Trainee Experience – a Proxy for Patient Safety

Trainees are the eyes and ears of the NHS

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Co-chair of Sharing Intelligence for Health & Care Group

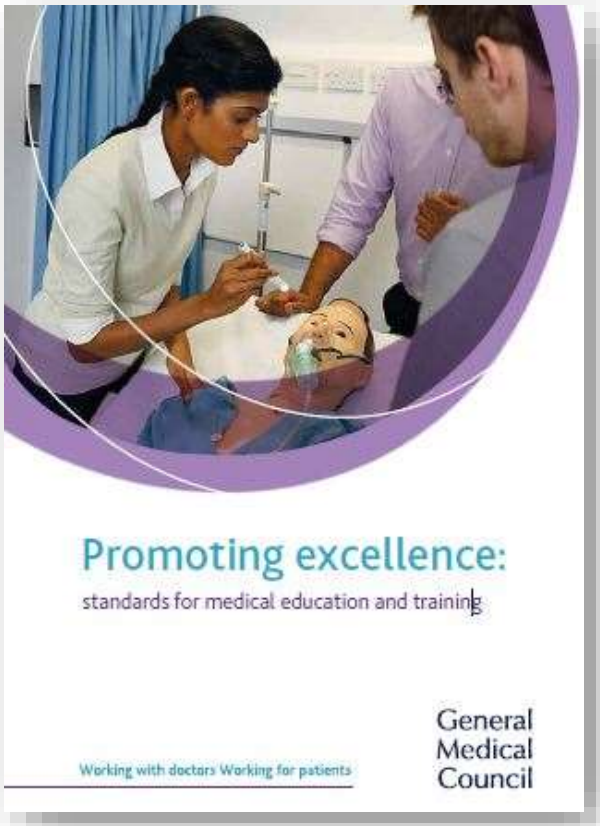
- **'Good practical training should only be given where there is good clinical care'**
- **'There is an inextricable link between the quality of care & quality of training'**
- **'Trainees are invaluable eyes & ears in a hospital setting'**

Recommendation 162

The GMC's standards & regulation should ensure that:

- **the safety of patients is the priority of the system of medical training**
- **clinical placements that fail to meet safety & quality standards should not take trainees**
- **action must be taken to address patient safety concerns raised when GMC & Deaneries monitor whether standards for training are being met**

Deanery's Quality Management Process



Monitoring Tools – are GMC standards met?	
Surveys (trainee)	Annual GMC NTS (UK)* Scottish Training Survey (each post)*
Reports (annual)	Board DME Report Deanery Programme TPD report
Others	Notification of Concern Process*
QM visit	Routine QM visit cycle*
Elucidating a potential signal of concern	
Enquiries	To DME To TPD
QM Visits	Fact-finding Meeting* Triggered (incl immediate) Visit* Enhanced Monitoring (+GMC) Visit*

* Include focus on safety of patients

Healthcare Improvement Scotland

Rapid Review of the Safety and Quality of Care for Acute Adult Patients in NHS Lanarkshire

In August 2013, the Cabinet Secretary for Health and Wellbeing commissioned Healthcare Improvement Scotland to undertake a Rapid Review of the safety and quality of care for acute adult patients in NHS Lanarkshire.

The terms of reference for the review were to:

- provide an independent expert diagnosis of the factors which may underlie the Hospital Standardised Mortality Ratio figures, including a Rapid Review assessment of any systemic factors which may be impacting on the safety and quality of care and treatment being provided to patients in NHS Lanarkshire's acute hospitals

Healthcare Improvement Scotland

Rapid Review of the Safety and Quality of Care for Acute Adult Patients in NHS Lanarkshire

21 Recommendations

- Patient safety (5)
- Communications (1)
- Patient feedback & complaints processes (2)
- Lack of engagement in improvement processes (3)
- Staffing levels & deployment:
  - medical (1)
  - nursing (5)
- Medical & board leadership & management (7)

Healthcare Improvement Scotland

Rapid Review of the Safety and Quality of Care for Acute Adult Patients in NHS Lanarkshire

Recommendation 7

NHS Lanarkshire should take prompt action to develop & implement a credible & practical model for medical staffing that meets patient needs:

Especially seniority & number of staff OOH

Robust arrangements for when staff on leave

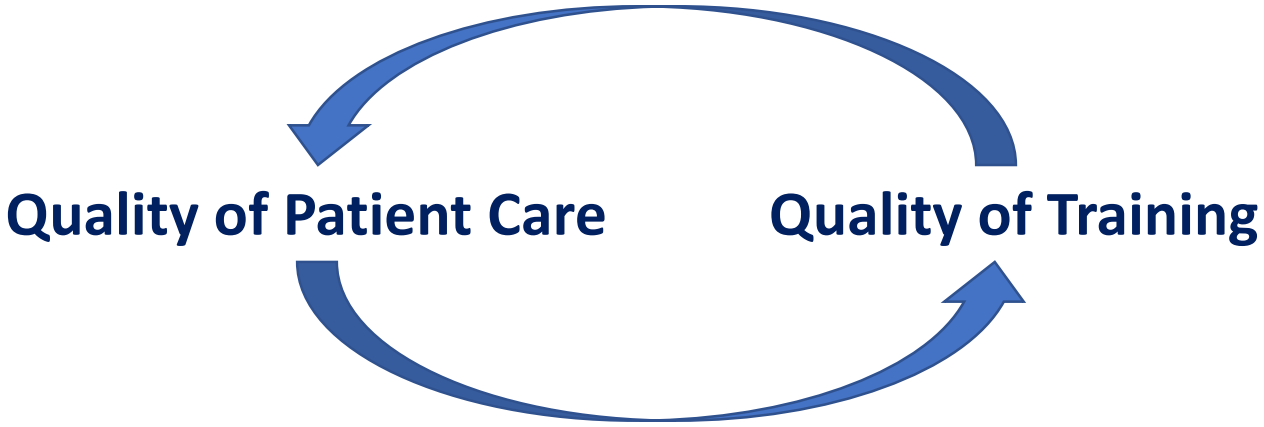
Immediate priority areas - staffing of orthopaedics, acute/general medicine, care of the elderly & emergency medicine

Concerns about PGMET in NHSLanarkshire signalled by the Deanery's quality management processes in 2013

LEP	Specialty		Clinical supervision	Educational supervision	Induction	Feedback	Workload	Overall satisfaction	Regional teaching	Adequate Experience	Study leave
Hairmyres Hospital	Emergency Medicine	ST		■	■	■	■	■	■		■
	Medicine	FY2				■				■	■
	Medicine	GPST	■								
	Geriatric Medicine	ST	■	■							
	Surgery	ST		■	■			■	■		
Monklands Hospital	Medicine	FY2	■								
	Medicine	CMT	■								
Wishaw General Hospital	Medicine	FY	■								
	Medicine	GPST	■								
	Medicine	CMT	■								
	Surgery	FY	■								
	Surgery	ST				■				■	

Concerns about PGMET in NHSLanarkshire signalled by the Deanery's quality management processes in 2013

Good clinical supervision is patient safety now



Outcome from the perspective of PGMET

GMC invoked 'special measures' ('enhanced monitoring') supporting the Deanery to drive improvements through its QM processes

Hairmyres Hospital – Emergency Medicine, Medicine, Surgery & Orthopaedics
Monklands Hospital - Medicine, Surgery & Orthopaedics
Wishaw General Hospital - Medicine, Surgery & Orthopaedics

'Enhanced monitoring' was in place 2014 - 2019

Mental Health Services – NHS Tayside

Concerns about training signalling wider service issues

Mar16 – Nov16	• **Deanery quality management visits to Murray Royal Hospital triggered by concerns in surveys & TPD reports** • **Persisting failure to meet GMC's standards around postgraduate medical training in general adult psychiatry in relation to:** **adequacy of the experience** **supervision & support** **leadership** **culture & behaviours**

Mental Health Services – NHS Tayside

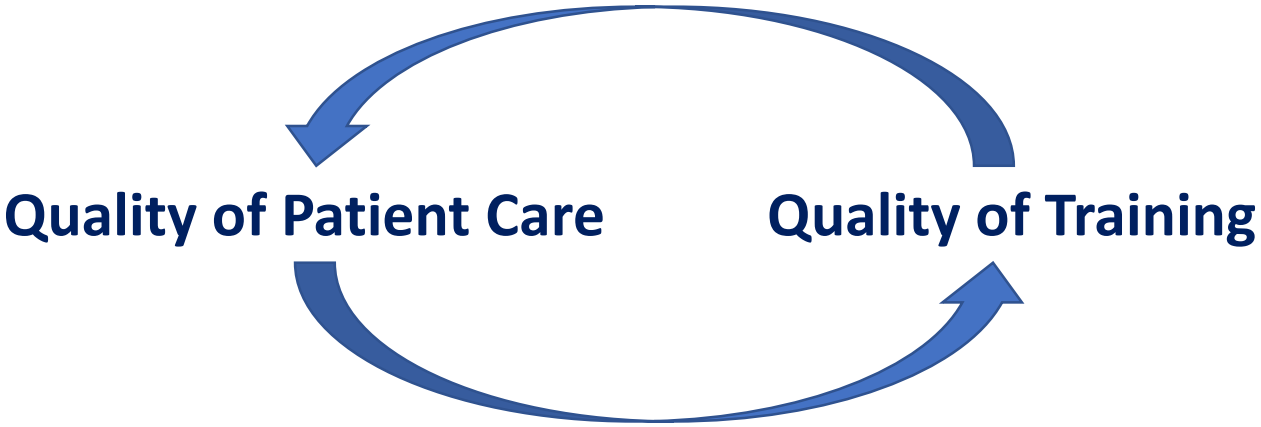
Concerns about training signalling wider service issues

Jul17	Re-visit – persisting problems, became clear wider than Murray Royal Hospital
Aug17	Sharing of concerns at Sharing Intelligence for Health & Care Group
Nov17-May18	2 Re-visits, refocused on general adult psychiatry training across NHS Tayside – same concerns, no progress
May18	Deanery escalated Tayside General Adult Psychiatry training to GMC's special measures ('enhanced monitoring')

Mental Health Services – NHS Tayside

Concerns about training signalling wider service issues

May18	NHS Tayside commissioned Independent Inquiry into Mental Health Services in Tayside led by David Strang
Jan19 & Oct19	Re-visits, same concerns, limited progress
Feb20	Publication of report of the Strang Inquiry 51 recommendations grouped by 5 themes: • Strategic service design • Governance & leadership responsibility • Engaging with people • Learning culture • Communication

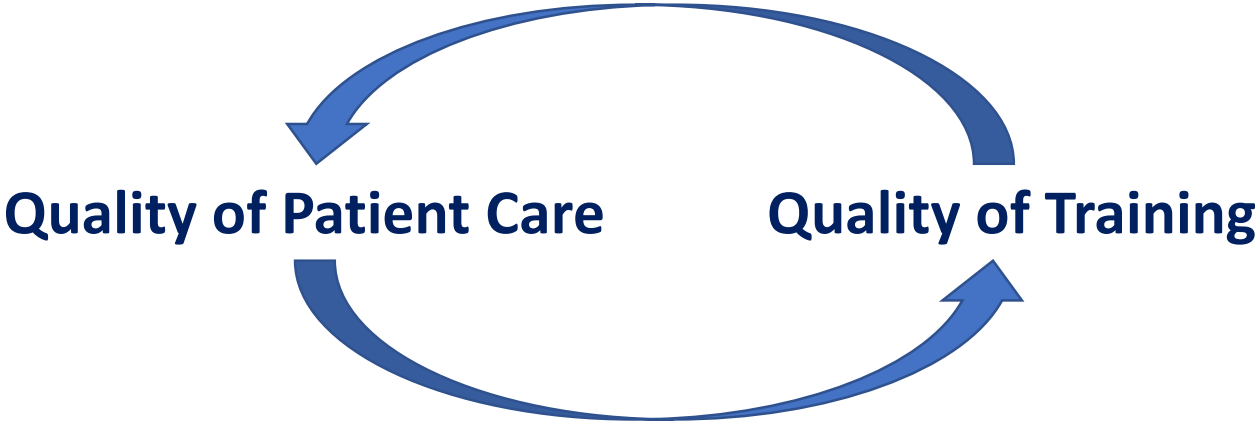


Trainees are the eyes and ears of the NHS

Training is patient safety for the next 30 years

Good clinical supervision is patient safety now

Trainee experience is a proxy for patient safety



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