Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	24 April 2019	**Level(s)**	ST
Type of visit	Enhanced Monitoring Revisit	**Hospital**	Aberdeen Maternity Hospital
Specialty(s)	Neonatal Medicine (Paediatrics)	**Board**	NHS Grampian

Visit panel	
Amjad Khan	Visit Lead, Lead Dean Director Obstetrics & Gynaecology and Paediatrics
Alastair Campbell	Visit Lead (shadowing), Associate Postgraduate Dean Quality
Peter MacDonald	Associate Postgraduate Dean Quality
Richard Tubman	GMC Associate
Robin Benstead	GMC Quality Assurance Manager, Visits and Monitoring
Alastair Hurry	Trainee Associate
John Cummings	Lay Representative
Hazel Stewart	Quality Improvement Manager
In attendance	
Gayle Hunter	Quality Improvement Administrator

Specialty Group Information		
Specialty Group	Obstetrics & Gynaecology and Paediatrics	
Lead Dean/Director	Amjad Khan	
Quality Lead(s)	Peter MacDonald and Alastair Campbell	
Quality Improvement Manager(s)	Hazel Stewart	
Unit/Site Information		
Non-medical staff in attendance	4	
Trainers in attendance	5	Including college tutor and clinical lead
Trainees in attendance	5	ST1 – ST8

Feedback session: Managers in attendance	Director of Medical Education, Associate Director of Medical Education, Clinical Director, Operations Manager & Nursing Manager

Date report approved by Lead Visitor	18 May 2019

1. Principal issues arising from pre-visit review

Neonatal medicine at Aberdeen Maternity Hospital was placed on to enhanced monitoring in 2017. This will be the third enhanced monitoring visit to the department. It was decided following the visit in 2018 that the department should remain on enhanced monitoring with a re-visit in 2019 to determine if actions undertaken had resulted a sustained improvement to the post.

Following the revisit in 2018, a total of 6 requirements were made. Some of these were carried forward from the previous visit and others were additional. The requirements at that visit related to provision of an adequate induction to all trainees that require it, out-patient clinic opportunities, improvement to team culture with a zero tolerance of bullying and undermining behaviours and an ability of all trainers to complete assessments.

2. Introduction

Aberdeen Maternity Hospital is part of NHS Grampian and serves the area of Grampian and the Islands of Shetland and Orkney. The hospital is based on the Foresterhill site. Also on the site are the Aberdeen Royal Infirmary and the Royal Aberdeen Children's Hospital.

A summary of the discussions has been compiled under the headings in section 3 below. This report is compiled with direct reference to the GMC's *Promoting Excellence - Standards for Medical Education and Training.* Each section heading includes numeric reference to specific requirements listed within the standards.

3.1 Induction (R1.13)

Trainers: Trainers reported there is an effective departmental induction which prepares trainees to undertake work in the department. They confirmed that this does not clash with the hospital wide corporate induction. This includes resus and scenario training and a tour of the department. Feedback is sought following induction and trainers reported that this has been positive. The rota is co-ordinated to ensure trainees who require an induction can attend, such as allocating trainees or locums already in post to cover nightshift. Where a trainee is starting out of sync, trainers reported that an individualised induction is provided.

Trainees: Trainees reported that they received a satisfactory half day hospital induction. Trainees felt the departmental induction worked well, covering all necessary areas for them to undertake their work. The departmental induction was over 2 days and includes Badgernet training, roles and responsibilities within the postnatal ward along with access to a handbook. Trainees who had returned to the department reported the induction had significantly improved.

Non-Medical Staff: None of the staff in attendance were directly involved with the induction. Staff did however feel that it was effective as trainees appeared to be well prepared for the work they require to undertake in the department. Some staff were also aware that feedback is sought from trainees and improvements made to the induction.

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

Trainers: Trainers described various teaching opportunities which are available to trainees, this includes:

- Weekly consultant led 'topic' teaching which is mapped to the new curriculum,
- Simulation training,
- Radiology meetings,
- Grand round
- Neonatal risk management meetings

In addition, trainers reported that they highlight the teaching opportunities available to trainees in their rota. A physician associate has been employed which has reduced some of the trainees' workload to enable them to attend teaching and have protected teaching time.

Trainees: Trainees reported they are able to attend up to 60% of formal teaching sessions available to them. They described a variety of regular teaching sessions available to them, including:

- Weekly departmental teaching with a 30 to 45-minute trainee presentation on Tuesdays and a 1-hour consultant or external presentation on Wednesdays.
- Grand round or journal club on Fridays, and
- Multidisciplinary (MDT) meetings.

Trainees felt that they were less able to attend the regional teaching sessions. They felt that this was due to the lack of notice provided to them from the trainee in the children's hospital that organises regional teaching.

Non-Medical Staff: Some staff reported that they will, when possible, hold the pager to support trainees to attend their teaching sessions. Staff also reported that if they are made aware of teaching sessions, they will look to adjust the timing of certain tasks to enable trainees to attend their teaching.

3.3 Study Leave (R3.12)

Trainers: Trainers reported that they were not aware of any challenges in supporting study leave. They reported that requests are submitted to the consultant rota co-ordinator who can make rota adjustments, if needed, to further support study leave requests.

Trainees: Trainees reported that it is very easy for them to request and take study leave.

3.4 Formal Supervision (R1.21, 2.15, 2.20, 4.1, 4.2, 4.3, 4.4, 4.6)

Trainers: Trainers reported that there are 3 educational supervisors in the department. They reported that they have adequate time in their job plans for this role. Both educational and clinical supervisors have undertaken recognition of trainers and this is reviewed annually through appraisal. Trainers reported that they have utilised the information provided by the Deanery on what can be used as evidence in their annual appraisal for the educational role. Trainers reported that meetings are arranged with previous supervisors if there are known concerns about a trainee due to start in post. They felt this enabled them to target the specific areas for improvement and monitor a trainee's progress in meeting the required competences.

Trainees: Some trainees reported that they informally meet with the supervisor daily. All trainees reported that they have met with their educational supervisor and agreed a personal development plan for their current post.

Non-Medical Staff: Staff felt that trainees can access senior support when required and that they are happy to seek support.

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

Trainers: Trainers reported they held a training session to ensure the supervisors were aware and had a good understanding of the new curriculum. Clinic time is now built into the rota to ensure trainees can attend clinics. Trainers reported that they ask trainees to highlight any curriculum competency requirements which they have not yet achieved and that there is a board for trainees to write what experience, such as intubation, they still require to achieve. Trainers felt that attendance at neurodevelopmental clinics was challenging for trainees to achieve, but they are working to address this through the allocated clinic time. They felt the balance was fair between educational activity and service-based work. Trainers advised that they have a phlebotomy service during the week and that the physician associate as well as midwifery staff help to reduce the trainee workload by undertaking tasks such as blood letting and baby checks to enable trainees to access more educational opportunities.

Trainees: Trainees reported that having allocated clinic time and protected teaching time to undertake educational work, such as quality improvement projects, was particularly good to enable them to achieve their curriculum requirements. Some trainees felt that some procedural skills, such as intubation, were more difficult to achieve due to limited patient numbers. However, they felt that the use of a notice board to highlight any competency areas they still require to achieve was very useful as staff will help trainees to access these training opportunities when they arise. Trainees reported that they attend clinics with junior trainees reporting attending at least 1 or 2 clinics per month and senior trainees approximately one per week. Trainees reported that the balance between educational and service-based work has improved.

Non-Medical Staff: Staff described various ways in which they contribute to the training of doctors, this included:

- Training on chest drain insertion,
- Resus training,
- Pharmacy input at ward rounds, and
- Simulation training (although staff indicated this requires further development).

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

Trainers: Trainers reported that they are aware of the trainee assessment requirements through the trainee ePortfolio (Kaizen). All felt that trainees can easily achieve their assessments, with trainers highlighting assessment opportunities to trainees.

Trainees: Trainees reported that whilst the initial discussion for their assessments is quickly undertaken, they often required to send a number of reminders to complete the assessment form. However, they did not feel they had to chase this more than any other post. They felt their assessment are fair and consistent.

Non-Medical Staff: Staff reported that they complete direct observation of procedural skills assessment forms and 360 degree multi-source feedback to contribute to the trainee's required assessments.

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

Trainers: Trainers reported a variety of multi-professional learning opportunities available in the department, such as:

- Morbidity and Mortality meetings,
- Simulation scenario training
- Radiology meetings

Trainees: Trainees reported that simulation training was very valuable and provided the opportunity for multiprofessional learning. One trainee reported that they had attended one simulation training event in three months and trainees would welcome more opportunities to access this training opportunity. Senior trainees reported that they have been offered the opportunity to lead a simulation training session.

Non-Medical Staff: Staff reported there are opportunities for joint learning among trainees and non-medical staff, including:

- Wednesday afternoon teaching sessions,
- Resus training

- Grand round.

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

Trainers: Trainers reported that there are a variety of quality improvement projects available to trainees. They highlighted that an upcoming quality improvement day is being co-chaired by a neonatal trainee, with 6 of the poster presentations submitted by specialty trainees from neonatal medicine.

Trainees: Trainees reported there is a quality improvement ethos within the department. They felt the trainers were very helpful in guiding them with suggestions of quality improvement projects they can undertake if the trainee is uncertain.

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

Trainers: Trainers reported there is a meet and greet during the departmental induction where trainees can introduce themselves to inform all staff of their level of training. They felt this developed over time as well as staff get to know the trainees more. Additionally, trainers reported that the rota highlights the different levels of trainee and that there is a separate pager number for the ST1 to ST3 trainee from the ST4+ trainees. They reported that all staff are informed of who to contact for support during the morning safety brief in addition to having the daily senior contact details provided on a board. Trainers were not aware of any instances where a trainee was left to cope with a problem beyond their competence. In addition, trainers will not allocate a more junior trainee to out of hours until they are deemed competent to do so.

Trainees: Trainees reported that they always know who to contact for clinical supervision during the day and out of hours. They felt they have never had to cope with a problem beyond their experience, highlighting a very supportive team. Trainees reported that there is a strong consultant presence in the unit and are very approachable and accessible if they require support.

Non-Medical Staff: Staff reported that they will differentiate between the varying levels of specialty trainees through discussion with them, asking what previous experience the trainees have. Staff suggested it would be helpful if there was a picture board in the department with the name and grade

of each trainee under a photo the trainee. Staff did however report that they are not aware of the difference in competency levels between, for example, a first year ST1 trainee and a ST3 trainee. Although staff reported that there were no instances there were aware of where a trainee had felt they had to cope with a problem beyond their competence, they did cite and example where a trainee had not recognised where a locum consultant was not managing a patient appropriately. This concern was later flagged to senior staff and a policy is now in place for non-medical staff to escalate a concern where they feel senior consultant input is needed.

3.10. Feedback to trainees (R1.15, 3.13)

Trainers: Trainers reported that informal feedback is provided to trainees and it is highlighted where this can be followed up formally through a workplace-based assessment (WPBA), such as a case-based discussion (CBD). They reported that the department has also recently introduced a 'hot debrief', which there's discussion and reflection on the management of a high-risk scenario.

Trainees: Some trainees reported that although they are not given feedback daily, they will be given feedback for example, following a procedure, with consultants advising trainees of what was done well and what could be better. Trainees also get feedback at a debrief following events such as resus. However, junior trainees felt they were not provided with any regular feedback, this being more formalised through their workplace based assessments.

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

Trainers: Trainers reported that there are feedback forms which they ask trainees to complete. These are collated by the clinical lead to review and take to the senior staff meeting for discussion of any improvements or changes that they department may want to undertake. They did however report that the uptake by trainees to complete these forms was variable. In addition, trainers reported that there is a trainee forum and what's app group through which the senior trainee can feedback any issues or concerns to the trainers at the senior staff meetings.

Trainees: Trainees reported that they have a what's app group and the trainee forum had just met on the morning of the deanery visit. Discussions through both mechanisms are fed back by a senior trainee at the senior staff meetings. Trainees reported that they were aware of the feedback form

which they can complete about the consultant of the week but had not engaged with this feedback process.

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

Trainers: Trainers reported that a significant amount of work has been undertaken by one of the consultants to improve the trainees' rota. Trainees are provided with a six-month rolling rota which has built in clinic time and protected teaching time. In addition, the trainee workload has been further improved through employment of locum doctors and a physician associate.

Trainees: Trainees reported that their workload is manageable. Those new to the department felt the rota was good and those who had previously worked in the department felt there had been significant improvements to the rota. All trainees felt the allocated clinic time and protected teaching time is very beneficial in enabling them to achieve the curriculum competences. Trainees reported they received their six-month rolling rota at least 6 weeks prior to starting in post. They could not suggest any further improvements to the rota.

Non-Medical Staff: Staff reported that they were not aware of any rota issues impacting on the trainees' wellbeing.

3.13. Handover (R1.14)

Trainers: Trainers described a very effective, structured, handover. The morning handover includes a safety brief which ensures all staff are aware of high-risk patients and who the resus team will be. All three handovers are consultant led with formal written copies available and updated during the day. Trainers reported that following an audit of their handover processes they reflected on the findings and made improvements to it. Trainers reported that following feedback from trainees, handover is not formally used as a teaching session.

Trainees: Trainees reported there is a structured, effective handover in place with includes a safety brief. Junior trainees reported that learning opportunities are highlighted to them at handover. Trainees who have previously worked in the department were very positive about the improvements

made to the handover and noted that previously heated disagreements at handover had evolved to positive open discussions which offered a more civilised atmosphere.

Non-Medical Staff: Staff reported that there is a separate handover for non-medical staff. It was reported that handover works well and the senior staff behaviour during the medical handover has significantly improved. Staff reported that, although a senior nurse attends the medical handover, they would welcome an MDT safety brief and suggest holding a safety brief at all handovers would provide additional improvements to handover.

3.14. Educational Resources (R1.19)

Trainers: Trainers reported that the educational resources available to trainees remains the same:

- Library
- Computers and wi-fi access
- Clinical skills area
- Simulation area (2 SimBaby available).

Trainees: Although trainees felt it would be helpful to have more computers within the maternity hospital, the reported that facilities and resources, such as libraries and computers, to support their learning is adequate.

3.15 Support (R2.16, 2.17, 3.2, 3.4, 3.5, 3.10, 3.11, 3.13, 3.16, 5.12)

Trainers: Trainers reported that they continue to encourage the trainee forum for trainees to feedback concerns about their training or experience. This is brought to the senior staff meeting for which there is a trainee representative. Trainers reported, that if they had concerns about a trainee they would highlight this to the educational supervisor and could escalate to the training programme director for additional support. Trainers also reported that trainees have access to a counsellor, a psychologist and to occupational health if the support required regarding the trainee's health and wellbeing.

Trainees: Trainees reported if they were struggling with the job they would be happy to speak to their educational supervisor or clinical lead and if necessary, escalate to their training programme director.

Trainees reported there is a very accessible psychologist they can go to for support as well as occupational health for any health and wellbeing concerns. None of the trainees the panel met with were working less than full time. Those who had been out of programme reported that a graded return to the department was offered but was not needed.

Non-Medical Staff: Staff reported that if they had concerns about a trainee's performance impacting on patient care, they would contact the trainee's educational supervisor or raise this with the clinical lead.

3.16 Educational governance (R1.6, 1.19, 2.1, 2.2, 2.4, 2.6, 2.10, 2.11, 2.12, 3.1)

Trainers: Trainers reported that there is neonatal representation at the specialty training committees. These meetings are held every quarter and includes staff within the deanery for which any changes or improvements can be fed back.

Trainees: Trainees were unclear about the educational governance structure within the hospital.

3.17 Raising concerns (R1.1, 2.7)

Trainers: Trainers reported that patient safety concerns are raised during the safety brief and can be formally reported through agreed systems. Trainers felt there is an embedded culture of learning from incidents and discussing patient safety both during handover and at the risk management meetings.

Trainees: Trainees reported that they would raise patient safety concerns with the on-call consultant and can also be discussed during the safety brief. They reported that concerns regarding their education and training can be raised at the trainee forum which is then highlighted by the senior trainee to the consultant team.

Non-Medical Staff: Staff reported that they would raise patient safety concerns with the charge nurse and would be happy to escalate to a consultant if required.

3.18 Patient safety (R1.2)

Trainers: Trainers felt the department provides a safe environment for both trainees and patients. Patient safety is routinely monitored through the safety brief at handover which trainees attend.

Trainees: Trainees reported that they would be happy about the quality and safety of care a family member would receive in the department.

Non-Medical Staff: Staff reported that in addition to handover and the safety brief there is a hospital wide safety huddle which a senior nurse will attend, which discusses hospital wide issues. Although this does not involve trainees, staff reported that trainees are welcome to attend.

3.19 Adverse incidents (R1.3)

All staff reported that adverse incidents are formally recorded through the datix system. All records are reviewed and discussed between a consultant and senior non-medical staff member. Adverse incidents are discussed at the risk management meetings and can also be discussed during morbidity and mortality meetings, with learning outcomes are shared with all staff via email.

Trainees also reported that additional learning has been provided following some incidents with external presentation to the multidisciplinary team and a consultant led teaching session.

Non-Medical Staff also highlighted there is a tick box on the datix forms to request feedback which closes the loop to ensure whomever submitted a report can receive direct feedback regarding an incident.

3.20 Duty of candour (R1.4)

Trainers: Trainers lead by example in demonstrating being open and honest with patient's parents, openly discussing patient management plans and explaining if something went wrong.

Trainees: Trainees reported that duty of candour is highlighted to trainees during their induction.

3.21 Culture & undermining (R3.3)

Trainers: Trainers reported that the team culture continues to develop. The clinical lead provides an informal social event to which all levels of staff are invited. They felt this was particularly helpful as an informal way to get to know each other outwith a clinical work setting. The clinical lead has also developed a manifesto for all staff describing how everyone is expected to behave and what to do if someone's behaviour is not appropriate. Trainers also highlighted that they have an open-door policy if anyone wishes to raise a concern either formally or informally and there is now a clear escalation policy in place regarding any bullying or undermining concerns. Trainers described a few scenarios where behaviours had been perceived to be undermining and mediated these incidents to a swift and satisfactory resolution.

Trainees: Trainees reported they have a good relationship with clinical team. One trainee described a situation they were involved in where some staff behaviour had been aggressive. This was raised with one of the consultants and satisfactorily resolved. Trainees who had previously worked in the department reported that there was a significant change in the culture with the whole team being much more supportive and more relaxed atmosphere.

Non-Medical Staff: Staff reported that there have been significant improvements to the team culture over the past few years. They felt that having multidisciplinary team building events has further improved team work. They felt the introduction of the manifesto regarding appropriate behaviours has had a positive effect with communication between staff which is now respectful of each other. In addition, staff felt the manifesto further promoted a zero-tolerance of bullying and undermining behaviours. Staff reported that if any issues do arise, they are flagged up as soon as possible to enable swift resolution.

Staff also wanted to highlight that the leadership over the last few years and senior support has significantly improved. They felt that the whole team now share the same overall vision for the department which has improved the working environment and enabled everyone to start looking forward in a positive way.

3.22 Other

Trainees were asked to rate their overall satisfaction with their post, in a scale of 0 (very poor) – 10 (excellent). The scores were as follows:
Range: 7 – 9, Average: 7.8 out of 10

4. Summary

This was a Quality Management visit by the Deanery with GMC support under the GMC's Enhanced Monitoring (EM) arrangements. This was the third EM visit and was scheduled to follow up on progress since the visit in April 2018 in the six requirements that were stipulated last year. Listed below is the assessment of the progress made by the department to meet those requirements.

Ref	Issue	Progress
7.1	The department must continue to work towards a culture of zero tolerance to bullying and undermining behaviours.	Standard met
7.2	Trainees must have the opportunity to attend clinics during their working hours.	Standard met
7.3	Hospital Induction must be provided to trainees that are returning to the site after completing a post in a different health board or returning from a break such as maternity leave or Out of Programme Experience.	Standard met
7.4	The department must ensure that the departmental induction does not clash with the hospital induction to ensure that all trainees receive their required inductions. If this is not possible, a catch-up departmental induction must be provided to trainees that are unable to attend on the scheduled date.	Standard Met
7.5	All trainers must be able to complete the online workplace based assessments and reviews for trainees.	Standard met
7.6	Due to the lower number of cases at this site, the department must have a plan in place to ensure both clinical and non-clinical aspects of higher training are achievable before the reintroduction of a Grid Trainee	TBC

Positive aspects of the visit

- Positive comments from all staff that there is an approachable and supportive consultant team
- Trainees were positive about the departmental induction which is comprehensive and enables trainees to start working in the department
- Handover experience is more positive. This was particularly highlighted by trainees who had worked in the department previously.
- Change in culture very positive, with good team work, respectful behaviour and good communication, providing a more positive working environment for all staff.
- Significant improvements have been made to the rota through allocated clinic time and protected teaching time.
- The provision of locums and a physician associate, as well as utilising nursing and midwifery staff, has provided trainees with more opportunities to attend local teaching and access training opportunities.
- The department actively seeks feedback from trainees which is acted upon if changes need to be made.
- The department provide individualised support to trainees. Additionally, there is access to a psychologist if needed.
- Multiple learning opportunities are made available to trainees to ensure they meet their curriculum requirements
- There is a clear safety culture embedded within the department through a variety of systems.

Less Positive aspects of the visit

- Trainees experience difficulty in accessing their regional teaching. The panel are aware that this is organised by a trainee in the children's hospital although the department should look at what they can do to facilitate trainee attendance.
- Lack of awareness of trainee competence/level, particularly from non-medical staff. It was suggested that a picture board of who the trainees are, and their training level could be used to address this concern.
- Simulation training requires to be improved. This is at an embryonic stage and requires further development
- Feedback to trainees is very variable with some receiving no informal feedback. It may be that consultants should be highlighting when what they are saying is feedback. In addition, some

trainees were not aware of the feedback forms which are available to them to complete and the department may want to highlight this is available to them and can be anonymous by removing the request for the trainee's name.

This was a very positive visit and we wish to strongly commend the progress and sustained improvements that have been made since our last visit. Most notably there has been the change in culture by the whole team, with feedback throughout this visit highlighting that there is now a culture of respect to all members of the team with good communication.

Given the significant progress made by the department to improving the overall training environment, there is the potential to recommend that the department be de-escalated from enhanced monitoring, with a final deanery revisit in 18 months' time to confirm that the significant positive changes continue to be achieved. A final decision to determine if this site should be de-escalated will be agreed at the Quality Review Panel in September 2019.

Is a revisit required?	**Yes**	**No**	**Highly Likely**	**Highly unlikely**

5. Areas of Good Practice

Ref	Item	Action
5.1	Adequate experience	Access to clinics is now built into the trainee rota
5.2	Rota/Workload	Protected time is allocated within the rota to enable trainees to undertake educational work, such as quality improvement projects
5.3	Culture and undermining	The development of the manifesto further promotes a zero tolerance to bullying and undermining behaviours and has improvement communication within the team.

6. Areas for Improvement

Ref	Item	Action
6.1	Feedback	The department should continue to promote trainee engagement with the trainee forum.

6.2	Feedback	The department should promote use of the feedback forms they have developed to improve trainee engagement with giving feedback on their training experience and areas for improvement.
6.3	Simulation Training	The department should continue to develop simulation training as a formal teaching and joint multidisciplinary team working opportunity.
6.4	Regional Teaching	The department should look at what they can do to support trainee attendance at regional teaching.

7. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
7.1	The level of competence of trainees must be evident to those that they come in contact with.	24 January 2020 (9 months)	All
7.2	Trainers within the department must provide more regular informal ‘on the job’ feedback, particularly in regard to trainee decisions and care planning.	24 January 2020 (9 months)	ST1-ST3