Health Education England

Camden and Islington Mental Health NHS Trust

All Training Programmes

Urgent Concern Review (focus group)

Quality Review report

14 March 2019

Final Report

Developing people for health and healthcare

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Quality Review details

Background to review	This urgent concern review was held following a critical incident at Highgate Mental Health Centre on 3 February 2019. The incident resulted in the death of a patient and was traumatic for all staff that were working either at the time or in the immediate aftermath. Health Education England felt that it was important to meet with a cross section of all trainee groups from across Camden and Islington Mental Health Trust to get an understanding of trainee wellbeing and safety across the Trust in light of, but not wholly concerning, the incident of 3 February.
Training programme / learner group reviewed	All training groups across Camden and Islington Mental Health NHS Trust. The review team met with: - Two General Practice trainees; - Nine Core Psychiatry trainees; - Two Foundation trainees; and - Four Specialty Training Year 4+ (ST4+) trainees
Quality review summary	The review team was pleased to hear that overall satisfaction among trainees of the Trust as a learning and training environment was good. The review team was confident that there were no immediate concerns regarding trainee safety at the Trust. The review team met with a large group of trainees from the foundation, core psychiatry, and general practice training programmes, along with several specialty training year 3 (ST3) trainees and above. Trainees reported good clinical and educational supervision, that they had exposure to a broad range of clinical training opportunities, and that the Trust was responsive when trainees raised concerns about their training or the clinical environment. The review team was concerned to hear that following the incident on 3 February that no formal debrief, be it for trainees or all staff, had taken place. This was seen by the trainees to be a continuation of poor communication from the Trust to staff in the hours and days following the incident. The review team also noted concerns around the induction process, particularly access to breakaway training for trainees, and an apparent lack of formal processes in place for handover, especially the morning handover from the night team to the day team.

Quality Review Team			
HEE Review Lead	Dr Elizabeth Carty, Deputy Postgraduate Dean, North Central and East London	**School of Psychiatry**	Dr Bill Travers, Deputy Head of School of Psychiatry, London
Lay Member	Jane Gregory	**HEE Representative**	John Marshall, Learning Environment Quality Coordinator, Health Education England

Findings

1. Learning environment and culture

HEE Quality Standards

1.1 The culture is caring, compassionate and provides safe and effective care for patients, service users, carers and citizens and provides a supportive learning environment for learners and educators.

1.2 The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in order to achieve the learning outcomes required by their curriculum or required professional standards.

1.3 The learning environment provides opportunity to develop innovative practice, engage in research activity and promotes skills and behaviours that support such engagement.

1.4 The learning environment delivers care that is clinically or therapeutically effective, safe and responsive, and provides a positive experience for patients and service users.

1.5 The learning environment provides suitable facilities and infrastructure, including access to quality assured library and knowledge services.

1.6 The learning environment and culture reflect the ethos of patient empowerment, promoting wellbeing and independence, prevention and support for people to manage their own health.

Ref	Findings	Action required? Requirement Reference Number
C&I 1.1	**Patient safety** Although trainees reported that they generally felt safe whilst working and did not have any specific concerns with regard to patient safety, the review team did hear of some instances where staff and patient safety had been compromised, especially out of hours. The review team heard that in one instance the police had to be called when a male patient became extremely aggressive toward one of the nursing staff in view of other staff and patients. It was noted that during the incident the lock on the door separating some patients and staff from the incident was broken. The situation was ultimately resolved by the police using a Taser to subdue the patient. The review team heard of a separate incident where a patient referred from the emergency department (ED) at the Whittington Hospital and who was then admitted to the Highgate Mental Health Centre became aggressive and barricaded staff in an office. Again, this incident was resolved through the intervention of the police. In this	Yes, please see C&I 1.1

	case the trainees involved felt that the referral pathway from the ED for this patient for whom informal (i.e. not under the Mental Health Act) admission was decided had not been clear. There was another reported incident where a patient under observation had cut their neck whilst the nurse responsible had fallen asleep. The incident was reported by the trainee but they were unclear whether or not any action was taken to learn from the incident and steps put in place to avoid recurrence.	
C&I 1.2	**Appropriate level of clinical supervision** The review team heard that all trainees felt that the level of clinical supervision, both in and out of hours, was suitable and that senior clinicians were always on hand to offer advice and support in clinical settings.	
C&I 1.3	**Induction** The review team heard that all staff received a Trust-wide induction and that there were tours of all sites that trainees could be expected to work at. It was reported that there was site-specific induction for Highgate Mental Health Centre. It was unclear whether this was mandatory, but those who had taken part in this induction praised its quality, noting that there were consultant led sessions and included simulations, rapid tranquilisation, and the roles within the multidisciplinary team (MDT) in response to a serious incident. However, the review team heard that due to capacity issues and the number of trainees requiring the training, that a number of trainees had been in post for several months before completing breakaway training. Trainees also reported that they were unsure where emergency kits were stored across all sites, and that it was often unclear who the duty immediate life support (ILS) member of staff was. Trainees also reported that they would like to see that the induction process covered better fire safety provision in terms of evacuation procedures for patients and staff, and a system that makes clear who the duty fire marshall is.	Yes, please see C&I 3a and C&I 3b Yes, please see C&I 3c
C&I 1.4	**Handover** The review team heard that trainee experience of handover was that it was generally informal, and in some instances conducted through WhatsApp or text message. Issues around handover were particularly acute at weekends where it was reported that in some cases issues that had been handed over had been lost. It was felt that the risk for patient information to be lost or not followed up at weekends was exacerbated by the fact that the weekend rota was split, meaning that the onus was on individual staff members handing over to each other directly rather than as part of a formal process. It was also reported that the handover from the night team to the day team was not robust and did not include the wider MDT. The trainees agreed that there was room for improvement at handover, noting the possibility to replicate practices they had experienced in previous posts and in medical settings – particularly the inclusion of the MDT. The trainees noted that an electronic handover via a live list that all staff had access to and could update in real time as appropriate would be beneficial, especially at weekends.	Yes, please see C&I 1.4

C&I 1.5	**Protected time for learning and organised educational sessions** The trainees that the review team met with confirmed that they had protected time in their job plans to attend educational sessions.	

2. Educational governance and leadership

HEE Quality Standards

2.1 The educational governance arrangements continuously improve the quality and outcomes of education and training by measuring performance against the standards, demonstrating accountability, and responding when standards are not being met.

2.2 The educational, clinical and corporate governance arrangements are integrated, allowing organisations to address concerns about patient and service user safety, standards of care, and the standard of education and training.

2.3 The educational governance arrangements ensure that education and training is fair and is based on principles of equality and diversity.

2.4 The educational leadership ensures that the learning environment supports the development of a workforce that is flexible and adaptable and is receptive to research and innovation.

2.5 The educational governance processes embrace a multi-professional approach, supported through appropriate multi-professional educational leadership.

C&! 2.1	**Impact of service design on learners** The review team heard that the majority of trainees felt that their training posts offered good ward experience and that they were well supported by their senior colleagues. It was also reassuring to hear that all trainees felt safe in the clinical environment. The more senior trainees that the review team met with reported that they will have experienced a diverse range of psychiatry subspecialties and patient presentations by the time they had reached specialty training year 5 (ST5). It was reported that the acute ward experience was a good learning experience but that the work was predominantly focused around psychosis. The review team heard that trainees on-call at Highgate Mental Health Centre had shared duties with the Whittington Hospital and other sites. It was reported that on-call work could entail a lot of medical work – particularly taking bloods and electrocardiograms (ECG). Trainees reported that it could be difficult prioritising medical duties and mental health work when on-call. This was exacerbated by trainees being unclear of the medical competencies of the mental health nursing team with regard to monitoring and managing the physical health of patients in a mental health setting. The review team was encouraged to hear that a consultant nurse had been appointed to assess and improve the provision of physical health care at Highgate Mental Health Centre among the MDT by upskilling the mental health nursing staff to take bloods and ECGs. It was also reported that MDT staff in the old age community team had been trained to take bloods. The review team heard that Whittington Hospital, and ultimately Highgate Mental Health Centre, received a large number of section 136 of the Mental Health Act presentations. It was reported that the flow of referral information between the two sites was good and that referrals were led by a liaison nurse based at the Whittington Hospital. The feeling among trainees was that handling section 136 cases presented a good training opportunity.	

	The review team heard that the risk assessment of patients was variable in terms of robustness and was dependent on a number of factors, including whether it was carried out by a doctor or mental health nurse, as well as the time of day. Whist it was felt that this was to be expected to an extent, there was scope to standardise the process. The trainees noted that there was an example of good practice demonstrated in the Psychiatric Intensive Care Unit (PICU). The PICU risk assessment included the assigning of a doctor and mental health nurse at the time of referral who would conduct the risk assessment together and would meet with the patient in the following days to monitor the patient. It was reported that there was a significant reliance on bank staff but it was not felt that this had a negative effect on the clinical environment or patient safety. However, in some cases trainees reported that they had recommended patients for increased observation to service managers but that this was not always undertaken. It was the impression of the trainees that this was due to a shortage of mental health nursing staff. The trainees reported that there was not a culture of working beyond their contracted hours. Whilst it was heard that they knew how to exception report these incidents, the reporting system was described as not user friendly.	
C&I 2.2	**Appropriate system for raising concerns about education and training within the organisation** The review team was pleased to hear that there was trainee representation at educational management meetings and that local faculty groups (LFG) were an effective forum for addressing trainee concerns about any educational or clinical issues. It was encouraging to hear that the concerns raised during LFG meetings were taken seriously and addressed. It was not clear to the review team if the LFG meeting included GP trainees. GP trainees reported that they did not have a formal forum for raising any concerns but felt comfortable doing so with their Vocational Training Scheme programme director. All of the trainees also reported that they could raise any issues with their educational and clinical supervisors.	
C&I 2.3	**Organisation to ensure access to a named clinical supervisor** All of the trainees reported that they knew who their clinical supervisor was and that they felt well supported in the clinical environment. They also reported that they felt comfortable in the event of needing to raise a concern in relation to the clinical environment. The review team heard however, that there was no formal process for raising any concerns they may have in relation to the competencies of the wider MDT.	
C&I 2.4	**Organisation to ensure access to a named educational supervisor** The review team was pleased to hear that all trainees enjoyed good relationships with their educational supervisors and met with them throughout their rotations. They also reported that they felt they could raise any issues they had about their training with them.	

3. Supporting and empowering learners

HEE Quality Standards

3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in their curriculum or professional standards and to achieve the learning outcomes required.

3.2 Learners are encouraged to be practitioners who are collaborative in their approach and who will work in partnership with patients and service users in order to deliver effective patient and service user-centred care.

C&I 3.1	**Access to resources to support learners' health and wellbeing, and to educational and pastoral support** The review team heard that immediately following the critical incident on 3 February the flow of information was felt to be unsatisfactory, particularly for staff coming on shift the following morning. It was reported that staff working on that day did not have a concise and accurate account of what had happened, and in the absence of an official communication from the Trust that they were receiving messages from colleagues asking what had happened. A number of trainees reported that they first heard about the incident in the press and that it took two days for an official Trust announcement to be made. Since the incident on 3 February the review team heard that whilst there had been a series of emails updating staff, no formal debrief had taken place. All of the trainees felt that this would be beneficial as they were still not in possession of a wholly accurate account of what had occurred and what could be learned from the incident.	Yes, please see C&I 3.1

4. Supporting and empowering educators

HEE Quality Standards

4.1 Appropriately qualified educators are recruited, developed and appraised to reflect their education, training and scholarship responsibilities.

4.2 Educators receive the support, resources and time to meet their education, training and research responsibilities.

C&I 4.1	**Access to appropriately funded professional development, training and an appraisal for educators** N/A	

5. Developing and implementing curricula and assessments

HEE Quality Standards

5.1 Curricula assessments and programmes are developed and implemented so that learners are enabled to achieve the learning outcomes required for course completion.

5.2 Curricula assessments and programmes are implemented so that all learners are enabled to demonstrate what is expected to meet the learning outcomes required by their curriculum or required professional standards.

5.3 Curricula, assessments and programme content are responsive to changes in treatments, technologies and care delivery models and are reflective of strategic transformation plans across health and care systems.

5.4 Providers proactively engage with patients, service users, carers, citizens and learners to shape curricula, assessments and course content to support an ethos of patient partnership within the learning environment.		
C&I 5.1	**Training posts to deliver the curriculum and assessment requirements set out in the approved curriculum** N/A	

6. Developing a sustainable workforce

HEE Quality Standards

6.1 Recruitment processes to healthcare programmes fully comply with national regulatory and HEE standards.

6.2 Learner retention rates are monitored, reasons for withdrawal by learners are well understood and actions are taken to mitigate attrition of future learners.

6.3 Progression of learners is measured from commencement to completion for all healthcare learning programmes.

6.4 First destination employment is recorded and retention within first year of employment monitored, including the recording of reasons for leaving during the first year of employment.

6.5 Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner.

C&I 6.1	**Appropriate recruitment processes** N/A	

Good Practice and Requirements

Good Practice
The review team was pleased to hear of the impact that the appointment of the consultant nurse to upskill the mental health nurse workforce with regard to monitoring and managing the physical health of patients had had at Highgate Mental Health Centre.

Immediate Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
	N/A		

Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
C&I 3b	The Trust is required to ensure that the Trust-wide induction and tour of all sites includes informing trainees of the location of emergency kits and where information of the duty ILS member of staff is displayed.	Please provide HEE with a copy of the updated induction guide that demonstrates this requirement within two months from the date of issue of this report.	R1.13
C&I 3c	The Trust is required to ensure that fire safety is covered as part of the induction process.	Please provide HEE with a copy of the updated induction guide that demonstrates this requirement within two months from the date of issue of this report.	R1.13
C&I 3.1	The Trust is required to conduct a formal non-compulsory debrief for all trainees that includes a full but concise account of what happened on 3 February 2019, the steps the Trust had taken to ensure to learn from the incident, and what lessons can be learned from the incident. The session should also reaffirm what support is available to trainees.	Please hold this debrief as matter of urgency and provide HEE with confirmation of its taking place, along with attendee numbers within one month from the date of issue of this report.	R3.2

Recommendations			
Rec. Ref No.	**Recommendation**	**Recommended Actions**	**GMC Req. No.**
C&I 1.1	The Trust is recommended to ensure that the clinical environment where trainees are present is safe and secure by ensuring that all doors close and lock appropriately.	Please consider an audit of all doors and locks within the clinical environment.	R1.2
C&I 3a	The Trust is recommended to ensure that breakaway training forms part of the Trust-wide induction for all trainees and that this is provided for each trainee before they work in the inpatient environment and commence shift work.	Please consider how trainees can be given breakaway training in a timely fashion.	R1.13
C&I 4	The Trust is recommended to assess the effectiveness of all handover procedures where trainees are involved, particularly the morning handover from the night team to the day team.	Please consider a trainee led review of morning handover.	R1.14

Other Actions (including actions to be taken by Health Education England)	
Requirement	**Responsibility**
N/A	

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	Dr Elizabeth Carty, Deputy Postgraduate Dean, North Central and East London
Date:	2 April 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.