Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	20th April 2023	**Level(s)**	FY/GP/ST
Type of visit	Triggered	**Hospital**	University Hospital Crosshouse
Specialty(s)	Paediatrics	**Board**	NHS Ayrshire and Arran

Visit panel	
Dr Alastair Campbell	Visit Chair -Assistant Postgraduate Dean - Quality
Dr Claire Alexander	Assistant Postgraduate Dean – OGP
Dr Rhona McMillan	GP Training Programme Director
Dr Surinder Panpher	Foundation Training Programme Director
Dr Emily Turner	Trainee Associate and Scottish Clinical Leadership Fellow
Mr Bill Rogerson	Lay Representative
Ms Fiona Paterson	Quality Improvement Manager
In attendance	
Mrs Susan Muir	Quality Improvement Administrator

Specialty Group Information		
Specialty Group	Obstetrics & Gynaecology and Paediatrics	
Lead Dean/Director	Prof. Alan Denison	
Quality Lead(s)	Dr Alastair Campbell & Dr Peter MacDonald	
Quality Improvement Manager(s)	Fiona Paterson	
Unit/Site Information		
Non-medical staff in attendance	2	
Trainers in attendance	9	
Trainees in attendance	4 x FY2, 3 x GP, 7 x ST1-4	

Feedback session: Managers in attendance	Chief Executive		DME	✓	ADME	✓	Medical Director	✓	Other	✓

Date report approved by Lead Visitor	11th May 2023

1. Principal issues arising from pre-visit review:

A summary of the discussions has been compiled under the headings in section 2 below. This report is compiled with direct reference to the GMC's Promoting Excellence - Standards for Medical Education and Training. Each section heading below includes numeric reference to specific requirements listed within the standards.

2.1 Induction (R1.13):

Trainers: All trainees receive induction to the hospital. Departmental induction is delivered over 2 days providing information on both paediatrics and neonatal medicine. Nurse practitioners deliver skills and drills scenarios for the tier 1 doctors and trainees are provided with an induction pack which details IT log in, educational supervisors etc. The neonatal induction has been improved following feedback from trainees. Some trainees felt anxious as they did not rotate to work within the neonatal for weeks or months after their initial induction. Trainees are now allocated a buddy and details provided on what is and isn't expected of them. MS Teams hosts a selection of videos for reference. Those working within the community receive a separate induction. The rota is coordinated to ensure trainees new to the hospital can attend on the day, those who can not attend are sent a pack and directed to the online guidelines.

FY & GP: Prior to starting trainees were sent online modules to complete for their hospital induction, this allowed a smooth transition on the day with access to IT systems set up. They all received comprehensive departmental induction which included tours of the departments, roles and responsibilities and common presentations. Trainees were scheduled to attend induction on the rota and were not assigned clinical duties. Many trainees agreed it was the best induction they had received.

ST: The majority of trainees received induction which adequately prepared them for their roles. Those who could not attend the main induction were invited to the unit prior to starting and given a tour of the departments and ID badge were arranged. Suggestions to improve the induction included targeted sessions for trainee levels, providing more information on practical procedures and responsibilities.

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

Trainers: Trainers acknowledged the challenges in providing interruption-free training. Paediatric teaching is delivered on Friday mornings after handover and Neonatal teaching on Thursday afternoons. Although not bleep free, nursing staff are aware that trainees should not be called unless it is an emergency. Teaching is also open to the wider multi-disciplinary team. Trainees are given time off to attend regional teaching, those scheduled to work nights are asked to seek a shift swap. Sessions are recorded using MS Teams which allows trainees to access later with time built into their rota.

FY: The trainees interviewed had only been in post since 5th April 2023 and had been unable to attend any sessions due to their rota allocation but felt there would be no barriers in attending going forward. Regional teaching is delivered weekly.

GP: Trainees estimated attending approximately 2hrs per week of local teaching. When working in the neonatal department trainees were able to attend both paediatric and neonatal teaching but told us this isn't replicated when working in the paediatric unit due to workload pressures, they are unable to attend the neonatal sessions. We heard that teaching is of a good standard and that it was relevant to their curricula. Regional teaching for GP trainees is a repeated rolling programme and most trainees have been able to attend some sessions.

ST: Trainees echoed the concerns of the GP cohort regarding access to neonatal teaching when in the paediatric department. They told us due to rota scheduling they would be able to attend limited neonatal teaching due to the timing of these sessions. Most trainees said they review recorded sessions within their own time to catch up. Those completing the University of Glasgow Postgraduate certificate in Child Health stated they have no issues in attending the teaching sessions.

2.3 Study Leave (R3.12) – Not asked

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

Trainers: We were told that trainees are allocated to educational supervisors (ES) based on their stage of training and interests if known. To help ensure familiarity with the curricular requirements trainers work with the same level of trainees in every rotation. All trainers have time recognised within job plans and roles are considered during appraisal. The department aspire to increase protected time for clinical and educational supervision into trainer job plans. Known concerns regarding a trainee are sporadic but useful when shared.

All trainees: All trainees have met with their ES and agreed learning plans. Those who have attended the unit previously suggested it would be beneficial to be attached to the same ES when returning.

2.5 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 staff can differentiate between the different levels of trainees using coloured id badges. There is a notice board with photographs of all team members which is updated regularly and during handover everyone states their name and grade.

Both during the day and out of hours (OOH) there is a clear escalation policy for who to contact for support. Within paediatrics the on-call consultant is present in the unit until 9pm, the neonatal consultant until 5pm and thereafter a robust rota watch system is operated via the switchboard.

All trainees – Trainees always felt well supported by their senior colleagues. They did not feel they had to work beyond their level of competence and reported no instances when they were required to do so.

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

Trainer: We were told that trainers keep up to date with the paediatric curricula utilising online teaching and resources on the college website. They are familiar with the requirements for the FY trainees, however they told us they rely on the GP trainees to keep them up to date with their specific learning needs.

Outpatient clinics are not formally built into the rota, however when staffing and workload allows opportunities to attend clinics are highlighted to trainees at morning handover. Trainees working within the community are allocated a number of clinics to attend each week to meet their learning and development needs.

FY: Trainees told us they have a scheduled float week on their rota which if service allows, they can attend outpatient clinics. However, they did note that this week is also used for their annual leave, limiting their opportunity to attend learning events. When the units are well staffed they confirmed consultants encourage them to attend clinics. The post has allowed them to develop their skills and competencies in managing acutely unwell patients. They advised that on average they spend between 2-3 hours per day on administrative tasks but felt overall the role was providing good educational learning.

GP: Like their FY colleagues they have a Float week on the rota but noted that these would be pulled to cover staff shortages or service pressures when necessary. They reported valued learning experiences when in the paediatric admissions unit as they assess patients and create management plans.

ST: Clinic attendance was described as limited with some trainees stating they rarely attend. They told us that when they attend a morning clinic, they will still be scheduled for ward cover in the afternoon which at times will be in a different location. They have no admin time post clinics. They estimated up to 40% of their day is non-educational detailing system issues, locum access queries and the administration of blood results to be the biggest burden. Within the neonatal unit trainees told us they are asked to manually copy blood results from 1 system to another and felt this was susceptible to error.

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

Trainers: Trainers advised they encourage submissions for workplace-based assessments

FY: Trainees felt it would be easy for them to complete their assessments, those that had completed said they were fair and consistent.

GP: GPST work-place based assessments require sign off by ST4+, trainees normally work alongside ST3 trainees therefore it is difficult to find the appropriate grade to complete. Within neonates they found it hard to find cases to relevant to their portfolio requirements but told us that baby checks were useful to their learning and subsequent roles in primary care.

ST: Trainees reported that they sometimes find it challenging to complete some of their workplace based assessments as there is a lack of senior staff to supervise undertaking procedures. Some consultants have emailed trainees suggesting they complete a case-based discussion after events. When available, consultants are willing to complete assessments.

2.8 Adequate Experience (multi-professional learning) (R1.17) – Not covered. No concerns raised in pre-visit information.

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

Trainers: Trainees are encouraged to complete projects and audits whilst in post.

All trainees – Trainees were actively encouraged at induction to participate in quality improvement projects however all said their ability to participate is limited by clinical workload.

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: Within neonates the consultant led handover provides opportunity to feedback to trainees. Multidisciplinary feedback is sought following simulation training. Paediatric trainers told us they spend a large proportion of time working with trainees and deliver real time feedback. In the assessment unit, trainers will discuss management plans and provide feedback. Most ward rounds are consultant led.

FY & GP: They get regular informal feedback when discussing management plans with a senior and always work alongside a registrar out of hours (OOH) in the neonates department.

ST: When in clinic they receive detailed constructive feedback however, there is little provision of feedback day to day in paediatrics. Trainees felt positive feedback was not forthcoming. They generally receive good, structured feedback when working in Neonates.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: Trainers highlighted the national surveys and educational supervisor meetings as a tool to gather leaners feedback. By creating an open-door policy trainees can raise concerns verbally at any time.

FY & GP: Trainees were unsure of a formal route to feedback to the management team. They told us if they had any issues, they would feel comfortable raising them. Handover was described as an informal mechanism to raise any issues.

ST: Trainees stated they can feedback concerns via an appointed trainee rep however they told us this lacked a formal process for escalating to the management team.

2.12 Culture & undermining (R3.3)

Trainers: Trainers believe the flattened hierarchy helps to create a positive culture and sense of supported team working. The civility saves lives campaign is displayed on a notice board within the department. Regular psychological safety discussions ensure trainees are empowered to raise any issues freely.

FY & GP: Trainees reported that they work within a very supportive team. When challenging events occur time is set aside for debriefs. They would escalate any concerns to the consultant in charge or their ES if ongoing.

ST: Overall trainees work in a supportive and friendly environment. There have been isolated incidents of poor behaviour, but these were not reflective of the department culture. Any concerns would be raised via the clinical lead.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: During the presentation Dr Williamson described acute staffing pressures from February-August 2022. Trainers acknowledged the vulnerability of the rotas and detailed some ongoing factors including:

- High amounts of leave, other than annual,
- Very small pool of individuals who take up bank or agency shifts,
- Consultant job plans are not flexible enough to allow for easy cover of the middle grade gaps: large knock-on effects at clinics etc,
- Increased workload within acute paediatrics,
- Reduction of middle grade trainees nationally and,
- Reduced number of SAS grade doctors willing to contribute to the out of hours rota.

To help mitigate against future issues a rota coordinator has been employed to support the management of both the tier 1 and 2 rotas. We were told of plans to increase the consultant work force alongside Advanced Neonatal Nurse Practitioners and Advanced Paediatric Nurse Practitioners.

Where possible trainers will coordinate learning opportunities to trainee interests.

FY: Trainees reported gaps on their rota. Some gaps are filled with locums and trainees have received emails seeking their support to cover gaps. They felt it would be reasonably easy to request changes to their rota but had not yet done so. They reported appropriate pre and post night recovery and highlighted the neonatal rota to be good.

GP: Trainees told us they are frequently asked to cover vacant shifts on their rota. They received their rota 4 weeks in advance of starting and on induction day the rota had been changed to include additional neonatal shifts without communication. GP trainees should complete 2 months neonatal and 4 months paediatric blocks throughout their placement however they are now working 3 months in each specialty. They described the rota pattern as difficult and told us it negatively effects their work life balance. A rota pattern of 4 long days, normal days to nights in paediatrics was particularly challenging.

ST: Trainees confirmed gaps on their rota which alongside heavy service provision, limits their availability to participate in learning events. They told us they feel under pressure to cover gaps and felt better communication as to the management of gaps would be helpful. Staffing levels in department can be variable with a unit having surplus 1 week and then lacking the next. Trainees reported no formal mechanism to feedback and felt there to be little to no improvement since August 2022. The pattern of working alternate paediatric and neonatal shifts is challenging due to the different ways of working in each unit, this also limits continuity of care.

2.14 Handover (R1.14)

Trainers: Structured and effective handovers take place daily at 9am and 9pm, these are multi-disciplinary events. When service allows consultants will provide 10-minute teaching sessions.

All trainees: Trainees reported that each department has a thorough, structured handover in place both AM and PM, which allows for discussion of all patients and staffing levels. There is an informal afternoon handover which trainees told us can at times feel disorganised as they can be unsure which patients have already been discussed. Attendance at handover is scheduled into their rota but occasionally the evening handover starts late and trainees need to stay past the end of their shift.

2.15 Educational Resources (R1.19)

Trainers: Not asked.

All trainees: Trainees reported they have access to the library and the seminar room for teaching sessions. IT equipment can be poor at times with slow computer connections and phones not working. There is a lack of computers available for trainees to access. There are currently 2 computers in the doctors room for all trainees which can be challenging to complete assessments or update their portfolio.

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

Trainers: To help support trainees there is an Ayrshire & Arran medical peer support network with wellbeing suites located within the hospital and Irvine. Members of the support team are identified to trainees when starting in post. Following a significant event trainees will participate in both hot and cold debriefs and the peers support group will also contact them to offer further support if required.

FY: At induction trainees were encouraged to raise any concerns through both their educational supervisor and the wider team.

GP& ST: Trainees reported that there are lots of available resources to support wellbeing which were provided at induction. They described the team as approachable and supportive and a culture of learning from incidents. 1 trainee was able to give an example of good support provided after a difficult shift. Some trainees who work LTFT or required reasonable adjustments felt the department was very accommodating in meeting their needs.

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

Trainers: There is a quality improvement group within the hospital which considers the quality of medical education as part of its internal processes.

FY & GP: Trainees confirmed if they had any concerns about their training, they would raise them with their Educational Supervisors (ES) or Training Programme Director (TPD). They were not aware of any trainee forum.

ST: Concerns would be raised via the trainee rep or they stated they would also be comfortable raising via the TPD.

2.18 Raising concerns (R1.1, 2.7) – Not covered. No concerns raised in pre-visit information.

2.19 Patient safety (R1.2)

Trainers: At times advanced nurse practitioners have to take on the role of nurse to cover gaps on their rota however, internal processes such as handover, safety huddles and escalation procedures ensure a safe environment for both patients and trainees. The open culture helps address concerns quickly and there are robust clinical management review groups.

All trainees: There are no concerns. Trainees would be comfortable raising concerns with any team member and described the nursing staff as excellent. The Watcher system clearly identifies at risk patients and these are highlighted at handover. Learning summaries are disseminated via email

2.20 Adverse incidents & Duty of Candour (R1.3 & R1.4)

Trainers: Trainees are encouraged to raise concerns at induction and throughout the culture of the unit. They utilise a system called SHINE which allows staff to record when something has gone well and once reviewed they receive a certificate. They advised that adverse incidents are reported through the Datix system, all incidents are reviewed and discussed at risk management meetings and learning outcomes shared via email.

All trainees: Trainees highlighted Datix as the system for reporting adverse incidents. 1 trainee had received a certificate through SHINE. They told us trainers lead by example and take responsibility when something goes wrong.

2.21 Other

Trainees were asked to rate their overall satisfaction experience of working within the department from a range of 0 (very poor) to 10 (excellent). The scores are listed below:

FY: Range 7-8, Average 7.5
GP: Range 7-8, Average 7.6
ST: Range 6-7, Average 6.8

3. Summary

Is a revisit required?	Yes	No	Dependent on outcome of action plan review

Positive aspects of the visit:

- Very positive culture and flattened hierarchy across the multi professional team. A supportive and accessible group of consultants
- Induction for the tier 1 doctors (FY and GPST) is very highly valued and adequately prepares them for their role in the department.
- No patient safety concerns with the standard of care provided to children and babies being extremely high.
- Wellbeing Support initiatives such as the Peer Support Structure and wellbeing suites.
- Recognising excellence through SHINE.
- The quality of educational and clinical supervision available to trainees is good.
- Commend the monthly supervisors meeting.
- Future initiatives to recruit ANPs and ANNP to help stabilise the rota and provide more learning opportunities for trainees.

Less positive aspects of the visit:

- The rota presents huge challenges particularly for the ST trainees, the switch between neonatal and paediatrics is challenging and requires attention.
- Good teaching programme within the department but access to this can be challenging at times as it is not protected.
- There are lots of QI and research opportunities but there is a lack of time for trainees to be able to do this is limited due to their clinical commitments.
- The environment for learning is positive but clinical workload again makes it challenging for trainees to learn effectively. The lack of continuity for specialty trainees in general paediatrics and neonates impacts on the ability to learn and develop from the variety and breadth of clinical work within the department
- Specialty trainees would appreciate a more tailored departmental induction detailing their role & responsibilities.

- Whilst mechanisms for trainees to provide feedback are in place a more formal route would be beneficial.

4. Areas of Good Practice

Ref	Item
4.1	Access to post significant event and wellbeing support are embedded in the culture of the department.
4.2	The SHINE initiative for recognising excellence.

5. Areas for Improvement

Areas for Improvement are not explicitly linked to GMC standards but are shared to encourage ongoing improvement and excellence within the training environment. The Deanery do not require any further information in regard to these items.

Ref	Item	Action
5.1	Induction	Consider providing a tailored induction for specialty trainees.
5.2	Feedback	Although trainees felt able to raise concerns within the department, there is no formal mechanism for feedback.
5.3	Rotas	Rotas should be consistently issued in a timely manner, usually 6 weeks in advance.
5.4	Handover	The afternoon handover can leave trainees unsure as to which patients have been discussed and require attention. A more formal process would be beneficial.

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	The Rota pattern must be reviewed with the trainees who are on the rota to identify ways to address their concerns.	20th January 2024	All
6.2	Alternatives to doctors in training must be explored and employed to address the chronic gaps in the junior rota that are impacting on training.	20th January 2024	All
6.2	There must be a protected formal teaching programme for doctors in training.	20th January 2024	All
6.4	A formal mechanism for all trainees to be able to feedback to the department must be established.	20th January 2024	All
6.5	There must be senior support, including from consultants/recognised trainers to enable doctors in training to complete sufficient WPBAs/SLEs to satisfy the needs of their curriculum	20th January 2024	GP
6.6	Tasks that do not support educational and professional development and that compromise access to formal learning opportunities for all cohorts of doctors should be reduced.	20th January 2024	All