Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	13th November 2019	**Level(s)**	FY/GP/Core/Higher
Type of visit	Revisit	**Hospital**	Royal Cornhill Hospital
Specialty(s)	Psychiatry	**Board**	NHS Grampian

Visit panel	
Amjad Khan	Visit Chair – Director of Postgraduate GP Education
John Cummings	Lay Representative
Norman Nuttall	Training Programme Director
Claire Langridge	Associate Postgraduate Dean – Quality
Dawn Mann	Quality Improvement Manager
In attendance	
Susan Muir	Quality Improvement Administrator
Alis Ballance	Shadowing Lay Representative

Specialty Group Information		
Specialty Group	Mental Health	
Lead Dean/Director	Amjad Khan	
Quality Lead(s)	Claire Langridge and Alastair Campbell	
Quality Improvement Manager(s)	Dawn Mann	
Unit/Site Information		
Non-medical staff in attendance	4	
Trainers in attendance	10 including APGD	
Trainees in attendance	4 FY2, 2 GP, 7 Core and 7 Higher	

Feedback session: Managers in attendance	Chief Executive		DME		ADME		Medical Director Yes		Other 7 including Board Director	

									and Education Manager	

Date report approved by Lead Visitor	19th December 2019

1. Principal issues arising from pre-visit review:

Royal Cornhill Hospital is the main centre in the North East of Scotland for the care and treatment of people with mental health problems and includes inpatient, outpatient and day patient care. Following concerns raised at the 2018 GP Quality Review Panel (QRP) and the GMC highlighting the site on the 2018 Triage list a triggered visit was carried out to Royal Cornhill Hospital on 7th November 2018. The main findings from the visit are detailed below:

The panel were left with an inconsistent picture of the quality of experience of Foundation and GP trainees, and those of Core and Higher trainees. The quality of experience of the latter groups is clearly better than the former and the visiting team gained an impression that Core experience is protected sometimes at the expense of FY/GP trainees' experience. We would suggest that some attention is required to improve the experience for Foundation and GP Trainees. It is evident there has been an element of unanticipated change caused by staffing pressures which have impacted on the training experience. With this in mind we would like to return in one year. It was clear that all involved in training are sympathetic to the needs of trainees and try to offer a supportive environment. We have highlighted below both the positive aspects from the visit, areas for improvement and requirements.

Positives:

- Strong support provided by the service and Training Programme Director (TPD) particularly for trainees that require less than full time and maternity leave.
- Support for Higher Trainees' attendance at national training, flexibility in supporting trainees to meet curriculum competencies, and support for out of hours Rota management.
- The Core teaching programme
- Junior and Higher Trainee forums and Higher trainee involvement in all management meetings.
- Strong support given to trainees following a significant incident, the significant incident group and a culture of shared learning from significant incidents.
- Handover arrangements that involve Higher Trainees and Consultants.

Areas for Improvement

- The Core TPD is lead for FY/GP which could potentially lead to some conflict of interest and consideration should be given to separating these roles.
- There was a session scheduled at induction for training on aggression management which did not go ahead for unavoidable reasons, but this was not rescheduled.
- GP trainees find it difficult to attend local teaching as they provide cover for core trainees.
- Junior trainee clinics in some cases involve remote supervision including for new patients, which can result in patients being seen by a series of junior trainees without direct input from a senior decision-maker.
- Recent staffing difficulties and the resulting closure of wards have impacted on the training experience of trainees, including; the fact that due to the ward changes the 9am handover has become more challenging, the newly opened Huntly ward does not have a fit-for-purpose interview room, and the required 1-hour supervision has become inconsistent for some trainees.
- The GMC have recommended the introduction of colour coded badges to help identify trainees' level of competence.

Requirements - Issues to be Addressed

- Departmental induction must be provided which ensures trainees are aware of all of their roles and responsibilities and feel able to provide safe patient care. Up-to-date handbooks may be useful in aiding this process but are not sufficient in isolation.
- Department must develop and sustain a local teaching programme relevant to curriculum requirements of the ST4+ trainees including a system for protecting time for attendance.
- Trainees must receive consistent weekly sessions with their appointed supervisor.
- Trainees must have access to personal alarms and appropriate training on how to use them.
- The site must develop an effective system of tracking and managing boarded patients and ensuring appropriate clinical ownership & oversight of patient care.
- All Consultants who are trainers must have time within their job plans for their roles to meet GMC Recognition of Trainers requirements.

Recent NTS and STS data highlighted concerns across different levels of trainees regarding local and regional teaching.

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 advised there is a very comprehensive induction programme in place which is carried out over several days. Induction includes some self-directed online learning and guest speaker sessions including ECT and the Hospital at night. We were advised the rota is created to allow new starts to attend induction but if trainees were to miss induction sessions the Core TPD would carry out catch up sessions.

FY and GP Trainees: Trainees advised they had attended induction, received an induction handbook and had IT passwords for the start of placement. Suggested improvements to induction included a more comprehensive tour and more clarity on what is expected from them during on call work and safety assessments. From discussion there appeared to be a discrepancy in the ward inductions with some being more structured and detailed than others. We were given an example of one ward where trainees received a comprehensive induction package for the ward which was felt to be very useful.

Core Trainees: Trainees advised they had received a hospital and a departmental induction which was felt to be of a good standard.

Higher Trainees: Trainees confirmed they had all received a hospital and departmental induction when starting their post.

Non-Medical Staff: It was felt it is helpful for there to be thoughtful rostering at the start of placements so new trainees are not on call straight away.

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

Trainers: The panel were advised there is a new Old Age Psychiatry teaching programme in place which is lead by consultants. Trainers advised there are case presentation sessions held on

Thursdays which all trainees are encouraged to attend, and local teaching takes place on Wednesdays mainly aimed at Core trainees but open to all. Higher trainees are invited to the monthly trainer CPD sessions. Foundation and GP have separate teaching sessions which they are enabled to attend and are scheduled at different times to local teaching.

FY and GP Trainees: The panel were advised that Foundation teaching takes place at Aberdeen Royal Infirmary which is approx. a 20-minute walk from the site. Some trainees advised they often miss the Foundation teaching for various reasons including the distance and overrunning clinics but were encouraged to attend by trainers. Trainees advised GP teaching was held infrequently approximately once a month, but some sessions were repeated from the previous year. We were told trainees are invited to local teaching, but it was felt this is aimed at Core trainees whose attendance is more protected.

Core Trainees: Trainees advised they attend teaching on a Wednesday which includes tutorials, case conference, Balint group and psychotherapy supervision, which they value. Trainees are encouraged to attend teaching and only miss if they were on call. It was felt the consistency of teaching has improved since the last Deanery visit as it used to be common for training to be cancelled.

Higher Trainees: Trainees who were part of a national programme were all supported to attend specialty specific teaching days and there is now local Old Age teaching available. The panel were told the local teaching is aimed at junior trainees, but higher trainees can attend if there is something relevant to them. We were told there is a weekly journal club and higher trainees are invited to monthly (drug company funded) consultant CPD sessions. Higher trainees have organised regular hourly local teaching sessions where they take turns to present. Trainees advised there is no General Adult Psychiatry specific teaching available and trainees felt this would be beneficial.

Non-Medical Staff: The panel were advised nursing staff are aware of teaching times and rely on the duty doctor during these times. It was felt there is a high level of commitment from consultants to allow trainees to attend teaching sessions, but some trainees felt unable to attend.

2.3 Study Leave (R3.12)

Trainers: Trainers raised no concerns regarding trainees obtaining study leave.

FY and GP Trainees: Most trainees advised they had no problems obtaining study leave.

Core Trainees: Trainees reported no problems with obtaining study leave.

Higher Trainees: trainees felt it was easy to get 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 advised that due to staffing numbers the consultant the trainee is attached to will normally be their clinical supervisor and often educational supervisor and the Clinical Leads will allocate the trainees accordingly. Trainers advised they all had SPA time in their job plan to undertake their educational role. It was felt trainers would be given information about a trainee with known concerns from the Training Programme Director (TPD).

FY and GP Trainees: All trainees had met with their educational supervisor.

Core Trainees: Trainees advised they had all met with their educational supervisor and it was easy to arrange appointments.

Higher Trainees: Trainees advised they all had regular meetings with their educational supervisor.

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

Trainers: The panel were told staff are informed of the different levels of trainees joining the departments. The site has not introduced the GMC recommended coloured badges to help differentiate the level of competency of trainees however, we were told the DME does hope to introduce these. Trainers felt there was a clear tiered line of contact in place so trainees should always be aware of who to contact for support both during the day and at night and would encourage trainees to contact registrars or consultants at any time for support.

FY and GP Trainees: All trainees received weekly supervision but not always a full hour. Trainees felt the consultants were approachable. Trainees did not feel they had to cope with problems beyond their experience and advised support would always be available either on site or by phone.

Core Trainees: Trainees advised they have access to weekly supervision. Trainees felt they were aware of who to contact for support starting with their consultant or the team consultant. The panel were told some wards have displayed rotas which was felt to be useful. Trainees did not feel they had to deal with problems out with their level of competence.

Higher Trainees: Trainees advised they were always aware who to contact for support during the day and OOH. The panel were advised trainees had not been in situations where they felt they had to deal with problems beyond their experience. Trainees felt the consultants were accessible and approachable.

Non-Medical Staff: The panel were told there are cover arrangements in place when consultants are on leave, but these are not always transparent. It was felt OOH supervision is well documented. We were advised that senior nursing staff is always accessible.

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

Trainers: The panel were told any changes to the OAP curriculum would be circulated by the clinical lead and Psychotherapy trainers attend regular training meetings. There are monthly trainer CPD sessions. The panel were told trainees are met after induction to discuss their objectives for placement. It was felt trainees get good exposure at the site as there is a varied range of specialties covered. Following feedback from the FY/GP trainees at the Deanery visit in 2018 the rota has been changed to allow FY/GP trainees access to emergency assessments. The panel were told there are Physician Assistants on some wards to assist with non-educational tasks and trainers felt the balance between developing as a doctor and non-educational tasks was OK. Trainers advised all trainees have access to clinics and a staged process is in place, so appropriate supervision is in place. It was felt it can be a barrier to FY2 trainees attending rural clinics if they don't drive.

FY and GP Trainees: The panel were advised the placement provided good access to learning opportunities. All trainees had access to clinics. It was felt the system meaning you jump daily between different roles (Duty A and Duty B) can be confusing at first but they appreciate the learning experience provided from access to both roles. The percentage of time trainees spend carrying out tasks of non-educational tasks varies depending which ward they are aligned to as some have access to a Phlebotomist while others were unaware there was one and some wards have a Physician's Assistant. We were also told that some trainees spend an excessive amount of time

writing discharge letters due to a shortage of admin support and it would be helpful if kardexes were electronic.

Core Trainees: Trainees felt they were able to achieve their competencies, and all had scheduled clinics. The panel were told there are staffing gaps across the site which can lead to trainees carrying out more non-educational tasks. We were told some wards have GPs but on other wards for example Forensics, trainees can spend a lot of time looking after patient's medical health.

Higher Trainees: Trainees felt they were able to achieve their competencies and learning outcomes. Several trainees work on dual posts and felt the site were accommodating and flexible to ensure these are achievable.

Non-Medical Staff: The panel were told nursing staff are available for joint assessments with trainees and on hand for guidance regarding protocols and systems.

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

Trainers: It was felt trainees did not have problems achieving their portfolio assessments. Trainers advised they have all received training on assessments including local FDA courses and felt this was interchangeable between the different levels of trainees. The panel were told there were not opportunities for trainers to benchmark assessments against those of other trainers.

FY and GP Trainees: Trainees advised they are able to complete workplace-based assessments, and these are fair.

Core Trainees: Trainees advised they are able to complete workplace-based assessments, and these are fair and consistent.

Higher Trainees: Trainees advised it can take some planning to get workplace-based assessments (WBA) due to consultants working hours but we were told senior staff are supportive of trainees achieving WBA.

Non-Medical Staff: The panel were advised Senior Nurse Practioners are involved in trainee assessments and nursing staff will be asked to carry out multi source feedback for trainees.

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

Trainers: Trainers informed the panel Multi-Disciplinary Team (MDT) meetings were a regular part of the education programme providing opportunities for multi- professional learning.

FY and GP Trainees: It was felt Community MDT meetings provide a good opportunity for multi-disciplinary learning.

Core Trainees: Trainees felt there were opportunities to learn with and from other health professionals for example on call work with care nurses and community mental health meetings.

Higher Trainees: Trainees advised they had regular opportunities for multi-disciplinary learning.

Non-Medical Staff: Nursing staff advised there is no formal joint training, but it was felt community mental health team meetings can be used as a learning opportunity.

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

Trainers: Trainers advised there is a named person responsible for audits and a regular audit group is in place. Trainees are encouraged to take part in audits.

FY and GP Trainees: Some trainees had taken part in quality improvement and audit projects however some had found this challenging due to workload.

Core Trainees: Trainees advised they were encouraged to take part in quality improvement projects.

Higher Trainees: Trainees advised there are opportunities for them to engage in quality improvement projects and audits.

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: The panel were advised that all trainees receive weekly supervision sessions and it was felt this provides a good opportunity for trainees to receive feedback. It was felt trainees will also receive feedback on a day to day basis during ward rounds and clinics.

FY and GP Trainees: Trainees felt they received useful feedback on their clinical decisions on a day to day basis and at the end of their placement.

Core Trainees: Trainees advised they would get feedback during clinical supervision. It was felt the quality of feedback on wards can vary especially due to consultancy vacancies and a high number of locums.

Higher Trainees: Trainees reported receiving daily feedback both during the day and out of hours. They felt the feedback was helpful and measured.

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

Trainers: Trainers felt there were opportunities for trainees to feedback on their learning experience through meetings with the TPD, end of placement meetings, the GMC survey and Grampian questionnaires. We were also told that trainees representatives are invited to attend and have a voice at all management and committee meetings.

FY and GP Trainees: Trainees advised they would feedback to their supervisor regarding the quality of training at the site. Trainees had been invited to attend junior doctor's forum meetings, but most had not been.

Core Trainees: The panel were told there is an active junior doctors committee which has representatives at all management meetings. We were told trainees meet with their TPD twice a year where they can provide feedback on the quality of the training at the site.

Higher Trainees: Trainees advised they have ample opportunities to provide feedback to trainers and management on the quality of their training and informed the panel there is a regular trainee forum with representatives that feed into all the management committee meetings.

2.12 Culture & undermining (R3.3)

Trainers: Trainers felt that there is an emphasis on team culture at the site and trainees are welcomed and supported. There is an active junior doctor's forum with representatives that feed into all management committees. We were advised Grampian have clear policies in place regarding bullying and undermining.

FY and GP Trainees: The panel were told trainees are very supportive. Trainees had not witnessed or experienced undermining or bullying behaviour but would raise concerns with their consultant with any concerns.

Core Trainees: Trainees felt the clinical team and senior staff were supportive and approachable. They had not experienced or witnessed any undermining or bullying behaviour but would feel comfortable to raise concerns with the TPD or consultants.

Higher Trainees: Trainees advised they had not witnessed or been subjected to undermining or bullying behaviours. Trainees were aware of the formal policies to follow to report such behaviour if they did become aware of any and would feel comfortable discussing with their supervisor.

Non-Medical Staff: It was felt that NHS Grampian promote a culture for learning and staff aspire to multi-disciplinary working where everyone's opinion was valid. The panel were told there are systems in place to allow bullying and undermining concerns to be raised anonymously.

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

Trainers: The panel were advised there are some gaps in the junior rota that they endeavour to fill with Locums. The panel were told there has been extensive work looking into the best way to cover short notice rota gaps. The panel were told there has been a considerable drop in substantive consultants in the past few years seeing the consultant rota fall from 1 in 14 to 1 in 22. It was felt the rota supports trainees to maximise training opportunities. We were advised there has been ongoing disputes regarding the rota as the medical staffing team are based at Aberdeen Royal Infirmary where rotas vary, it was felt these issues have now been resolved and the rota system is more trainee friendly.

FY and GP Trainees: The panel were advised the rota is organised by trainees, the rota was received well in advance and swaps are accessible. Trainees advised there are rota gaps at present which are mainly covered by Locums, it was felt short term gaps can be challenging for example a Locum recently walked of the job and a trainee was randomly selected to cover the shift with little notice.

Core Trainees: The panel were advised trainees act as rota masters which they feel can be helpful to enable swaps and avoid teaching. Trainees advised there are currently a number of rota gaps and there has been some disagreement on how best to manage these with the rota originally being made with gaps. It has now been decided that the rota will be created to fill the gaps by increasing the base level, we were told the banding is still appropriate. Trainees would appreciate more transparency on how trainees are picked to cover short term rota gaps. Following the previous deanery visit the rota system was changed so FY, GP and Core take turns working on both Duty A and Duty B, it was felt this has reduced the learning opportunities available to core trainees however they feel they will still achieve their emergency case competency. Trainees felt it would be beneficial if there was a process in place to ensure two FYs were not on call together due to patient safety.

Higher Trainees: Trainees advised they currently have no rota gaps and the number of trainees on the rota has increased since our last visit due to the addition of child and adolescent mental health (CAMHs) trainees to the higher rota. The rota is produced by an ST7 with no named consultant with overall responsibility for the rota, but it was felt to be flexible and amenable to swaps. The panel were told there has been rota monitoring 3 times in 8 months. Trainees were asked how they felt regarding the split of the junior rota and it was felt it may be helpful if the jobs were shared out (possibly at handover) instead of a formal split of Duty A and Duty B.

Non-Medical Staff: It was felt the level of protection trainees have following OOH shifts is better but covering short time absences can be hard.

2.14. Handover (R1.14)

Trainers: The panel were told there has been a great deal of work carried out to improve the handover process with trainees involved in a quality improvement project. Handover takes place at 9 am, 4.45pm and 9pm during the week and 9 am on weekends. All levels are present at the weekend handovers and 9pm Friday evening. Handover takes place in the hub and a white board is used to list new patients. It was felt the new handover was used as a learning opportunity.

FY and GP Trainees: The panel were told an am and pm handover is in place with a more structured handover on weekend mornings. Trainees advised the morning handover will take place in the Hub with representatives attending from all wards. We were advised new admissions will be detailed on

the white board and consultants and registrars will often only be in attendance at weekend handovers.

Core Trainees: Trainees advised there is a 9am,5pm and 9pm handover during the week and 9am on weekends. Trainees have been involved with an audit project to improve the handover. Trainees advised the weekday handovers are less formal and consultants and registrars are not often present. It was felt the more formal weekend handovers with all levels of staff present can be used as a learning opportunity. Trainees felt the handover process could be further improved.

Higher Trainees: The panel were told handover takes place at 9am, 5pm and 9pm on weekdays and 9am on weekends with higher trainees only present at weekends. The panel were told there have been changes to the handover this year with lots of ongoing discussion at committee meetings to the best way to carry out handover. It was felt handover was more of a learning opportunity for Core trainees.

Non-Medical Staff: The panel were advised there has been a lot of work carried out to improve the handover process and it was felt the Friday evening handover is good with presence from all levels. We were told there is now an allocated room for handover where notes are kept for information. It was felt handover can provide an informal opportunity for learning.

2.15. Educational Resources (R1.19)

Trainers: It was felt there are adequate resources to support learning at the site.

FY and GP Trainees: Most trainees felt they had adequate access to educational resources however we were told on one ward there are 2 computers shared among 5 people and it was felt more computer access would be beneficial.

Core Trainees: Trainees felt there are adequate educational resources available.

Higher Trainees: Most trainees felt they had adequate access to educational resources although not all had access to an office/computer on the ward they worked and had to use facilities elsewhere.

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 Training Programme Director (TPD) would be involved if it was felt a trainee was struggling. It was felt there is lots of additional support available if required including extra supervision, involvement of local TPD or National Programme TPD or referral to the Performance Support Unit (PSU) within the Deanery.

FY and GP Trainees: Trainees advised they would feel comfortable approaching their supervisor if they required support and felt the site would be open to reasonable adjustments, but they had not had reason to raise concerns.

Core Trainees: Trainees advised there is support available for trainees that may be struggling both health wise or educationally. It was felt the site is supportive of less than full time working (LTFT).

Higher Trainees: Trainees felt there was support available at the site and felt the site was supportive of LTFT working.

Non-Medical Staff: Nursing staff advised that where they had concerns regarding a trainee's performance depending on the level of concern, they would discuss this with the trainee or with their consultant.

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 data is collected and shared with the medical staffing/business unit to monitor the quality of education and teaching at the site. The panel were told trainers are involved in local quality processes and work closely with NES.

All Level Trainees: All but one trainee was unaware who their Director of Medical Education was or what their role entailed.

2.18 Raising concerns (R1.1, 2.7)

Trainers: Trainers felt that patient safety is the focus of what staff do everyday and this culture would encourage trainees to raise concerns regarding patient safety. Trainers advised all new patients admitted will have a risk assessment. If trainees had an immediate concern it was felt, they would

discuss this with their consultant in the first instance or this would be feedback at weekly clinical team meetings. The panel were advised there are trainee representatives on all management committees allowing trainees opportunities to raise concerns regarding their education and training.

FY and GP, Core Trainees: Trainees felt there was a high level of awareness amongst staff of patient safety. We were told there is a risk assessment form completed for all patients. Trainees would raise patient safety concerns with senior nursing staff.

Core Trainees: Trainees advised they would raise any patient safety concerns with their consultant. We were told there is a safety huddle in place for nursing staff but trainees are not involved.

Higher Trainees: Trainees advised there are different processes for raising concerns across the specialties and wards however all were aware how to raise concerns and felt they would be listened to and acted upon.

Non-Medical Staff: Nursing staff felt patient safety concerns would be discussed with consultants and advised trainees had raised concerns with senior nursing staff. The panel were told there are daily ward safety huddles for nursing staff and a clinical pause on acute wards where staff can raise patient safety concerns.

2.19 Patient safety (R1.2)

Trainers: Trainers advised that temporary ward closures that occurred shortly before the last Deanery visit in Nov 2018 are still in place due to a shortage of nursing staff. It was felt this has impacted on all levels of staff leading to a site that is very stretched and pressured and has left trainees feeling unsettled. The panel were told the ward closures have led to a reduction in beds and the creation of hybrid wards. It was felt these changes have led to minor patient safety concerns and concerns regarding boarding patients.

FY and GP Trainees: Trainees advised if they had a friend or relative admitted to the site, they would have some concerns regarding the mixed use wards within General Adult care. Trainees also raised some concerns regarding boarding at the site which can impact on staff's awareness of patients.

Core Trainees: Trainees raised concerns regarding boarding patients including confusion regarding which consultant the patient is assigned to, who to contact OOH and the risk of patient jobs being missed.

Higher Trainees: Trainees advised that boarding remains a concern with a lack of beds and patients in mixed use wards. It was felt the current situation allows for a risk of patients being missed.

Non-Medical Staff: It was felt that boarding and bed acuity levels are not ideal but significant steps have been taken to address things. It was raised there can be an imbalance in the allocation of patients to trainees and we were given an example where one trainee was allocated 12 patients whilst another had 4.

2.20 Adverse incidents (R1.3)

Trainers: The panel were advised adverse incidents are reported through Datix and are then directed to the relevant parties to investigate and manage, with different protocols in place dependent on the severity of the incident. Trainers advised trainees will be given feedback on reported incidents and there are monthly adverse event reviews for all staff.

FY and GP Trainees: Trainees advised they would report adverse incidents using Datix and felt staff were encouraged to report incidents and are supported if incidents occur. Trainees were unaware of adverse incident meetings or shared learning from incidents.

Core Trainees: Trainees advised they would report adverse incidents through Datix. A trainee advised they had been involved in a recent adverse incident review which was very supportive and non-judgemental. Trainees were aware of regular adverse incident meetings where shared learning is discussed.

Higher Trainees: Trainees advised adverse incidents would be reported through Datix. Trainees were aware of the review and escalation process following reporting an adverse incident and advised there are meetings several times a year where shared learning from incidents is discussed. Trainees advised they are supported when incidents occur and felt the review process was fair.

Non-Medical Staff: The panel were told adverse incidents are reported through Datix and will be reviewed by approvers and investigated according to severity level. We were told there is a regular adverse event group and learning will be shared with all levels of staff.

2.21 Other

Trainees advised they had access to personal alarms.

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 8 with an average of 7
Core Trainees: Trainees scored between 7 and 9 with an average score of 7.75
Higher Trainees: Trainees scored between 7 and 9 with an average score of 8

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 consultants and nursing staff
- Culture of focussing on education meaning trainees can easily achieve competencies and assessments even with the strain of limited substantive consultants
- Regular formal Junior doctors committee meetings take place with trainee representatives on all management committees
- Improvements have been made to the induction process which is felt to be robust and includes a handbook

- There have been improvements to the teaching provision with the introduction of Old Age Regional teaching, better consultant attendance and less timetable cancellations

Less positive aspects from the visit:

- Boarding still proves challenging and leads to confusion among trainees for accessing support and managing patients care
- Improvements have been made to the handover process for weekend and 5pm handover but it was felt there is still room for improvement
- The rota is trainee led which provides flexibility however, benefit from consultant oversight especially when things go wrong for example short term cover
- GMC encourages the use of coloured badges to help differentiate the varying levels of trainees and their level of competency
- We would encourage a General Adult Regional Teaching programme

Requirements from November 2018 Visit:

- Departmental induction must be provided which ensures trainees are aware of all of their roles and responsibilities and feel able to provide safe patient care. Up-to-date handbooks may be useful in aiding this process but are not sufficient in isolation. **MET**
- Department must develop and sustain a local teaching programme relevant to curriculum requirements of the ST4+ trainees including a system for protecting time for attendance. **Partially Met – No General Adult Specific Teaching in place.**
- Trainees must receive consistent weekly sessions with their appointed supervisor. **MET**
- Trainees must have access to personal alarms and appropriate training on how to use them. **MET**
- The site must develop an effective system of tracking and managing boarded patients and ensuring appropriate clinical ownership & oversight of patient care. **NOT MET**
- All Consultants who are trainers must have time within their job plans for their roles to meet GMC Recognition of Trainers requirements. **MET**

The panel were left with an impression of a supportive and approachable senior staff who have worked hard to ensure trainees achieve their competencies throughout a time of change and diminished substantive consultants. A number of requirements follow with the main concern arising from ward

closures and boarding. The panel will suggest to the mental health sQMG that Royal Cornhill Hospital returns to the 5 year quality management cycle with appropriate monitoring.

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	The weekend handover has been improved with a greater attendance and structure, however weekday handover could benefit from greater structure, senior attendance and a written component.	
5.2	There should be a named consultant with oversight of the Rotas especially to provide assistance for short term cover.	

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	The site must develop an effective system of tracking and managing boarded patients and ensuring appropriate clinical ownership & oversight of patient care.	9 months	All
6.2	There must be a process that ensures trainees understand, and are able to articulate,	9 months	All

	arrangements regarding Educational Governance at both site and board level.		
6.3	A programme of formal teaching that is appropriate to the curriculum requirements of trainees should be maintained.	9 months	GAP trainees
6.4	The level of competence of trainees must be evident to those that they come in contact with. The use and promotion of colour coded badges as part of the must be introduced.	9 months	All