NHS
Health Education England

Central and North West London NHS Foundation Trust

Core Psychiatry Training and General Psychiatry

Urgent concern review (senior leader conversation)

Quality Review report

29 January 2019

Final report

Developing people for health and healthcare

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Quality Review details

Training programme	Core psychiatry training and general psychiatry
Background to review	This review was planned following a trainee focus group on 22 November 2018, where trainees raised a number of concerns. These included three areas of serious concern which were escalated to the Trust management team within 24 hours for urgent action: • Patient and staff safety at the Section 136 units at The Gordon Hospital and the Park Royal Centre for Mental Health required urgent review. HEE was aware that the new Section 136 suites at the St Charles Hospital had been completed but only one was operational at the time of the review • The Trust required a robust system for proactively checking personal safety alarms to ensure that they were functional at all times • Trainees at several of the Trust sites did not have access to the necessary IT and investigation result reporting systems. Trainees were obliged to have colleagues log into these systems for them and to use personal devices for writing reports, resulting in delays to clinical decision making and creating significant risk of data protection breaches. Examples were given of log in details being passed down from previous to current trainees to enable access to these systems in an effort to facilitate safe patient care.
HEE quality review team	Orla Lacey Deputy Postgraduate Dean, North West London Health Education England Vivienne Curtis Head of the London Specialty School of Psychiatry Health Education England Samara Morgan Principal Education QA Programme Manager Visits and Monitoring Team, General Medical Council Louise Brooker Learning Environment Quality Coordinator Health Education England, London Ed Praeger Deputy Quality, Patient Safety and Commissioning Manager Health Education England, London Paul Smollen Deputy Head, Quality, Patient Safety and Commissioning Health Education England, London
Trust attendees	The review team met with the following Trust representatives: • Chief Executive Officer • Medical Director

	• Director of Medical Education • Deputy Director of Medical Education • Head of Medical Education.

Conversation details

GMC Theme	Summary of discussions	Action to be taken? Y/N
1	**Feedback from previous quality review** The review lead enquired about the Trust team's response to the report from the previous quality review in November 2018. The Chief Executive Officer (CEO) reported that the management team had been surprised by some of the findings in the report, especially the issues around trainee retention and morale. The CEO advised that managers regularly spent time at Trust sites, talked to clinicians and monitored incident reports weekly. It was suggested that changes in the nature of the service and the patient profiles may have impacted on trainee morale, particularly in the community setting and the section 136 suites. The Director of Medical Education (DME) reported that trainees' negative feedback had previously focused on pay rates and the requirement for senior trainees to cover junior roles due to rota gaps, but that both of these issues had been resolved. The CEO indicated that the Trust executive had been surprised by the level of trainee concern about the section 136 suite at The Gordon Hospital and the trainees' feeling that the Trust did not act on their feedback.	
2	**Section 136 suites** It was noted that the section 136 suite at The Gordon Hospital remained closed and that the new suites at St Charles Hospital had been opened earlier than planned in order to provide this service. The Medical Director (MD) advised that there were no plans to reopen the suite at The Gordon Hospital as the Trust had always intended to close this during 2019. The CEO had met with local managers, trainees and nurses to discuss service provision in the section 136 suites and assess whether the suites were sufficiently staffed and resourced. Based on this, the Park Royal Centre for Mental Health section 136 suite was due to reopen with an additional member of staff allocated to each shift and a plan in place to add a second door for staff to access the unit. The MD described some of the challenges around section 136 service provision, including increased patient numbers (particularly referrals from the police service), service recalibration to reduce the number of section 136 suites and pressure from commissioners to reduce costs. The review team was informed that the Trust was working with the Metropolitan police to improve the interface between the two services and the joint management of patients.	
3	**Trust IT systems** The Deputy DME (DDME) reported that the postgraduate medical education (PGME) team had taken over responsibility for ensuring all trainees had logins for The Doctors	

	Laboratory (TDL) pathology results system. At the time of the review, logins had been arranged for all current trainees and for the incoming trainee cohort. Additionally, some trainees had initially been given incorrect links to access the system so the PGME team had communicated the correct link to all trainees. The DDME advised that the Trust information technology (IT) team was due to set up a helpline for trainees so that any technical problems could be addressed quickly. There was a long-term plan to replace the main Trust Pathology IT system and the DDME noted that the helpline call log would be useful to record common or recurring problems and to determine what was needed from the new system. The review team enquired about the information governance issue raised by trainees at the previous review. The Head of Medical Education stated that TDL was informed when trainees left the Trust so that their accounts could be deleted.	
4	**Personal alarms** The review team was informed that the Trust personal alarm policy had been updated and communicated to all of the trainees. There were systems in place to ensure that all staff and trainees checked alarms at the start of each shift and had access to chargers for the alarms. The DME reported that there had been a Trust-wide review of access to alarms which had confirmed that all trainees either had an alarm assigned to them or were able to collect an alarm at the start of every shift. The Trust planned to upgrade the alarms to a type which would alert the user if the battery needed to be charged. The DME advised that each Trust site was to produce an action plan which would be submitted to the Trust safety committee. The PGME team was to be involved in formulating these action plans to ensure that trainees' needs were met.	
5	**Recruitment and retention** The review team heard that in recent years the Trust had reduced the number of locum consultants and successfully recruited to substantive posts. It was noted that some subspecialties were more difficult to recruit to, such as child and adolescent mental health services (CAMHS) and community paediatrics services, but that this reflected national staff shortages and was not a Trust-specific issue. The MD reported that during recent recruitment to a consultant post, four of the six applicants had been trainees at the Trust. The Trust had continued to hold junior-senior doctor meetings and the MD advised that the managers were considering ways to improve the escalation process for trainee feedback. The MD described a drive towards involving staff and trainees in research and quality improvement projects. There was also a Trust research conference planned for 7 May. It was hoped that research work would raise the profile of the Trust and make it more attractive to trainees and prospective staff.	
6	**Clinical supervision in medical psychotherapy** The DDME reported that the PGME team had recently surveyed trainees about psychotherapy training and was working with the local divisional directors to ensure that each area was able to provide an appropriate level of training. The survey had identified that psychotherapy training in most regions met the trainees' needs but that there were not enough consultants in the Brent area to provide supervision for long psychotherapy cases. The DDME advised that there was a working group in place to	

	address this and that the Trust was encouraging trainees to join this group. The Trust planned to recruit another consultant medical psychotherapist in Brent but if this was not successful the MD indicated that the Trust would consider redeploying a consultant from another area. The review lead emphasised that the Trust needed to ensure a consultant was in post prior to the August trainee rotation date. The review team was informed that there was a named substantive consultant in the role of psychotherapy tutor, although the Trust representatives were unsure whether there were programmed activities (PAs) allocated in the tutor's job plan. The CEO advised that the tutor ran a comprehensive psychotherapy teaching programme.	Yes, please see Other Actions
7	**Physical healthcare** The review team heard that the Trust had a physical health strategy and steering group in place and was monitoring the compliance rates for physical health training. The DME reported that the target compliance rate was 90% and at the time of the review 65% of staff had undertaken the training. In addition, the Trust was training some senior nurses to become advanced clinical practitioners (ACPs) and was considering a programme to upskill healthcare staff in skills such as phlebotomy. It was hoped that these roles would relieve junior medical trainees of basic tasks such as vital sign monitoring and venepuncture, as well as improving patient care. The MD noted that the ethos of medical and nursing training had changed in recent years so trainees and newly qualified nurses tended to view mental and physical healthcare as integrated rather than as separate. The CEO informed the review team that the Trust had started to use the System One clinical information system which allowed access to local general practitioners' online records and test results. The system had been launched three days prior to the review, but the CEO advised that it was working well so far and that it should make completing patients' physical health records simpler and more efficient. The Trust was also looking into technological solutions for managing patients' physical conditions in the community setting, such as DnaNudge.	
8	**Health Education England (HEE) support** The Deputy Postgraduate Dean (DPGD) informed the Trust representatives that HEE could offer funding for a fellowship position to work on a quality improvement project. The CEO agreed that this would fit well with the Trust's overall quality improvement work and help to further some proposed projects.	Yes, please see Other Actions

Next steps

Conclusion
The review team thanked the Trust for facilitating the review and for the action taken to address the concerns of HEE and the trainees. It was agreed that the next step in working with the trainees was to improve morale and ensure good communication between trainees and managers. The Trust representatives suggested a follow-up meeting and it was agreed that HEE would arrange a further review in April or May 2019 to discuss the progress made and assess whether further actions or support were needed. The DPGD and DME agreed to hold regular meetings in the interim.

Requirements / Recommendations

Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
	None		

Recommendations			
Rec. Ref No.	**Recommendation**	**Recommended Actions**	**GMC Req. No.**
	None		

Other Actions (including actions to be taken by Health Education England)	
Requirement	**Responsibility**
The Trust should consider potential projects for a clinical fellow and submit these to the Postgraduate Dean.	Trust
The Trust should work to ensure appropriate supervision for trainees in psychotherapy, in particular: • The Trust should ensure that the psychotherapy tutor has allocated PAs in job plan for tutor role. • The Trust requires a medical psychotherapy consultant to cover trainee supervision for psychotherapy cases and Balint groups in the Brent area. The Head of School will liaise with the Trust about these issues on an ongoing basis.	Trust and Head of School
HEE will work with the Trust to plan a follow-up review in April or May 2019.	HEE Quality Reviews team

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	Dr Orla Lacey
Date:	11 June 2019

What happens next?

We will add any requirements or recommendations generated during this review to your LEP master action plan. These actions will be monitored via our usual action planning process. An initial response will be due within two weeks of receipt of this summary report.