MUCKAMORE ABBEY HOSPITAL INQUIRY

WITNESS STATEMENT

Addendum to Statement of Joanne Camille Harron

Date: 06/05/2023

1.1 Following attendance at the Inquiry hearing on 27 April 2023, I have clarified that a NIMDTA visit took place to the Psychiatry programme at BHSCT in 2017, visit report listed as CH/5. This visit was a cyclical visit to the specialty and the placements reviewed would have included those in Intellectual Disability.

1.2 During the 2017 visit, higher specialty trainees reported that there was no formal handover in Muckamore Abbey Hospital. With regard to practical experience, core trainees in Muckamore reported that it could be difficult covering the duty bleep due to rota gaps (the visit report had noted that three out of nineteen core trainees working across the Trust were on long term sick leave). There were no patient safety issues reported and comment was made that there was a daily safety briefing at Muckamore. The visit report did not document any areas of concern or for improvement with regard to the Muckamore training site. Please see attached document for the visit report.

1.3 I apologise for this omission in my original witness statement. This information fits chronologically after section 4.6 of my original witness statement.

Signed:

Date: 6th May 2023

NIMDTA
Deanery Visit to Belfast Trust

FINAL REPORT

Hospitals	Belfast Trust
Specialty Visited	Psychiatry
Type of Visit	Cyclical visit
Trust Officers with Postgraduate Medical Education & Training Responsibility	Dr Cathy Jack, Medical Director Dr Una Carabine, Director of Medical Education
Date of Visit	25th May 2017
Visiting Team	Dr Richard Tubman, Associate Dean (Chair) Dr Joanne Minay, Training Programme Director (General Adult), School of Psychiatry Dr Mark Luty, Assistant Director of Medical Education, NHS Ayrshire and Arran; External Representative Dr John Harty, Foundation Representative Mr Eoin Doyle, Lay Representative Mrs Geraldine McCullough, Hospital Specialty Executive Officer, NIMDTA

Purpose of Deanery Visits	The General Medical Council (GMC) requires UK Deaneries/LETBs to demonstrate compliance with the standards and requirements that it sets (GMC-Promoting Excellence 2016). This activity is called Quality Management and Deaneries need to ensure that Local Education and Training Providers (Hospital Trusts and General Practices) meet GMC standards through robust reporting and monitoring. One of the ways the Northern Ireland Deanery (NIMDTA) carries out its duties is through visiting Local Education and Training Providers (LEPS). NIMDTA is responsible for the educational governance of all GMC-approved foundation and specialty (including General Practice) training programmes in Northern Ireland.
Purpose of this Visit	This is a cyclical visit to assess the training environment and the postgraduate education and training of trainees in Psychiatry in the Belfast Trust.
Circumstances of this Visit	The Deanery Visiting Team met with educational leads, trainees and trainers in Psychiatry at Mater Hospital.
Relevant previous Visits	Cyclical visits to Psychiatry units in Belfast Trust, 18th November, 25th November and 1st December 2011
Pre-Visit Meeting	24th May 2017
Purpose of Pre-Visit Meeting	To review and triangulate information about postgraduate medical education and training in the unit to be visited.
Pre-Visit Documentation Review	Previous visit reports 2011 and subsequent Trust Action Plans Trust Background Information Template for Belfast Trust, April 2017 Pre-visit SurveyMonkey® May 2017 GMC National Training Surveys 2016
Types of Visit	<u>Cyclical</u> Planned visitation of all Units within 5 years <u>Re-Visit</u> Assess progress of LEP against a previous action plan Decision at Quality Management Group after grading of cyclical visit Reconfiguration of Service <u>Problem-Solving Visit</u> Request of GMC Request of RQIA Quality Management Group after review of submitted evidence sufficient to justify investigation and not suitable for investigation at Trust or Specialty School level.
Grading Outcome	**B2 : Satisfactory (with conditions)** *See final page for grading descriptions.*

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This report reflects the findings from the trainees and trainers who were available to meet with the visiting team on the day of the visit and information arising from the pre-visit survey.

Please note the following recommendations from the Francis Report on Mid-Staffordshire NHS Foundation Trust Public Inquiry on Training and Training Establishments as a Source of Safety Information:

- **Recommendation 160: Proactive steps need to be taken to encourage openness on the part of trainees and to protect them from any adverse consequences in relation to raising concerns.**
- **Recommendation 161: Training visits should make an important contribution to the protection of patients. Obtaining information directly from trainees should remain a valuable source of information.**

Educational Leads Interviewed

Dr Peter Trimble, Specialty Education Lead in Psychiatry
Dr Andrew McAllister, Foundation Programme Director (MIH)
Dr Hilary Boyd, Consultant Psychiatrist (CAMHS)
Dr Peter Sloan, Consultant Psychiatrist (Adult Psychiatry)

Trainees Interviewed

	F2 and GPST	CT1-3	ST3+
Posts	5 F2, 6 GPST1	19	10 (5 General adult, 1 Psychotherapy, 1 Forensic, 1 Old Age, 2 Intellectual Disability)
Interviewed	4 F2, 2 GPST1	12	6

Trainers Interviewed

Trainers x 15

Feedback provided to Trust Team

Dr Peter Trimble, Specialty Education Lead in Psychiatry
Dr Andrew McAllister, Foundation Programme Director (MIH)
Dr Dearbhail Lewis, Foundation Programme Director (RVH)
Mr Barney McAnearney, Co-Director Mental Health Services BHSCT
Dr Peter Sloan, Consultant Psychiatrist (Adult Psychiatry)
Dr Hilary Boyd, Consultant Psychiatrist (CAMHS)
Dr Philip McGarry, Consultant Psychiatrist (Adult Psychiatry)

Contacts to whom the visit report is to be sent to for factual accuracy check

Dr Cathy Jack, Medical Director
Dr Una Carabine, Director of Medical Education
Dr Peter Trimble, Specialty Education Lead in Psychiatry

Background

Organisation: Inpatient mental health services are provided in Knockbracken Healthcare Park, Mater Hospital (both adult), Beechcroft (CAMHS) and Muckamore (ID). There are outpatient clinics at several venues across the Trust area. Much of the clinical care is provided in the community setting or in outpatient clinics by a range of consultant-led multidisciplinary teams.
The facilities at Windsor House, BCH and Shaftesbury Square Hospital have closed. There are plans to locate a large component of inpatient adult mental health services in a new centre on the BCH site, although some specialist inpatient services will continue at Knockbracken.

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Staff: There are 65 consultant Psychiatrists (34 General adult, 16 CAMHS, 9 ID and 6 Old Age) and 16 Associate Specialist/Specialty Doctors (9 General adult, 3 CAMHS, 2 ID and 2 Old Age) in Belfast Trust.
There are 10 ST3+, who take part in the second tier rotas.
There are 19 core trainees (three of whom have been on long term sick leave), 6 GPST1 and 5 F2 doctors who take part in the first on-call rotas.

National Training Surveys:
NB: BCH and Shaftesbury Square Hospital appeared on the 2016 NTS returns.
There were green indicators for Clinical Supervision out of hours at Knockbracken and at Muckamore and for Handover and Induction in General Psychiatry in the 2016 Trainee Survey.
There were red indicators for Organisational Culture, Time for Trainers and Support for Trainers in Mater Hospital, and a red indicator for Supportive Environment at Muckamore in the 2016 Trainer Survey.

Previous Visits/Concerns: All four visit reports from 2011 (Knockbracken, BCH, Mater, Muckamore) were graded: **B1 Satisfactory**.

Findings against GMC's Standards for Medical Education and Training (Promoting Excellence, 2016)

Theme 1: Learning Environment and Culture
S1.1: The learning environment is safe for patients and supportive for learners and educators. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers and families.
S1.2: The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in *Good Medical Practice* and to achieve the learning outcomes required by their curriculum.

Induction (R1.10, 1.13, 1.19)
Trust induction in August 2016 was comprehensive and met trainees' needs. There were no delays in getting badges or passwords.
Unit induction lasted for 4 days (three for F2 who did not need CAMHS induction). Teaching covered important areas including rotas, the mental health order and rapid tranquilisation protocols, and there were handouts. Trainees met some of the mental health team at induction.
All trainees received personal alarms and breakaway/MAPA training as part of induction.
Core trainees said that the F2 buddying system hadn't been explained to them so they were not clear on their roles and responsibilities.
ST3+ trainees said that they had received an induction about cross-covering SEHSCT out of hours. However, their lines of responsibility were not clear, and they would have appreciated more explicit written details about cover and handover at weekends.

Clinical Supervision (R1.7-1.10, 1.12a, 1.13, 1.15)
Trainees reported that clinical supervision was good at all times including out of hours. F2 trainees reported that they would feel more comfortable during their unscheduled care shift if they had the support of a senior mental health nurse. Senior help was readily accessible when needed.
F2s reported that some of them liked the previous buddy system as it meant there was an extra pair of hands out of hours. GPST trainees reported that they were never buddied by core trainees even though their previous psychiatry experience was similar to that of F2s. The core/F2 buddy system has now been discontinued largely because of rota pressures.
Tier one trainees reported that F2, GPST and core trainees were all termed "SHO" by nursing staff.
ST3+ trainees reported that they received about 1 hour per week of formal clinical supervision, which was generally good.

Handover (R1.14)
There is a morning handover at 8.30am at Fairview (MIH) throughout the week including weekends. There is a consultant present at this. All unscheduled care patients are discussed.
Handover is person to person on weekday evenings. There is a formal evening handover only at weekends, which the first tier trainee and the on-call registrar attend. The ST3+ trainees said that "they were not sure what their role was" in the weekend handover.

ST3+ trainees reported that there was not a formal handover in Muckamore.

Practical Experience (R1.19)
F2: practical experience depended on which ward F2s were attached to. Ward work comprised about a 50:50 split of medical and psychiatry duties and included admissions, discharges and consultant ward rounds. There was not an excess of non-educational tasks. F2s in acute adult psychiatry did not attend outpatients but those in old age psychiatry did: they were able to see new and review patients and discuss them with the consultant.
F2 trainees covered the wards in Knockbracken and MIH out of hours. They did liaison psychiatry and no longer were "buddied" by the core trainees. They had psychiatric nursing support and could phone the on-call registrar when necessary.
GPST: trainees reported that they got a good balance of inpatient and outpatient work including home visits. They covered two CAMHS units and Muckamore out of hours.
Core: trainees have a wide range of duties depending on their attachments. These included inpatient and outpatient work, home visits, unscheduled care/liaison work, tribunals and prison visits, psychotherapy sessions, etc. In general trainees were satisfied with their clinical experience although core trainees in Muckamore reported that it could be difficult covering the duty bleep, as there were rota gaps.
Core and ST3+ trainees said that there is an imbalance between the F2 and core trainees in exposure to on-call liaison. Core trainees' liaison opportunities have decreased.
ST3+: trainees reported that they received a wide range of opportunities according to their sub-specialty. They were able to carry out duties and make decisions at a suitably senior level.

Workload (R1.7, 1.12)
Workload was said to be variable depending on the placement – MIH was busy but old age psychiatry in Knockbracken was quieter. Out of hours workload was manageable.

EWTR Compliance (R1.12e)
Trainees reported that rotas were complex and at times constructed ad hoc because of rota gaps.
The first tier rota has two trainees covering liaison/unscheduled care and the wards from 5-9pm, then one trainee covering nights or weekends. F2 trainees said that they were currently working an excess of weekends, which they believed was due to rota gaps.
GPST trainees were able to get a half-day off after their shift but reported that the 48-hour shift at weekends could be arduous and was sometimes followed by an outpatient clinic on Monday.
Core trainees reported that they did on average 1:6-7 on-calls, which were manageable. They reported that there had been a high sickness rate, which resulted in a lot of extra shifts needing cover.

Hospital and Regional Specialty Educational Meetings (R1.16)
F2, GPST and core trainees were able to attend regional teaching events. There is no specific regional teaching for higher trainees.

There is protected local teaching each week from 9-11am on Fridays at Musgrave Park Hospital. Trainees said that this was "really good". Consultants attended and presented. Trainees could present at the meeting but said that they would value more opportunities to do so. There is a Balint group on Wednesday morning at Knockbracken. All trainees are encouraged to attend this.

Educational Resources, Internet Access, Simulation Facilities (R1.19, R1.20)
The visit team noted the comprehensive new educational facilities in MIH.

Quality Improvement and Audit (R1.3, 1.5, 1.22)
Trainees reported that there were opportunities to do audit or QI projects.
ST3+ trainees reported that there were few opportunities for research in psychiatry.

Patient Care (R1.1, 1.3, 1.4)
Trainees reported that in their view the standard of patient care was excellent. The nurses in unscheduled care were well trained and provided a good service. The nurses in the Forensic service were held in high regard.

Patient Safety (R1.1-1.5)
No issues reported. There is a daily safety brief at the unscheduled care handover, and in Muckamore.

Trainees appear to have a variable understanding of the Trust incident reporting system.

Theme 2: Educational Governance and Leadership

S2.1: The educational governance system continuously improves the quality and outcomes of education and training by measuring performance against our standards, demonstrating accountability, and responding when standards are not being met.
S2.2: The educational and clinical governance systems are integrated, allowing organisations to address concerns about patient safety.
S2.3: The educational governance system makes sure that education and training is fair and is based on principles of equality and diversity.

Educational Supervision (R2.11, 2.14, 2.15)
All trainees had named educational supervisors and had met with them regularly. This was generally of good quality, with one notable exception, of which the School of Psychiatry is aware and will follow up at ARCP.
There were no barriers to completion of WBAs.

Theme 3: Supporting Learners

S3.1: Learners receive educational and pastoral support to be able to demonstrate what is expected in *Good Medical Practice* and to achieve the learning outcomes required by the curriculum.

Feedback on Performance, Development and Progress (R3.13)
Trainees reported that they regularly received informal feedback from consultants and at clinical supervision meetings, which usually lasted approximately 30-60 minutes each week. There were opportunities for feedback at the morning handover meeting.

Trainee Safety and Support (R3.2)
Trainees said that their safety was taken seriously. They reported that they always saw patients in the company of another staff member. Potentially difficult patients were flagged up on the Paris system. However there were no alarms in the liaison rooms in either of the EDs in RVH or MIH.
Trainees reported that the Fairview building had been broken into one evening in the week before the visit (this is their office base out of hours). They said that the nurses were now nervous about working there out of hours. There did not appear to be any security cameras or alarms there. Staff had not been given any feedback or reassurances about their future safety at Fairview.
Trainers reported that the Liaison Office in RVH was "dreadful and oppressive". There was a constant leak of water from the physio pool in the floor above into the office.

Undermining (R3.3)
No specific issues were reported. Trainees reported that they felt supported, valued and appreciated by the mental health nurses.
F2 trainees said that they sometimes felt pressurised by consultants and the workforce coordinator to fill rota gaps. Shifts were organised by the workforce coordinator and they "had no real say in the matter". Core trainees also said that they found the rota issue stressful, particularly as in their view "they were not communicated with until the last minute". They said that they felt that they were put under a lot of pressure to fill the gaps.

Study Leave (R3.12)
No difficulties obtaining study leave. GPST trainees were able to attend Diploma of Mental Health teaching on Wednesdays. The visit team noted the significant up-front costs for trainees in psychotherapy.

Theme 4: Supporting Educators

S4.1: Educators are selected, inducted, trained, and appraised to reflect their education and training responsibilities.
S4.2: Educators receive the support, resources and time to meet their education and training responsibilities.

Trainer Support (R4.1-4.6)
Trainers reported that their educational roles were included in job planning, they were funded properly and that there was a system for educational appraisal.
Trainers were supported to get to training courses and all named supervisors were fully recognised by NIMDTA.

Theme 5: Developing and Implementing Curricula and Assessments

S5.2: Postgraduate curricula and assessments are implemented so that doctors in training are able to demonstrate what is expected in *Good Medical Practice* and to achieve the learning outcomes required by their curriculum.

There were no concerns that trainees were unable to meet curricular requirements during the duration of their placement.

Summary of Conclusions

The below conclusions have been categorised as follows:

i) Educational governance (training)

ii) Clinical governance or patient safety issues

Comment
Trainees hold the mental health nurses in very high regard. They are skilled, helpful and supportive to trainees. The visit team noted the comprehensive new educational facilities in MIH.

Good Practice (includes areas of strength, good ideas and innovation in medical education and training):
1. Trainees receive breakaway training and personal alarms at induction.

Areas for Improvement (issues identified has a limited impact on a trainee's education and training, or the quality provision for the patient):

	Educational Governance	Clinical Governance
1. Induction. ST3+ trainees said that they had received an induction about cross-covering SEHSCT out of hours. However, their lines of responsibility were not clear, and they would have appreciated more explicit written details about cover and handover at weekends.	✓	✓
2. Practical Experience. There is an imbalance between the F2 and core trainees in exposure to on-call liaison. Core trainees' liaison opportunities have decreased which is disappointing given the previously good standard.	✓	
3. Potential Patient Safety. Trainees appear to have a variable understanding of the Trust incident reporting system.	✓	✓

Areas of Concern (trainees are able to achieve required outcomes, but the quality of education and training is recognised as requiring improvement; patients within the training environment are receiving safe care but the quality of their care is recognised as requiring improvement):

	Educational Governance	Clinical Governance
1. Clinical Supervision. Tier one trainees reported that F2, GPST and core trainees were all termed "SHO" by nursing staff. This does not acknowledge the potentially wide range of experience and competences across this group of trainees.	✓	✓
2. EWTR Compliance. Trainees reported that rotas were complex and at times constructed ad hoc. Core trainees said that they found the rota issue stressful, particularly as in their view "they were not communicated with until the last minute". The organisation of rotas would benefit from using an electronic template that could provide allocations and calculated hours well in advance to trainees.	✓	✓

Areas of Significant Concern (patients/trainees within the training environment are at risk of coming to harm; trainees are unable to achieve required outcomes due to poor quality of the training posts/programme):

	Educational Governance	Clinical Governance
1. Trainee Safety & Support. Trainees reported that the Fairview building had been broken into in the week before the visit. They said that the nurses were now nervous about working there out of hours. There did not appear to be any security cameras or alarms there. Staff have not been given any feedback or reassurances about their future safety at Fairview.		✓

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2. Trainee Safety & Support. Trainers reported that the Liaison Office in RVH was "dreadful and oppressive". There was a constant leak of water from the physio pool in the floor above into the office. Trainers reported that this is not fit for purpose for training/supervision of trainees. This has been shared for information only.	N/A	N/A

	Grading Outcome	Description	NIMDTA Review
A1	**Excellent**	**Exceeds expectations for a significant number of GMC standards.**	**Cyclical**
A2	**Good**	**Meets expectations under all GMC standards.**	**Cyclical**
B1	**Satisfactory**	**Areas for improvement identified but no areas of concern. No amber ratings.**	**No Automatic Revisit / Cyclical**
B2	**Satisfactory (with conditions)**	**Areas for improvement identified. Specific concern to be addressed. Amber concern(s) to be addressed. No red ratings.**	**Cyclical / No Revisit Required - issues will be monitored via Quality Reporting from the LEP or School.**
C	**Borderline**	**Areas of concern to be addressed (may include one red or multiple amber RAG ratings).**	**NIMDTA Review within 12 months (unless all concerns are adequately addressed by the LEP within 6 months of rated action plan being issued). The review may include a revisit.**
D1	**Unsatisfactory: Urgent Action**	**Urgent action required on significant areas of concern or multiple red RAG ratings.**	**NIMDTA Review within 6-12 months of rated action plan being issued. This is expected to include a revisit unless all areas have been adequately addressed.**
D2	**Unsatisfactory: Unsafe Training Environment - Immediate Action**	**May apply if multiple red RAG ratings requiring immediate action are identified. LEP representative will be informed and may result in the implememtation of the 'Removal of Trainees' process.**	**NIMDTA Review within 3-6 months which may include a revisit. If no improvements within this period, the 'Removal of Trainees' process may be initiated.**
U	**Unable to Assess**	**Unable to assess due to lack of trainee and/or trainer engagement with visit.**	

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