Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	9th October 2019	**Level(s)**	FY/GP/Core/Higher
Type of visit	Enhanced Monitoring Revisit	**Hospital**	Pan Tayside
Specialty(s)	General Adult Services	**Board**	NHS Tayside

Visit panel	
Amjad Khan	Visit Chair - Postgraduate Dean
Robin Benstead	GMC Visits & Monitoring Manager
Rosie Lusznat	GMC Enhanced Monitoring Associate
Stuart Holmes	Lay Representative
Wai Lan Imrie	Training Programme Director
Rekha Hegde	Foundation Programme Director
Claire Langridge	Associate Postgraduate Dean – Quality
John Crichton	College Representative
Dawn Mann	Quality Improvement Manager
Timothy Jagelman	Trainee Associate
In attendance	
Susan Muir	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	2 Senior Charge Nurses	
Trainers in attendance	13	

Trainees in attendance	4 FY, 5 GP, 8 Core and 5 Higher	

Feedback session: Managers in attendance	Chief Executive		DME Yes		ADME		Medical Director Yes		Other 6	

Date report approved by Lead Visitor	04.11.2019

1. Principal issues arising from pre-visit review:

Following four visits to Murray Royal Hospital where it was identified the 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, please see the below summary of findings on the day:

Overall it was pleasing to see some positive steps toward change including:
The establishment of working groups such as the TTMG with trainee representation.

- The new programme of Thursday morning teaching sessions received positive feedback.
- The Local Adverse Incident Reviews are viewed more positively and provide feedback in a supportive manner to those involved in an incident.
- The creation of the senior trainees' handbook, although there are some discrepancies between this and the junior trainees' handbook which require to be addressed.
- Careers events and a commitment to recruitment which has led to full recruitment to Core training.

The visit identified specific aspects that require to be addressed (in addition to requirements from previous visit):

- A clear decision is required regarding who is responsible for Liaison out of hours assessments as there is confusion regarding if this lies within the role of Core or Higher trainees, regularly creating a flash point during shifts. This can then be included in both induction handbooks.
- There is not a named duty consultant for all sites during the day.
- Difficulty contacting the duty doctor both in and out of hours due to problems with phone and WIFI signal, causing a significant amount of wasted time spent looking for the correct individual. This is a recognised long-standing problem which has not been addressed.
- There is no consultant oversight of any rotas and trainees note the written process to cover unexpected leave is not working.

• Concerns raised regarding the workload mainly within General Adult programme impacting on trainees' education due to service requirements.

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 panel were told that changes have been made to the induction programme which garnered positive feedback from trainees. It was highlighted previously that there was no process in place for trainees who missed the induction sessions so previous cohorts of trainees were asked to create an information handout that can be reviewed with the supervisor. The panel were informed there is a lengthy induction booklet sent to trainees prior to starting their post.

FY and GP Trainees: Most trainees had received a two-day site induction and were sent two handbooks prior to starting in post. We were given an example of a trainee who had missed induction and no formal catch up process was in place, trainee was unaware they should have received breakaway training. Trainees advised they were informed who their supervisor was before commencing their placement. Some trainees reported not having IT access set up prior to the start of placement. There was a lack of consistency across trainees as to the depth of their ward induction dependent on their location. It was also raised that different locations like information recorded in a different manner or use systems differently and it would be helpful to have details on this.

Core Trainees: Trainees advised they had received an adequate site induction, it was felt it would be helpful to have more IT information at induction and to have IT passwords prior to starting. Trainees advised site specific induction varied and was sometimes not done as soon as in post. Suggested improvements included patient handovers and more practical guidance on how and where to document as this can vary across the sites.

Higher Trainees: Trainees advised they were not invited to induction if they had been in Tayside previously or started out of synch. Higher trainees are involved in providing the induction for junior

trainees. Trainees advised they received post specific information from their supervisors. It was felt it would be beneficial to have more IT guidance at induction.

Non-Medical Staff: Non-medical staff advised they are involved in delivering sessions at the trainee induction including continuous intervention and safety and alarm systems.

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

Trainers: The panel were advised that local teaching is run weekly on a Thursday morning and all trainees are encouraged to attend. We were told there is a Psychotherapy Balint group held on a Wednesday. It was felt trainees are supported to attend relevant regional teaching.

FY and GP Trainees: Trainees advised there is an expectation they attend the local Thursday morning teaching which is driven by a trainee with consultant support. Trainees have no scheduled work commitments at this time and will only miss the teaching if they are duty doctor. Trainees advised they have protected time for attending regional teaching and have no concerns about achieving their mandatory teaching hours.

Core Trainees: The panel were informed local teaching is run on a Thursday morning and normally consists of a trainee led case presentation followed by a consultant supervision slot. Trainees are all able to attend the local teaching unless on call. CT1 and CT2 trainees attend regional teaching in Edinburgh on a Wednesday morning with clinical skills teaching once a month. Trainees are given protected time to attend regional teaching.

Higher Trainees: Trainees advised they can attend the Thursday morning local teaching. Trainees within national programmes are able to attend regional teaching. The panel were informed there was a timetable created for a monthly regional General Adult Teaching programme with support from the Training Programme Director (TPD). However, there was little consultant support for the teaching and slots often ended up with no speaker, the trainees advised it was left to them to fill the slots which was challenging, and the teaching often didn't go ahead. One trainee is currently based in Fife as there was no available consultant supervision for her post in Tayside. Trainees felt it would be beneficial to have a journal club.

Non-Medical Staff: Non-medical staff advised there is a programme of CPD training sessions in place.

2.3 Study Leave (R3.12)

Trainers: Trainers were not aware of any obstacles to trainees getting study leave.

FY and GP Trainees: Trainees reported no concerns with accessing study leave, we were given an example of a trainee who had access to a taster week.

Core Trainees: Most trainees reported no issues organising study leave. We were informed there has been a trainee post removed in Rehab due to a lack of consultants, no cross-cover arrangements have been made causing some barriers to trainees in accessing study leave. Trainees raised concerns regarding how study leave would be approved going forward following the resignation of the Core TPD.

Higher Trainees: Trainees reported no concerns with accessing study leave

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

Trainers: The panel were told Tayside have a list of standard posts which trainees are assigned to, each post has a defined clinical supervisor. All substantive consultants have a supervisor role. Trainers advised there have been challenges in the past receiving information regarding trainees with known concerns before they arrive in post. The panel were told there is a training event run for trainers each year. Trainers advised a high number of them do not have a job plan and have no allocated time for teaching.

FY and GP Trainees: All trainees had met with their educational supervisor and set goals and objectives. Trainees advised they received one-hour weekly supervision sessions although due to a lack of substantive consultants this was sometimes hard to schedule.

Core Trainees: All trainees had met with their educational supervisor and set objectives. Most trainees reported no issues receiving their one-hour supervision although we were advised of one trainee who has these alternate weeks due to a clash in scheduling.

Higher Trainees: Trainees advised they received one-hour weekly supervision. It was felt the high turnover of consultants can be disruptive to supervision.

Non-Medical Staff: It was felt that there is a high turnover of locums which can lead to discrepancies in senior support.

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: We were told the use of coloured lanyards is in place to identify trainees of different levels. Trainers advised trainees receive information regarding who to contact for support at induction and that consultants' mobile numbers are available in the handbook. Trainers were not aware of any instances where trainees had to cope with problems out with their competence level.

FY and GP Trainees: Trainees advised they are aware of who to contact for support both during the day and out of hours. We were given an example of a time it was challenging to contact the on-call registrar, but support was provided by the duty consultant. Trainees did not feel they had to deal with problems beyond their level of competence however did advise working on out of hours (OOH) can feel daunting at first if you are new to Psychiatry or have missed the induction.

Core Trainees: The panel were informed that there is no longer a funded Psychiatric Liaison service to Perth Royal Infirmary and there is a lack of clarity as to the process now for deliberate self-harm patients with junior doctors often contacted in error or to provide the correct contact details; it was also reported that it can be difficult getting support when reviewing these patients. We were given an example of a trainee who struggled to get senior support whilst detaining a patient. We were also given an example of a trainee who sometimes found it difficult to access support whilst in clinic as there is no supervisor in the building and struggled to contact the consultant by phone.

Higher Trainees: Trainees advised they are aware of who to contact for supervision both during the day and out of hours. Trainees reported they had not faced problems that were beyond their

competence. Trainees felt the consultants available are supportive and approachable. It was reported that consultant shortages can cause uncertainty for trainees as some posts have been stopped or changed at short notice due to lack of supervisors.

Non-Medical Staff: Non-medical staff were aware of the coloured lanyards and their use in identifying different levels of trainees. The panel were also advised there is a list of doctors covering OOH duties and what level they are. Staff were not aware of instances where trainees had to cope with problems beyond their experience.

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

Trainers: The panel were advised any curricula changes would be discussed at the annual trainers training event and trainers are expected to familiarise themselves with the curricula for trainees. Trainers advised there are some known concerns regarding trainees accessing psychotherapy cases and due to a shortage of consultants there are no clinics running in areas of General Adult Psychiatry. Trainers advised there is a survey currently taking place to identify how many blood tests and ECGs are being carried out by trainees.

FY and GP Trainees: The panel were told in ward 1 there are insufficient consultants available to supervise clinics, so GP trainees had not had access to outpatient clinics. All other trainees had access to supervised clinic experience. The panel were advised tasks such as taking bloods and ECGs primarily fall to the trainees on wards due to a lack of availability of trained non-medical staff.

Core Trainees: Trainees advised they have some difficulties getting Psychotherapy cases as there are delays in identifying potential cases. The panel were informed that due to consultant shortages some clinics have been suspended so trainees have had reduced access to outpatient experience, it is hoped this has now been resolved. Trainees felt that up to 50/60% of their time can be spent carrying out non educational tasks such as taking bloods, ECGs and discharge summaries as there is limited support available for these tasks.

Higher Trainees: The panel were informed that educational supervisors are supportive of trainees carrying out special interest work but there is a lack of opportunities across Tayside impacted further by a lack of available supervisors with experience in that special interest area. The service is

supportive of trainees going out with Tayside if the trainee can arrange this. All trainees were able to achieve outpatient experience.

Non-Medical Staff: Non-medical staff advised they are involved in the trainee induction but no other formal training, they are always happy to help and advise on the wards.

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

Trainers: It was felt it is the trainee's responsibility to request workplace-based assessments from consultants. It is hoped that the trainers teaching day will allow trainers an opportunity to benchmark workplace-based assessments.

FY and GP Trainees: Trainees advised senior staff are very helpful when asked to complete workplace-based assessments. It was felt that due to consultant shortages trainees need to be proactive in seeking these. It was felt assessments are consistent and fair.

Core Trainees: Trainees advised they need to be proactive to obtain work place-based assessments (WBA) due to reduced numbers of substantive consultants. It was highlighted by trainees that consultants are supportive of carrying out WBA's but have limited time. It was felt assessments are fair and consistent.

Higher Trainees: Some trainees advised they had to be proactive in planning workplace-based assessments due to a lack of available consultants.

Non-Medical Staff: It was reported that non-medical staff are asked to complete 360-degree feedback for trainees.

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

Trainers: Trainers felt multi professional learning is encouraged.

FY and GP Trainees: Trainees advised they attend multi-professional CMT meetings.

Core Trainees: Trainees advised pharmacy have provided training and the nursing staff are very welcoming.

Higher Trainees: CAMHs trainee advised they have had the opportunity to shadow a Paediatrician.

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

Trainers: The panel were advised there is a consultant lead for clinical audit who provides support for quality improvement and audit. A proforma has been designed and if the completed audit fits the criteria trainees are provided with a certificate.

FY and GP Trainees: The panel were told there was a teaching session on quality improvement and trainees were able to drop into the office based at Carseview for additional guidance.

Core Trainees: The panel were told several trainees are currently collecting data about how many bloods and ECGs are performed on wards as part of an improvement project. Some trainees felt there were opportunities to get involved with audit and quality projects however they lacked the time or support. Some trainees had completed audit projects and presented at the bi-annual quality presentation group meeting.

Higher Trainees: Trainees advised there are opportunities available for them to get involved in quality projects and audits.

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: Trainers advised feedback will be provided in weekly supervision sessions. We were advised by one consultant that they check trainees' letters following clinics and provide feedback.

FY and GP Trainees: Trainees advised they will get feedback provided at clinics and ward rounds.

Core Trainees: Most trainees felt they received useful feedback.

Higher Trainees: Trainees get feedback at their weekly supervision session but advised there are not many other opportunities to gain feedback during the day or out of hours. Trainees would appreciate more feedback on their clinical decisions and felt it would be especially helpful in cases their educational supervisor works in a different area than they are carrying out some of their work for example some supervisors don't carry out outpatient work. One trainee did advise their consultant checked patient letters and provided feedback.

2.11. Feedback from trainees (R1.5, 2.3)

Trainers: The panel were advised that at the end of placement trainees will be asked to provide feedback regarding what went well and not so well. A trainer advised they have suggested a new format for collating feedback from trainees similar to iMatter but with the ability to identify the grades to help act on feedback.

FY and GP Trainees: Trainees felt weekly supervision was an opportunity for them to provide feedback. The panel were informed there is a trainee forum after Thursday morning teaching, but trainees felt this was more aimed at psychiatry trainees.

Core Trainees: Some trainees had been asked to complete 360-degree feedback for consultants. The panel were advised there is a junior doctor forum in place with trainee representatives invited to the TTMG meeting to feedback. It was however raised that trainees were not aware of any completed actions from the meeting and felt concerns raised were not taken on board by senior staff.

Higher Trainees: Trainees advised they meet 6 monthly with their TPD which could provide an opportunity to provide feedback regarding their training experience.

2.12 Culture & undermining (R3.3)

Trainers: Trainers advised they try to create a positive culture by encouraging trainees to talk openly about concerns and by showing professionalism. Trainers were aware of several trainees who had raised concerns and felt these had been resolved.

FY and GP Trainees: Trainees felt nursing staff and consultants were very supportive and approachable. Trainees had not witnessed or experienced undermining behaviour and would feel comfortable raising concerns to their supervisor.

Core Trainees: The panel were given examples of undermining behaviour and of a culture that creates fear of raising concerns.

Higher Trainees: Most trainees felt the clinical team and senior colleagues were supportive. It was discussed that there is not always consistency in styles or expectations among senior staff and trainees can feel pressurised into situations they are not always comfortable with. Trainees were aware of how to raise concerns regarding undermining behaviour.

Non-Medical Staff: Staff were aware of trainees having been party to undermining behaviour from a consultant and advised this had been raised.

2.13. Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Trainers advised there are significant gaps on the consultants' rota but felt the junior doctor's rota was in a good position. It was reported there is no consultant lead for rotas, but fulltime admin support is now in place.

FY and GP Trainees: The panel were advised there are currently no rota gaps. Trainees advised the rota is organised by a core trainee with admin support. The panel were told emergency cover arrangements were discussed at the trainee forum and a list produced to cover sickness absence, exam cover etc. It was felt it would be advantageous to tweak the rota as there have been two less than full time (LTFT) trainees placed on ward 2.

Core Trainees: Trainees advised there were no current rota gaps. Trainees organise the rota with no consultant overview although there is now admin support. The panel were informed that trainees carry out 24 hr shifts which they have been advised by HR should not be happening. It was felt it would be easier if two LTFT trainees were not in ward 2 as this impacts negatively on the rota and it was felt this could have been better organised. Due to a shortage of consultants some placements have been changed and we were told of a case where the placement had been changed 4 times and was not finalised until one week before the trainee started.

Higher Trainees: Trainees advised they are responsible for organising the rota and there is no consultant oversight. The current rota is down from 14 to 8 trainees available to cover meaning trainees are carrying out more out of hours duties. They have been in touch with HR regarding this as their shifts have almost doubled but have not received any guidance on whether the rota is compliant or how this should be monitored. We were also given an example of an occasion where there was a known gap on the rota at core trainee level where no action had been taken by the service and the higher trainee was expected to provide cover.

Non-Medical Staff: Non-medical staff were not aware of rota concerns that may impact on doctors' wellbeing but did highlight the out of hours work can be challenging as it is multi-site so they can get called to cover several emergencies at once at different sites.

2.14. Handover (R1.14)

Trainers: It was confirmed consultants take no part in handover for GAP during the week. There has been a weekend safety huddle introduced which all levels attend which is felt to be effective but is not used as a learning opportunity.

FY and GP Trainees: Trainees advised handover can vary across sites but mainly all use the generic mailbox to communicate handover information. All junior trainees should have access to the mailbox, but the panel were told this was not set up prior to starting in post and trainees had to arrange access. During the week there is no consultant involvement in handovers. There has been a weekend safety huddle introduced which is used as weekend handover and is attended by trainees, consultants and nursing staff.

Core Trainees: Trainees advised during the week, emails are sent to a generic mailbox as handover. All trainees have access to the mailbox, but it would be useful to have this set up prior to starting in post. It was raised that sometimes there are lots of emails and there could be a possibility of information becoming lost and it may be useful sometimes to call directly. Consultants are not involved in weekday handover. The panel were told there is now a weekend safety huddle that all levels attend, it was felt the information discussed at this meeting has become reduced and thought it was helpful to have more discussion regarding what is required on the wards.

Higher Trainees: Different areas carry out handover differently, but trainees reported no formal handover processes during the week and would contact the appropriate person directly if they had anything relevant to share. They do not have access to the generic mailbox used by junior trainees. Trainees were involved in the weekend safety huddle.

2.15. Educational Resources (R1.19)

Trainers: N/A

FY and GP Trainees: Some trainees had faced problems accessing IT systems at the start of their placement and thought more IT coverage at induction would be helpful. We were advised several sites had limited or no WIFI, but this did not have a massive impact and on call cover would be routed through the switchboard.

Core Trainees: It was discussed that the library facilities are out of date however trainees advised they can order books if required and look up journals online.

Higher Trainees: Trainees advised there is limited or slow WIFI access at some locations which can hinder learning.

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 panel were advised the educational supervisor or TPD would be contacted if trainers had concerns about a struggling trainee. We were told trainees can be referred to the PSU unit within NES or occupational health for support.

FY and GP Trainees: Trainees did not have experience of requesting reasonable adjustments but would feel comfortable asking senior staff.

Core Trainees: Trainees advised the educational supervisors and TPD are very approachable. We were advised one trainee sought additional support and found this challenging to access. We were also given an example of a trainee being refused access to reasonable adjustments which had been advised by occupational health.

Higher Trainees: Some trainees advised they were unsure who to contact for support but felt the TPD was supportive. We were given an example of a trainee who had requested reasonable adjustments with the support of occupational health, and it took some time to receive the necessary equipment.

Non-Medical Staff: It was felt there are systems in place to manage the situation where the performance of a trainee gives rise to potential concern, the charge nurse will be informed, and appropriate follow up conversations had.

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 advised that trainees are asked at the end of placement for feedback. We were told the TTMG meet every 3 months.

All Level Trainees: All trainees were unaware of who the Director of Medical Education was or their responsibilities.

Higher Trainees: Higher trainees advised they have a regular peer support group in place and although not formally invited trainees have attended the TTMG meetings.

2.18 Raising concerns (R1.1, 2.7)

Trainers: Trainers advised trainees are encouraged to raise concerns from the start of their training with this being emphasised at induction. It was felt morale was low amongst trainers due to the recent negative feedback. It was discussed that a more consistent management structure would be beneficial and more support from medical management would be appreciated.

FY and GP, Core Trainees: Trainees reported they would raise concerns regarding patient safety to the charge nurse or consultant in the first instance. Trainees felt patient safety concerns would be taken seriously by senior staff.

Core Trainees: Trainees advised patient safety is everyone's main focus and any concerns raised to the charge nurses or clinical supervisors are taken seriously.

Higher Trainees: Trainees had no experience of raising patient safety concerns but advised they would be comfortable raising with the consultant.

Non-Medical Staff: it was felt staff are very aware of how to raise patient safety concerns and these are taken seriously. There is a weekly reflection group amongst non-medical staff where concerns can be discussed in a safe and non-judgemental way.

2.19 Patient safety (R1.2)

Trainers: Trainers were aware there had been concerns raised regarding pinpoint alarm coverage. Trainers reported there is currently no clinical lead for General Adult psychiatry, it was felt this removes the ability for them to have direct conversations with the lead regarding issues trainees have raised with them and sometimes they are unsure how to proceed. It was raised that the high number of locums could impact on patient safety and there should be more supervision in place, especially for those that have no membership of the Royal College of Psychiatrists.

FY and GP Trainees: Trainees would have no concerns for the care of a friend or family member if they were admitted to their units. It was felt boarding is not a concern as the ward team where the patient is based will take responsibility for their care and there is a board that should be completed to assist with tracking for boarders.

Core Trainees: Trainees would have no serious concerns if a friend or family member were admitted although it was felt that resources are currently very stretched which could impact on the time staff have with patients. We were also told that there is only one ECG machine which limits access and it was felt it would be beneficial if another was available.

Higher Trainees: Trainees would not have concerns regarding the care of a friend or family member although did feel there could be inconsistency of clinical care within the General Adult wards due to a high number of locum consultants.

Non-Medical Staff: It was felt the safety of the environment has improved in recent years and the non-medical staff feel consulted in changes. We were given the example that there is currently a

mock room set up for staff to provide feedback on before being rolled out. The panel were informed there are three safety briefings a day for nursing staff, but trainees are not involved in these.

2.20 Adverse incidents (R1.3)

Trainers: Trainers felt the verifier should provide feedback on Datix concerns. We were told there is currently no formal system in place to allow shared learning from adverse incidents, but it has been suggested a meeting should take place similar to a morbidity and mortality meeting.

FY and GP Trainees: Trainees advised they would raise adverse incidents through Datix but had no recent experience of doing so. It was mentioned that Datix is not a user-friendly system, but all know how to use it. The panel were informed there are no formal processes to receive feedback or shared learning from incidences but felt they would be provided with feedback if an incident arose.

Core Trainees: Several trainees had reported adverse incidents using the Datix system, feedback was not regularly received or if it was, it was not in a timely manner and trainees were not invited to the SEA (Significant Event Analysis) or informed formally of the outcome of the SEA. We were told there are no formal methods for shared learning from adverse incidents for trainees.

Higher Trainees: Several trainees had raised Datix concerns and advised they generally do not receive feedback, or if they do, it is a basic email. Trainees were unsure of the formal procedure of how Datix' s should be followed through. The panel were advised there is no opportunity for shared learning from adverse incidents.

Non-Medical Staff: The panel were advised there is a weekly Datix meeting for senior nursing staff where clinical and environmental scenarios are reviewed, it would be expected the verifier would provide feedback and share the action plan with the individual who raised it. It was felt that any Datix raised in the last 24 hrs will be highlighted at the daily safety huddle.

2.21 Duty of candour (R1.4)

Trainers: N/A

FY and GP Trainees: Trainees had no experience of something going wrong with a patient's care but felt they would be adequately supported if this was to occur.
Core Trainees: The panel were given an example of a trainee who had dealt with a traumatic incident whilst on call, the trainee had received very good support from the nursing staff but no consultant support or follow up.

Higher Trainees: Trainees felt they would be supported if something went wrong.

2.22 Other

When trainees were asked to score their 'overall satisfaction' with their training in their current post, with '0' being 'lowest level possible for overall satisfaction' and 10 being the 'highest level of satisfaction possible', the following scores were recorded:

Foundation and GP Trainees: Trainees scored between 6 and 9 with an average of 7.75
Core Trainees: Trainees scored between 4 and 9 with an average score of 6
Higher Trainees: Trainees scored between 5 and 8 with an average score of 7

Trainees: Trainees felt there was a lot of good work being carried out by the consultants as they are doing extra to try to protect trainees' learning.

3. Summary

- Put the table below at the start of the section and only highlight one option from yes, no, highly unlikely, highly likely.

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

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 a formal 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 on 8 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.

Requirements from January 2019 Visit:

- 8.1 A regional teaching programme for the General Adult Psychiatry training programme must be established and supported by a Consultant/Training Programme Director. - **Not met**

- 8.2 Clarity of roles and responsibilities regarding Liaison assessment out of hours. This can then be confirmed in both trainee handbooks to limit discrepancies. – **We were told there is no longer a Liaison service in Perth but that has caused different concerns including trainees being contacted to provide cover and a lack of awareness of who to contact for support.**

- 8.3 There is a need to reconsider the role of all FY1 trainees to ensure a valuable learning experience. - **Met**

- 8.4 Difficulty contacting the duty doctor both in and out of hours due to problems with phone and Wi-Fi signal, causing a significant amount of wasted time spent looking for the correct individual. New solutions must be identified. - **Met**

- 8.5 The culture of blame, fear of raising concerns and undermining must continue to be addressed. – **Not Met**

- 8.6 The department must work with the Board in implementing changes to improve the educational environment for all grades of doctors in training. – **Not Met**

- 8.7 Trainees must be able to complete educational assessments at out-patient clinics -**Partially Met**

- 8.8 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**

- 8.9 The practice of trainee led clinics should be addressed to ensure patients have proper and consistent consultant involvement in their care. - **Met**

- 8.10 Review of the workload for trainees within General Adult Psychiatry programme to improve educational experience. – **Partially 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. Following finalisation of the report, a discussion will be held between the deanery and GMC to explore not only the place of conditions around the continued approval of ongoing training in Tayside in General Adult Psychiatry, but also to consider the scope of the visit. We will propose a Pan Tayside revisit takes place in June 2020 to look at the progress that has been made across the sites.

4. Areas of Good Practice

Ref	Item	Action

5. Areas for Improvement

Areas for Improvement are not explicitly linked to GMC standards but are shared to encourage ongoing improvement and excellence within the training environment. The Deanery do not require any further information in regard to these items.

Ref	Item	Action
5.1	There should be a process that ensures trainees understand, and are able to articulate, arrangements regarding Educational Governance at both site and board level.	
5.2	Trainees should be given support to identify if the rota is compliant.	
5.3	It was felt there is inconsistency of tasks across sites and trainees would appreciate clarity or specific information on how to carry out tasks in different departments.	
5.4	There were concerns from some trainees regarding the ease of meeting their Psychotherapy competencies.	
5.5	Limited opportunities for special interest work.	
5.6	Due to a shortage of consultants some clinics have been cancelled and some trainees have struggled for support during clinics.	
5.7	A shortage of consultants and a high turnover of locums is impacting on the training experience of trainees with inconsistent support, short notice of placement changes and more of a challenge to arrange WBA and supervision. Available consultants are supportive but overstretched.	

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	A regional teaching programme for the General Adult Psychiatry training programme must be established and supported by a Consultant/Training Programme Director	6 months	Higher
6.2	The culture of blame, fear of raising concerns and undermining must continue to be addressed	6 months	All
6.3	The department must work with the Board in 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 Rota's, including a Rota with named duty consultants for all sites with a working process to cover unexpected leave	Immediately	All
6.5	Review of the workload for trainees within General Adult Psychiatry programme to improve educational experience	6 months	All
6.6	Trainees must receive feedback on incidents that they raise and there must be a forum for learning from adverse events.	6 months	All
6.7	A process must be put in place to ensure that any trainee who misses their induction session is identified and provided with an induction.	6 months	All
6.8	Handover must be formalised and happen consistently in all areas for all levels to ensure safe handover and continuity of care.	6 months	All

6.9	All Consultants who are trainers must have time within their job plans for their roles to meet GMC Recognition of Trainers requirements.	6 months	Trainers
6.10	All trainees must have timely access to IT passwords and system training through their induction programme.	6 months	All
6.11	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
6.12	Trainers within the department must provide more regular informal ‘on the job’ feedback, particularly in regard to trainee decisions and care planning.	6 months	All
6.13	Clarity on who to contact for Liaison services at Perth Murray Royal should be given and timely support available.	6 months	All