Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	16th May 2019	**Level(s)**	Foundation (FY), GP, Specialty (ST)
Type of visit	Scheduled	**Hospital**	St John's
Specialty(s)	Paediatrics	**Board**	Lothian

Visit panel	
Peter MacDonald	Visit Chair – Associate Postgraduate Dean Quality
Fiona Jefford	GP Programme Director
Anne McEntegart	Foundation Programme Director
Aoife Duignan	Trainee Associate
Hazel Stewart	Quality Improvement Manager
Jan Lyall	Lay Representative
In attendance	
Fiona Conville	Quality Improvement Administrator

Specialty Group Information	
Specialty Group	Obstetrics and Gynaecology and Paediatrics
Lead Dean/Director	Alan Denison
Quality Lead(s)	Peter MacDonald, Alastair Campbell
Quality Improvement Manager(s)	Hazel Stewart
Unit/Site Information	
Non-medical staff in attendance	2
Trainers in attendance	8 including clinical leads
Trainees in attendance	4
Feedback session: Managers in attendance	DME

Date report approved by Lead Visitor	12/08/2019

1. Principal issues arising from pre-visit review

A scheduled visit was arranged to Paediatrics at St John's Hospital as part of the 5-year visit cycle.

The visit team take the opportunity to gain a broad picture of how training is carried out within the department and to identify any areas of innovation or good practice for sharing more widely. The visit provides an opportunity for trainees and staff within the unit/department to tell the Deanery what is working well in relation to training; and to highlight any challenges or issues, the resolution of which could be supported by the Deanery.

2.1 Induction (R1.13)

Trainers: Trainers reported there is an effective whole day induction for trainees. This includes discussion of general paediatrics topics as well as an orientation through the department. Trainers felt it was important to hold the induction over a full day to allow sufficient time for trainees to understand and absorb the information being provided. Trainers reported that if a trainee is working night shift then a focused induction on specific areas is provided with an additional catch-up induction provided at a later date. The department seeks feedback from trainees following each induction which is generally positive. Where improvements are suggested, trainers have adapted the induction to address the issues raised. Trainers reported difficulties in joining up the community child health induction with the acute out of hours induction as this is currently based in Edinburgh. The out of hours induction is prioritised with flexible sessions or ad hoc induction provided for the community child health.

Trainees: Trainees reported, with one exception, that they received a hospital induction. Trainees reported they received a comprehensive departmental induction which equipped them to work in the department. They could not suggest any improvements to the induction.

Non-Medical Staff: Staff felt the induction works well. The advanced nurse practitioner (ANP) leads the induction within A&E and the children's ward. They advised that an induction package is sent to trainees ahead of their post and feedback is sought following each induction to determine if any improvements are required.

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

Trainers: Trainers reported a variety of teaching sessions available to trainees, this included:

- Wednesday morning consultant led teaching,
- Grand round.
- Case based discussions, and
- Neonatal teaching.

The Wednesday teaching sessions are bleep free, as a nurse practitioner will hold the bleep during this time. In addition to the teaching listed above trainers reported that they provide GP specific teaching with review of triage referrals and discussion of their usefulness.

Community child health teaching is provided on a monthly basis across NHS Lothian and involves the whole CCH department. Trainees working in CCH are encouraged to attend the general paediatric grand round.

Trainees: Trainees reported there is a variety of formal teaching available to them. This includes:

- Teaching session every Wednesday (75% consultant led, 25% trainee led),
- Grand round on Tuesdays,
- Case presentation on Thursdays,
- Peer review child protection.

Trainees are generally able to attend teaching unless there is an emergency. It was suggested that the paediatric trainee could participate in leading some of the teaching sessions. Trainees reported they are able to attend regional teaching when needed.

Non-Medical Staff: Staff reported that the advanced neonatal nurse practitioner will take the bleep to prevent trainees being called out of the Wednesday teaching sessions.

2.3 Study Leave (R3.12)

Trainers: Trainers felt that they had no challenges in supporting study leave for trainees.

Trainees: Trainees reported it was easy for them to request and take study leave.

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

Trainers: Educational supervisors are allocated to trainees by the consultant group. There are separate supervisors allocated to Foundation and to GP trainees. Trainers reported that known concerns about a trainee's performance are provided to them with good notice, and there is discussion with trainees on how to achieve the required improvements. Trainers reported that they have attended curriculum meetings relevant to GP training and they have also received training through supervisor courses. They reported that their roles are reviewed through recognition of trainers at their annual appraisal. Community child health supervisors reported but they also completed the supervisor course provided by the college.

Trainees: Trainees reported they had formally met with their supervisor up to 3 times since starting their post and regularly meet informally on the wards.

Non-Medical Staff: Staff reported that trainees could access senior support at any time, as and when they need it.

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

Trainers: Trainers reported that they attend GP curriculum update meetings and are aware of the super condensed curriculum for GP training. Trainers reported that both Foundation and GP trainees will discuss with consultants their curriculum-mapped learning needs and trainers will highlight what they would find useful to meet these curriculum requirements. Trainers reported that they meet with their foundation trainee regularly to review eportfolio, develop personal development plans, discuss career intentions and what they can get out from the post. Community child health trainees will meet their trainers to identify the strengths of the post and any gaps training mapped to the curriculum. The weekly list of clinics is provided to junior trainees who have the option to opt in to attend these clinics when they are working on a standard week. Trainers reported that they impress upon the trainees to say if they are going to attend a clinic in order to ensure all staff are aware. Trainers also advised that ST specific clinics for community child health trainees are built into the rota. Trainers were not aware of any learning outcomes which would be difficult for trainees to achieve. Trainers felt that the

balance between developing as a doctor and time spent on activities of little to no educational benefit was good with educational work being prominent in the post.

Trainees: Trainees reported that having the department open 24 hours, 4 days per week, was beneficial as they could continue gaining paediatric training experience out of hours as they could now take admissions during those days. This provided trainees with more opportunities to achieve their competences. They did not feel that any competences were difficult to achieve. Out-patient clinic access was available to trainees but due to clinic time not being routinely built into the rota it is not viewed by trainees as a necessity to support their development and some trainees feel unable to delay basic ward tasks to attend the out-patient clinics. Some trainees felt that other opportunities, such as taking calls from GPs, would be of considerable use to them. Trainees felt that, overall, the balance between educational work and that of little or no educational value was good. Trainees felt that, whilst undertaking baby checks is educationally beneficial initially, over time this becomes monotonous and feels more service based than continuing to be educational.

Non-medical Staff: ANP staff deliver some of the formal timetabled teaching sessions, as well as providing more informal bedside teaching to trainees.

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

Trainers: Trainers felt that trainees can easily achieve their portfolio assessment within the department. Those interviewed reported that they had received training to undertake workplace based assessments but had not yet had the opportunity to benchmark their assessments against other trainers.

Trainees: Trainees feel that they could complete their assessments with ease and that they were completed in a fair and consistent manner.

Non-Medical Staff: Staff reported that the ANP completes case based discussions for trainees and all staff are happy to complete the multi-source feedback questionnaire when asked.

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

Trainers: Trainers reported at present there are no opportunities for multi professional learning. They did report that the department are looking to provide simulation training with the aim of running one session every 2 months. This would involve the multidisciplinary team (MDT). Trainers reported that community child health placement is a multi-professional learning environment on a daily basis with regards to child health planning meetings and involvement in child protection.
**Following the visit is was fed back that there may have been a lack of understanding of the question asked. The department confirmed that the following opportunities for mutli-professional learning are available:*

- *Participation from APNP and ANNPS at teaching sessions and grand rounds.*
- *Trainers encourage both trainee and nurse attendance at paediatric simulation exercises provided by anaesthetic team with the emergency department.*

Trainees: Trainees reported that the ANP can attend teaching sessions and that teaching within community child health always involves the multi-disciplinary team.

Non-Medical Staff: Staff reported that resus training is multi-disciplinary and they believe there is an aim to deliver MDT formal teaching.

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

Trainers: Trainers reported that they encourage trainees to identify audit projects whilst they are in post. They reported that at least 2 trainees are undertaking audits at present.

Trainees: Trainees reported that there are plenty of quality improvement project opportunities. If a trainee wants to be involved, they will discuss this with a consultant who will provide guidance and support.

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 that they can identify the varying levels of trainee through colour coded badge holders. Trainers also felt that, as they had a small department, staff quickly get to know the

different trainees. Trainers reported that whilst they understand that the training needs for the Foundation and GP trainees are different, the basic knowledge that both require is similar. Trainers reported that trainees are aware of who to contact when support is required, with consultant supervision on site from 8am until 8pm. In addition, there is a resident consultant available to provide support during out of hours. Trainers reported that there is no parallel consulting within community child health but trainees can phone if they experience any difficulties and are regularly encouraged to seek help if needed. Trainers reported that they were not aware of any instances where trainees have felt they had to cope with the problems beyond their competence. They advised that there is a clear colour coded escalation policy in place when there are any concerns about a patient.

Trainees: Trainees reported that they always have access to clinical supervision and know who to contact for that support at any time. Some trainees reported that they felt nervous at the start of their post, but support was always available to them. All felt that their senior colleagues were accessible and approachable.

Non-Medical Staff: Staff reported they can differentiate between the different grades of trainee by the colour coded badges provided. Staff acknowledge that initially they treat GP and foundation trainees the same, as they have little experience of Paediatrics, but quickly they see the difference in competency levels. They were not aware of any instances where a trainee had to cope with a situation beyond their competence.

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

Trainers: Trainers reported that as they work directly with trainees, there are lots of opportunities to provide feedback. They advised that there is a lot of informal feedback provided to trainees through case management discussions.

Trainees: Trainees reported that they receive regular, often instant, feedback from consultants on their clinical decisions. As they work alongside the consultants, trainees felt they had plenty of opportunities to present cases to their colleagues. All reported that their feedback is constructive and meaningful.

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

Trainers: Trainers reported that, in addition to feedback sought following induction, a feedback questionnaire is sent to trainees to complete at the end of each teaching session to determine if any further improvements require to be made**.**

Trainees: Trainees felt that senior staff were very approachable and could easily feedback to them on their experience in the department. They reported that they are asked at the start of their post to provide any suggestions that could improve their training and experience.

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

Trainers: Trainers reported there is a 6-person rolling rota which is continuous over a 6 week period. Teaching opportunities are available following each hand over. Trainers reported that they aim to deliver additional teaching following the ward round. They also advised that larger numbers of staff are rostered to work on Wednesdays to maximise trainee attendance at the weekly teaching sessions. Trainers reported that the rota for community child health trainees during out of hours can be problematic as travel time is not factored into the rota. This can impact on the trainee's ability to undertake community based work and administration such as dictation.

Trainees: Trainees reported that their rota is very manageable and highlighted that they are very well supported out of hours. However, trainees suggested that amending their rota or the timing of handover would be beneficial as trainees often end up working beyond their rostered time to participate. It was felt that when working within community child health, the opportunities to work in clinic was restricted if working an evening out of hours shift as this is undertaken at the children's hospital in Edinburgh and so the commute prevents the specialty trainee from undertaking an afternoon clinic. It was suggested that undertaking some OOH within St John's would enable trainees to hold a full clinic in the afternoon.

Non-Medical Staff: Staff reported they were unaware of any concerns about the rota that may impact on the trainees' wellbeing.

3.13. Handover (R1.14)

Trainers: Trainers reported that handover is held at 8am and 8pm and is highly effective, with discussion of all patients in the department. There is also a small hand over at 4 PM where the day-time consultant will hand over to the on call doctor. There is a written handover for the neonatal department, and this includes a safety brief. Within community child health there is a handover for child protection which follows the SBAR format.

Trainees: Trainees reported that there is a good handover in place which works well.

Non-Medical Staff: Staff reported there is an effective handover in place which ensures information about sick patients is passed to the next team.

3.14. Educational Resources (R1.19)

Trainers: Trainers reported a variety of resources are available to support trainees learning within the department this includes access to computers, seminar teaching, access to Lothian wide neonatal guidelines, a library and the college website.

Trainees: Trainees reported that having access to more computers and faster internet would be useful both for completing their electronic portfolio and inputting patient information.

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 trainees can feedback concerns about their experience within the department to their clinical and educational supervisor. They reported that one of the Foundation trainees has been collating feedback from trainees to present to the consultants. Trainers reported that the ST trainee attends committee meetings and can feedback any issues. Trainers reported that if they had any concerns about a trainee, they would discuss this with the relevant clinical or educational supervisor and sited an example of changes which were made to support a trainee in the department.

Trainees: Trainees reported that support would be available to them if they were struggling in any way. None of the trainees were working less than full time.

Non-Medical Staff: Staff reported that if they had concerns about a trainee's performance, they would raise this with a consultant but also look to see what additional support could be given to the trainee from them.

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 good engagement with the Associate Medical Director, with feedback provided to ensure they are meeting the required guidelines. Trainers reported that they also discuss STS and NTS RAG data and any concerns would be highlighted to the Deanery through specialty training committee.

Trainees: There was a lack of awareness of the educational governance structures with the hospital.

3.17 Raising concerns (R1.1, 2.7)

Trainers: Trainers reported that they encourage trainees to raise concerns about patient safety through the datix reporting system. Where concerns relate to education and training, the trainers advise trainees to raise their concerns with their clinical or educational supervisor.

Trainees: Trainees reported they would raise patient safety concerns with a middle grade doctor or consultant and could escalate further, such as to the clinical director, if needed. They were confident that patient safety concerns would be effectively addressed. Trainees reported that if their concern related to education or training, they would initially raise this with their supervisor and would be comfortable to escalate to their programme director.

Non-Medical Staff: Staff reported that they would raise patient safety concerns with the consultants or senior charge nurse.

3.18 Patient safety (R1.2)

Trainers: Trainers reported that the department provides a very safe environment for both trainees and patients. Trainers reported that they have faced challenges with the closure of the out of hours as they require to decide what patients to admit and if a patient will need to be transferred to another hospital however they did feel that they had sheltered trainees from such logistical issues. In addition to the handover trainers reported that there is a regular safety brief which includes a topic of the week for discussion and a hospital wide safety huddle. Trainers also reported that for CCH, there is a clear structure in place for any child protection concerns.

Trainees: Trainees reported that they would be happy with the care a relative would receive from the department.

Non-Medical Staff: Staff felt that the department provides a safe environment for patients.

3.19 Adverse incidents (R1.3)

Trainers & Non-Medical Staff: Trainers and staff reported that adverse incidents are recorded through Datix. They reported that everyone is encouraged to submit a detailed form which is reviewed at the monthly risk management meetings. Learning is shared through safety briefs with individual feedback provided to whoever submits the datix.

Trainees: Most trainees reported that they would submit a datix report following an adverse incident, although some were not aware of how to do so. All trainees would raise an incident with a consultant. They reported that if they are involved in an adverse incident, they will receive some immediate feedback via a hot debrief. They also reported that incidents are discussed during handover and may be presented as a case presentation for shared learning.

3.20 Duty of candour (R1.4)

Trainers: Trainers reported but they support trainees to be open and honest with patients through consultant conversations to families with trainees in attendance.

Trainees: Trainees felt they would be supported if they were involved in an incident where something had gone wrong.

3.21 Culture & undermining (R3.3)

Trainers: Trainers felt that as they were small group there is a sense of team within the department this is the same for the community child health (CCH). Trainers within CCH reported that they feel very lucky as they work together in the same shared unit, compared with larger sites where staff required to hot desk. Trainers reported that they were unaware of any bullying or undermining issues and they would encourage trainees to raise any such concerns with their clinical or educational supervisor. They advised that there is a formal process, which all staff are aware of, should anyone require to report a bullying or undermining issue within the organisation.

Trainees: Trainees reported that they work in a supportive environment and have not experienced or witnessed any negative behaviours from staff during the post. All reported that if they had any concerns, they would be happy to raise this with their supervisor.

Non-Medical Staff: Staff felt that they promoted a positive team culture and staff are encouraged to be open and honest. They were not aware of any trainee having received comments which may be less supportive of undermining. Staff reported that if there were any bullying or undermining behaviours this would initially be raised with a consultant and could be escalated, if needed, to a formal complaint.

3.22 Other

Score range 8 – 9, average 8.25 out of 10

4. Summary

Positive Aspects of the Visit

- Supportive environment with a cohesive team.
- Strong consultant leadership on the ground provides excellent supervision to trainees.
- Happy and positive trainees.

- Day to day care within the department has a well-integrated multidisciplinary team approach, particularly from the APNP, due them undertaking work on the middle grade rota.

Less Positive Aspects of the Visit

- Although there are opportunities for junior trainees to attend out-patient clinics. Due to clinic time not being built into the rota it is not viewed by trainees as a necessity to support their development and some trainees may not feel that they can delay basic ward tasks to attend the out-patient clinics available to them. GP trainees in particular miss out on significant relevant training opportunities if they do not receive out-patient clinic experience as part of their training.
- Departmental induction clashes with hospital induction for junior trainees.
- Acute out of hours induction clashes with community child health induction.
- Lack of adequate computers for trainees to undertake educational and clinical work; those currently available have a very slow speed. In addition, computers (or IT settings) prevent trainees from effectively accessing the paediatric eportfolio.
- Out of hours evening sessions are compromising clinical time within community child health due to trainees having to leave their core community work in West Lothian mid-afternoon in order to travel to Edinburgh acute sites in time for a handover. There is a case to critically assess this aspect of the trainee experience and ensure that all time is used to be effect without compromising the training opportunities within community child health.
- Junior trainees feel that the volume of baby checks undertaken is excessive and can rapidly become a task of little to no educational benefit. However, it is positive that the department have already taken steps to address this by having some midwifery staff trained to undertake this task and share the workload amongst the wider team.

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

5. Areas of Good Practice

Ref	**Item**	**Action**
5.1	Team Culture	Very positive and supportive multi-disciplinary team
5.2	Adequate Experience	Training of midwifery staff to reduce volume of baby checks completed by trainees

6. Areas for Improvement

Ref	Item	Action
6.1	Induction	The department should their induction timetable to ensure this does not clash with the hospital induction for trainees.

7. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
7.1	Ensure that service needs do not prevent trainees from attending clinics and other scheduled learning opportunities	16 March 2020	FY, GP
7.2	The Board must provide sufficient IT resources to enable doctors in training to fulfil their duties at work efficiently and to support their learning needs.	16 March 2020	FY, GP, ST
7.3	The Board must review the out of hours rota allocation for ST trainees to ensure this does not adversely affect clinical experience in Community Child Health.	16 March 2020	ST

Action undertaken by NHS Lothian to address requirements can be found by logging in to NHS Lothian's Medical Education Directorate website. See "Action Plan" - located at the bottom of the webpage.