Trainees: Trainees reported that they are able to attend their regional deanery teaching with protected time or handing over the duty phone. However, not all were aware of this at the start of their post. Not all trainees were aware of the departmental teaching on offer and those that were aware, suggested that a number of sessions had been cancelled and that the timing clashed with handover. Those that were aware of the local teaching provided, had not yet raised the timing issue with the chief registrar or consultant team.

2.3 Study Leave (R3.12)

Trainers: Trainers reported there had not been any challenges in supporting study leave.

Trainees: Trainees reported that although they have been able to take study leave and have this approved by a consultant, some have experienced issues with their rotas not being updated resulting in trainees being marked as working when on approved leave.

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

Trainers: Trainers reported that they have time built within their job plan to undertake their educational role and this role is reviewed during appraisal. Trainers reported that they provide one hour of supervision per trainee each week.

Trainees: Trainees reported they had formally met with their educational supervisors at the start of the post and all trainees had agreed a personal learning plan. Whilst some trainees were able to meet with their clinical supervisor for their weekly 1-hour supervision meetings, others had not done so. The main issue for being unable to access these sessions was due to not working in the same ward as the consultant and therefore not having regular contact to arrange this.

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: Trainers reported that the ability to differentiate between the different grades of trainee was clear to other medical staff, but may not be readily apparent to nursing staff. Within general psychiatry the weekly rota highlights the staff that are working and who to contact for support. Within old age psychiatry, the inpatient consultant is available 3 days per week to provide support to trainees, with contact details of other consultants providing cover is made available to trainees for the other days of the week. Trainers reported that they reiterate to trainees that the consultant team are there to be contacted. It was acknowledged that there had been past issues with locum consultants and a lack of supervision, but trainers reported that once they were made aware of the issues, these were swiftly dealt with. This has also resulted in a more proactive team that have fortnightly or monthly meetings to discuss any concerns trainees may have.

Trainees: Trainees reported that they know who to contact for support and have never had to cope with problems beyond their competence. Trainees felt that their senior colleagues and advanced nurse practitioners (ANPs) had been very approachable when support had been sought. Trainees suggested that there is no automatic way for the team to identify their level of training, but they felt that others will get to know this with time. Some trainees will introduce themselves and highlighted that their level is always recorded when writing their notes.

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

Trainers: Trainers reported that they tend to supervise the same level of trainee to ensure there's a good understanding of the trainees' curricular requirements. A training session was due to be held the day after the visit to discuss changes that were made to Core Psychiatry. Both GP and Core trainees are provided with clinical and inpatient experience as well as carefully selected patients for foundation trainee experience. Trainers also felt that the cross-cover of psychiatry specialties out of hours provided a variety of learning experiences for trainees. Trainers acknowledged that the balance for trainees spending time developing as a doctor and undertaking activities of limited benefit, such as phlebotomy and echocardiogram (ECG), required improvement. A number of changes to nursing staff meant that new staff required phlebotomy and ECG training, however there was an ECG technician available in-hours to help reduce the burden of tasks.

Trainees: Only one trainee reported having allocated clinic time. It was felt that working out of hours provided more opportunities to assess patients and make decisions. The majority of trainees indicated that the 60% or more of their time was spent carrying out non-educational tasks such as doing phlebotomy and writing discharge letters.

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

Trainers: Trainers reported that the weekly hour of supervision and discussions of the out of hours experience meant that it was easy for trainees to achieve their portfolio assessments.

Trainees: Trainees reported that they are able to complete their assessments, but this can be challenging when working in a different ward from the consultant involved in the patient encounter. All trainees felt that their assessments were completed fairly and consistently.

2.8 Adequate Experience (multi-professional learning) (R1.17) – Not asked

2.9 Adequate Experience (quality improvement) (R1.22) – Not asked

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: In addition to the weekly supervision session, trainers reported that feedback is provided on management plans following the trainees' review of new patients at clinics.

Trainees: Most trainees reported that they receive feedback on their clinical decisions but for some this had not happened out with weekly supervision sessions. Those that had received direct feedback found this to be constructive and meaningful.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: Trainers reported that they meet with trainees near the end of their post and seek the trainees' feedback on their experiences. In addition, the chief registrar meets with trainees fortnightly. Any concerns raised by the chief registrar can be discussed at the monthly psychiatry division meetings.

Trainees: Not asked.

2.12 Culture & undermining (R3.3)

Trainers: Trainers reported they were not aware of any concerns relating to undermining behaviours. They felt that trainees being attached to the same consultants helped build rapport within the team and that prior to covid, both consultants and trainees would meet for lunch which was felt to aid in feeling part of the team.

Trainees: Trainees reported that senior colleagues, both nursing and clinical, are supportive and approachable. None of the trainees had experienced or witnessed any undermining behaviours from any staff in the hospital. One trainee experienced some undermining from an external source (not NHS) whilst assessing a patient and had raised this with their consultant.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Trainers reported that clinic time is built into the rota to support trainee's curriculum requirements. They were not aware of any issues with the rota that would compromise the trainees' wellbeing.

Trainees: Trainees reported the rota works reasonably well now, but highlighted an issue earlier in post with a trainee that required significant support. This had impacted on their rota allocation and caused changes in shifts at short notice. It was also felt that there had been some poor communication which caused further tensions at the time, although the matter has since been resolved. However, trainees felt that communication with the rota co-ordinator confirming authorised leave remains an issue. Some felt that the process was overly complicated and required trainees to constantly chase up to achieve a response; despite being told this was changing, the trainees reported that it had not yet happened.

2.14 Handover (R1.14)

Trainers: Trainers felt that handover worked well, particularly within out of hours where a lot of work had gone in to make improvements. There are daily huddles and an electronic record of handover to ensure that information is available to all staff, even if they are unable to attend handover in-person. Whilst the handover itself is not used as a learning opportunity, trainers indicated that trainees could discuss an interesting case more in-depth after handover.

Trainees: Trainees reported that there is a good, structured handover in place that provides safe continuity of care for patients.

2.15 Educational Resources (R1.19)

Trainers: Trainers reported that trainees are provided with their own laptop which enables trainees to dial into online teaching sessions as well as having access to an education centre.

Trainees: Trainees reported that they are provided with their own laptop.

2.16 Support (R2.16, 2.17, 3.2, 3.4, 3.5, 3.10, 3.11, 3.13, 3.16, 5.12) – Not asked.

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: Trainers reported that there are consultants that lead on training and co-ordinate training, with regular meetings with trainees. They also reported that a group has recently been set up to look at the learning needs of higher specialty psychiatry trainees and if any improvements require to be made.

Trainees: Trainees reported that they would speak to their educational supervisor if they had concerns about the quality of their training. None of the trainees felt that they would need to do so.

2.18 Raising concerns (R1.1, 2.7)

Trainers: Trainers reported that trainees are well versed in raising patient safety concerns via datix. They also highlight at the start of their post how trainees can raise concerns. In addition to this, trainees can raise patient safety concerns and concerns about their training during the weekly supervision session.

Trainees: Trainees reported that they would raise patient safety concerns with their supervisor or the senior charge nurse. One trainee had submitted some datix reports relating to other sites that they had covered out of hours but had not yet received feedback on the outcome of those. None had any concerns about their own safety in the post.

2.19 Patient safety (R1.2)

Trainers: Trainers felt that the department provides a safe environment for both trainees and patients. All trainees are provided with breakaway training for dealing with aggressive patients and how to get out of situations where a patient is making physical contact. Trainees are also provided with alarms that they carry at all times. Trainees are informed at the start of their post how to use and charge the alarm as well as emphasising the importance of being aware of each patient's risk assessment.

Trainees: Trainees reported they would have no concerns about quality or safety of psychiatric care if a friend or relative was admitted to the ward. Some flagged concerns in relation to how physical health issues were dealt with. These concerns related to lack of a clear referral pathway for medical problems as well as a lack of acute medical knowledge for staff, resulting in some issues not being picked up or addressed as quickly as they should be. Trainees suggested that this was a common problem within psychiatry wards and not unique to this department.

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

Trainers: Trainers reported that trainees would receive support in the immediate aftermath of any incident. These are dealt with at both a pastoral and organisational level with full discussion and debriefs and any further investigation that is deemed necessary. In addition there are specific staff within the department that would spend time with the team, including trainees, following any incidents to provide support.

Trainees: Trainees were unaware of any systems in place to share learning among the whole team following an adverse incident. Those that had been involved in an incident where something went wrong or had a poor outcome reported that they felt well supported by nursing and consultant colleagues.

2.21 Other

Trainees were asked to rate their overall experience in their post between 0 (worst) to 10 (best) at the site.

Range: 6 – 10, Average: 7.3 out of 10

3. Summary

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

Following the last pan-Fife visit in 2020 and survey results from 2021, it is evident that the department has continued to put in a significant amount of work to improve the training experience for trainees in the department. However there appears to be a need for more progress with some outstanding

issues within old age psychiatry, especially in relation to exposure to clinic opportunities, but overall this was a relatively positive visit

Highlighted below are both the positive and less positive aspects from the visit:

Positive aspects of the visit:

- Active input from trainees to the induction pack to General Adult Psychiatry provides trainees with more relevant and up to date information of the daily workings and the trainee's role in the department
- Trainees feel very well supported from an engaged and approachable consultant and nursing team
- Good access to clinical inpatient experience
- Individual laptop provision enabling access to teaching
- Good debrief and support mechanisms in place for trainees involved in adverse or challenging incidents
- Trainees feel safe working in the department.
- Supervisor allocation to specific trainee group provides greater understanding of trainees' educational needs.
- Clear clinical escalation pathways.
- All trainees are able to achieve their required attendance at regional teaching sessions.

Less Positive Aspects of the Visit

- Lack of information at induction relating to Old Age Psychiatry and lack of formal OOH induction.
- Most trainees were unclear about when local teaching sessions occur and those that are aware suggested that workload and the timing of these sessions in relation to handover, mean they can be difficult to attend.
- Whilst it is noted that newer nursing staff are being trained up to complete some tasks, such as phlebotomy, a significant volume of non-educational tasks is still being carried out by trainees, which impacts on their ability to access learning opportunities.
- Weekly clinical supervision meetings are not being achieved for all trainees, particularly when the supervisor does not work directly on site with the trainee.

- Patient safety concerns were raised relating to the management of physical health issues, particularly in older adults with multiple co-morbidities or those developing an acute medical illness.
- Communication with the rota management team for official reporting of leave (both study and annual) is problematic and approved leave is often not reflected on the rota.

4. Areas of Good Practice

Ref	Item	Action
4.1	Provision of Breakaway training to all trainees is very valuable in supporting the safety of trainees	
4.2	Outpatient clinic attendance is built into the rota for Core trainees within General Adult Psychiatry	

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	Rota Management	A more streamlined approach should be sought to recording trainees leave, either study or annual, to ensure this is reflected accurately and that the clinical teams are aware of when trainees are available.
5.2	Non-educational Tasks	The site should continue with its plan of training up nursing staff to undertake tasks, such as phlebotomy, to enable trainees to access more educational opportunities, such as outpatient and community clinics.
5.3	Teaching	All trainees should be made aware of the various local teaching sessions that are available to them. Consideration should also be given to changing the timing of some sessions to maximise the ability of trainees to attend.

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	Trainees of all grades should be provided with supervision sessions which are beneficial for feedback and learning	5th April 2023	Foundation, GP
6.2	Appropriate outpatient clinic training opportunities must be provided for Core and GP Trainees, particularly within Old Age Psychiatry.	5th April 2023	Core and GP
6.3	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.	5th April 2023	All Trainees
6.4	Trainees must be provided with a clear escalation and referral policy for patients who develop acute deterioration in their physical health, including how to access support from other specialties where relevant	5th April 2023	All Trainees
6.5	The unit must provide routine team-based opportunities for trainees to access learning from clinical incidents, including receiving feedback from DATIX submissions they have been involved with.	5th April 2023	All Trainees
6.6	A mechanism should be introduced to ensure that all staff can clearly differentiate between different grades of trainees that they encounter.	5th April 2023	All Trainees