Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	7th May 2019	**Level(s)**	ST
Type of visit	Scheduled	**Hospital**	Royal Hospital for Children, Glasgow
Specialty(s)	Anaesthetics	**Board**	NHS Greater Glasgow & Clyde

Visit panel	
Dr Fiona Ewing	Visit Lead & Associate Postgraduate Dean (Quality)
Dr Cameron Weir	Training Programme Director, Anaesthetics, East Region
Dr Ailie Grzbek	Trainee Associate
Mrs Marie Cerinus	Lay Representative
Miss Kelly More	Quality Improvement Manager
In attendance	
Mrs Fiona Conville	Quality Improvement Administrator

Specialty Group Information		
Specialty Group	Emergency Medicine, Anaesthetics and Intensive Care Medicine	
Lead Dean/Director	Professor Adam Hill	
Quality Lead	Dr Mohammed Al-Haddad	
Quality Improvement Manager(s)	Miss Kelly More	
Unit/Site Information		
Non-medical staff in attendance	2 pain nurses, a theatre manager and a department secretary.	
Trainers in attendance	8 consultants including the clinical lead & college tutor	
Trainees in attendance	2 St4s, 1 ST6 & 1 ST7	
Feedback session: Managers in attendance	A clinical service manager and an associate director of medical education	

Date report approved by Lead Visitor	15/05/19

1. Principal issues arising from pre-visit review

The Deanery's scheduled visit programme aims to visit each unit/location delivering training once every five years. Accordingly, a scheduled visit is being arranged to the Anaesthetics department at the Royal Hospital for Children, Glasgow. The visit team will 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 also to highlight any challenges or issues, the resolution of which could be supported by the Deanery.

At a previous visit to the Anaesthetics department at the Queen Elizabeth University Hospital in February 2016 there were no specific requirements for the children's hospital in that visit however there was comment made about the rota under areas for improvement – a review of the Children's Hospital rota should be undertaken to ensure there are sufficient numbers to run two tiers of trainees safely.

At the pre-visit teleconference the panel decided that the areas of focus for the visit were teaching, induction and rota.

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.

2.1 Induction (R1.13)

Trainers: The college tutor is responsible for induction. The induction includes written information as well as information about departmental hints & tips, drug dosing & packaging, a hospital tour, a resuscitation update and the e-learning information available via the Royal College of Anaesthetists.

If a trainee is not able to attend the induction for any reason an ad-hoc session is provided. The college tutor does contact the sub-specialty that the new trainee is coming from to try and ensure that they are available to attend induction.

All trainees: All the trainees had been in the Queen Elizabeth hospital campus previously so did not attend a hospital induction when starting in this post. The departmental induction was good and included things like how to use Trakcare and receipt of ID badges. Trainees received a handbook and the on call rota before they started. One of the trainees started at a different time but the college tutor came in from annual leave to induct the trainee.

Non-medical staff: They feel that induction is very effective in preparing trainees for the role. There is also support available for the trainees when they need it.

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

Trainers: Formal teaching is provided but as this is delivered in a consultant's Special Programmed Activity (SPA) time the time and date are not fixed. It is a rolling 8 week programme mapped to the curriculum. A log is kept of trainee attendance and reasons for non-attendance are recorded. If a trainee is on an emergency theatre list they are hopefully released to attend but this depends on workload and the type of case that is in theatre. During teaching one trainee will have the on-call phone and another will have the arrest page.

Trainees can attend a monthly continuing medical education meeting (CME). A journal club has also recently started.

All Trainees: The teaching sessions are fitted in as and when both consultants and trainees are available. Consultants facilitate the sessions and trainees present topics although because trainees often do not know if the teaching is happening they are unable to prepare anything to present. Many of the trainees were not able to attend these sessions due to shift patterns and pressures of emergency work.

They also have access to simulation training and pre-exam (FRCA) teaching. The exam teaching requires study leave to attend and is organised by trainees.

Non-medical staff: The departmental secretary shares the rolling teaching dates with trainees via email. Trainees are let out of theatre lists to attend teaching sessions.

2.3 Study Leave (R3.12)

Trainers: It is very rare for a trainee's request to be turned down provided they give the minimum 6 week notice.

All Trainees: Requests for leave were submitted before the trainees started in post so that these could be added to the rota. This is welcomed but led to the trainees getting the rota 2 weeks before starting in the post.

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

Trainers: A trainee's educational supervisor will remain in their base hospital. The college tutor is the nominal clinical supervisor for all trainees in the department and meets them at the start and end of their time in the department. If there are concerns about a trainee these are shared informally. All supervisors in the department have been trained. The roles are included in appraisal. The time in their job plans is variable depending on their role and their contract.

All Trainees: Trainees' educational supervisors are in their base hospital. All of them had met the college tutor who acts as their de-facto clinical supervisor.

Non-medical staff: It is clear from the rota who is around to support trainees and they are also reminded at induction to call for help should they need it.

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

Trainers: Trainees are allocated to appropriate lists by the college tutor. Staff are aware of trainees' requirements. Each list whether it is elective or emergency is seen as a learning and teaching opportunity.

Competencies such as neonates can be more difficult to achieve as the workload is variable. The short duration of the rotation (8 weeks) makes it tricky to fit everything in. Previously the rotation was 3 months and during the third month things were really starting to sink in for trainees in terms of consolidation of their knowledge. Staff are disappointed that the duration of the rotation was reduced.

All Trainees: Trainees feel that the majority of their experience is on call rather than doing elective lists. Those on the junior tier of the rota are running around answering the page, assessing patients and other routine tasks so they do not see a case all the way through. The senior trainees feel that they are relearning things they learned previously and as they can work on either rota the expectations and experience varies depending on which shift they work.

Emergency lists are so busy there is not much time to consolidate available learning opportunities. Trainees do feel that all their competencies are met although they do feel that the emphasis is on service rather than training.

Non-medical staff: They are not really involved formally in trainees' training.

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

Trainers: Staff all know which assessments need to be completed and have had the necessary training in how to carry them out. Trainees are expected to be proactive in getting these completed.

All Trainees: If you ask to have an assessment signed off it will be done.

Non-medical staff: They only fill in multi-source feedback forms for consultants not trainees.

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

Trainers: Simulation training is multi-disciplinary as is any work carried out in the intensive care unit.

All Trainees: Trainees learn a lot from pain nurses but this is ad-hoc rather than planned formal learning.

Non-medical staff: There are simulation days that involve all the theatre team including doctors in training.

2.8. Adequate Experience (Quality improvement) (R1.22)

Trainers: There is not really much time for audits and projects during an 8 week rotation. There is work going on in the department for example around fasting times which trainees will be aware of but not perhaps directly involved in.

All Trainees: As they are only in post for 2 months there is limited time for quality improvement projects or audits.

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

Trainers: Staff are aware of what grade a trainee is as there photos up in the department. The rota shows the grade and conversations are had with trainees if they have not met them before. Trainees know who to contact both in and out of hours. This is told to them at induction and they are all encouraged to seek support whenever they need it.

All trainees: Trainees know who is supervising them both in and out of hours. They are aware of the escalation procedures and are happy to contact consultants should they need to. They have not had to cope with anything beyond their competence although one trainee had a negative experience out with the department but the college tutor had approached them to discuss this.

Non-medical staff: There are photos up in the department which give the trainee's name and grade. The staff are also introduced to the trainees. All staff in the department are good at voicing concerns when they need to do so.

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

Trainers: A debrief takes place at the end of a non emergency list. Consultants fill in feedback forms about trainees, the content of which is pulled together and shared with the trainee at the end of their rotation.

All Trainees: The provision of feedback depends on which consultant they are working with. They reported receiving no direct feedback on out –of-hours work. They are aware that they will get formal feedback at the end of their post. They would perhaps like some more positive feedback.

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

Trainers: Trainees are given an anonymous questionnaire at the end of their rotation which is used as an opportunity to provide feedback. The consultant responsible for this shares the content with their colleagues.

All Trainees: Trainees are asked to complete a survey at the end of their block.

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

Trainers: All requests for study and annual leave are added into the rota. Drawing up the rota is challenging as the number of trainees in each rotation is not consistent. There are two tiers on the rota, both rotas are very busy with on call shifts and shifts of differing intensities. The rotas are tiring. Any gaps on the rota are filled by fellows or consultants if trainees are not able to fill them.

The on call rota was issued two weeks before the trainees started in post, all leave requests were granted and incorporated in the rota which is why it was issued slightly later. The day time rota is issued on a Friday for the following week. There is a WhatsApp group where the trainees discuss any issues and these are fed back to the consultants. Monitoring took place in February and the results are still to be analysed.

After working on call there is a bed that trainees can use but it is in an office. Trainees are offered a taxi if they do not feel safe to drive. If they live further away they can also stay in a hotel.

All Trainees: Trainees feel very tired and permanently exhausted but as they are only in the post for 2 months they just get on with it. The rota was described as the most intense on the West of Scotland anaesthesia training program. They do not get all the rest days that are outlined on the rota template used to be monitored against. They feel that the department does not need a 2 tier rota as there are often not enough trainees to fill all the slots.

Consultants do fill these slots where trainees are not able to. They are not forced to cover the gaps. They feel that the day to night transition is very poor on the rota and the on call facilities are not conducive for sleeping.

Non-medical staff: Staff are not aware of any issues with the rota that would affect trainee wellbeing. They do not appear to be fatigued and they would raise it if they had concerns about a trainee's wellbeing.

2.13. Handover (R1.14)

Trainers: The pain team handover was said to work especially well and is used as a learning opportunity. Handovers take place in intensive care. The emergency team are working on strengthening their handover procedure at the moment as they feel that it could work better.

All Trainees: The pain handover is good, there is a written record, patients are discussed and it is multi-disciplinary. Any other handovers are mainly trainee to trainee.

Non-medical staff: The pain team are involved in a handover twice a day, morning and evening. This is a written handover and a plan for all patients is discussed. This is said to be very effective. Handovers can also be used as a learning opportunity as decisions made about each patient discussed.

2.14. Educational Resources (R1.19)

Trainers: Trainees have access to a meeting room with computers and an airway training station as well as simulation facilities, a library and an app for paediatric guidelines.

All Trainees: They have access to a room with computers, a library and simulation facilities.

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

Trainers: There are three mentors in the department. Support is offered to trainees from any of the consultants. If any of the trainees were struggling then the college tutor would raise this with the trainee's educational supervisor in their base hospital.

Trainees are offered consultant interview practice.

All Trainees: They were told about the 3 departmental mentors at induction.

Non-medical staff: If a member of the team had a concern about a trainee's performance they would raise this with one of the consultants. They have done this in the past.

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

Trainers: Staff have good interaction with the associate director of medical education for their department.

All Trainees: They are aware of the postgraduate medical education team.

2.17 Raising concerns (R1.1, 2.7)

Trainers: Concerns can be raised in theatre at the safety brief. Out with theatre concerns can be raised with any of the team including nursing staff.

All Trainees: None of the trainees had raised any concerns but if they did they would do it with one of the consultants. They are sure they would be addressed. Concerns about the rota had been raised with the college tutor but they are unsure if they would be dealt with.

Non-medical staff: If a member of the team had a concern about patient safety they would raise this with one of the consultants.

2.18 Patient safety (R1.2)

Trainers: The environment is very safe. Trainees are encouraged to take their breaks and to ask for help when they need it. There is no pressure from within or out with the department to work on a case that a trainee is not comfortable with.

All Trainees: The trainees had no concerns about patient safety.

Non-medical staff: Theatre nurses have a safety huddle in the morning. All staff are involved in a safety brief at the start of a list, a surgical pause before each patient and a debrief at the end of a list.

2.19 Adverse incidents (R1.3)

Trainers: These are reported on Datix and discussed at the morbidity and mortality (M&M) meetings which are part of the CME meeting. Any findings from these meetings are shared with trainees. Learning for excellence is also discussed as part of these meetings.

All Trainees: They would raise it with their supervisor and/or put it on Datix. After an incident there is an immediate team debrief and a whole team debrief. Depending on the nature of the incident it may also be reported to hospital management. Trainees have also been invited to attend debriefs in the emergency department if they have been involved in an incident.

Non-medical staff: These are reported via Datix. The forms are reviewed weekly by a consultant and immediate feedback provided where appropriate. If a trainee has submitted a Datix and the feedback is available after they have left the department, it will be sent on to them. Any incidents are used as learning opportunities.

2.20 Duty of candour (R1.4)

Trainers: This is encouraged by demonstrating positive behaviour when interacting with a patient's family.

All Trainees: The level of support given would depend on the consultant.

2.21 Culture & undermining (R3.3)

Trainers: It is an open, friendly approachable team. This topic is included in the end of block trainee survey and so far, no issues have been identified. Due to the short trainee rotation it can be difficult to get to know a trainee on a more personal level and build a rapport with them.

All Trainees: They do not have much interaction with other staff groups as there is no shared coffee break area. The majority of consultants are supportive.

Non-medical staff: All of the consultants are approachable and easy to get on with. The theatre staff work well as a team and there is no evidence of undermining. The pain team are not always with the trainees but if they did have any concerns about bullying or undermining these would be raised with a consultant. Staff try and check in with the trainees to see that they are ok.

2.22 Other

All Trainees: Overall satisfaction scores ranged from 4-6.

3. Summary

Is a revisit required?	**Yes**	**No**	**Highly Likely**	**Highly unlikely – we will monitor survey data via the SQMG**

Positive aspects of the visit were:

- The college tutor is very dedicated and hardworking covering induction and clinical supervision.
- The induction is comprehensive.
- Trainees are able to gain a broad range of experience including sub specialties such as cardiac and neurology. There are also fellows in the department.
- The pain team works well with a robust handover and a multi-disciplinary team culture.

- There are clear escalation policies in place for contacting senior staff and for adverse incidents.
- Trainees have access to good educational resources including simulation training.
- Trainees are able to provide feedback via their end of block survey.
- The approval of study leave works well provided that trainees give enough notice.
- The departmental handovers are generally robust.

Less positive aspects of the visit were:

- The teaching timetable needs to be more formal with set days and times set aside for teaching. This should be bleep free.
- The rota leaves trainees fatigued and permanently tired. It's pattern also has an effect on attendance at teaching and ability to attend elective lists. Consideration should be given to its pattern and whether or not it is sustainable given the trainee numbers in the department.
- Rotations are currently 2 months which doesn't give much time to get to grips with the post or to build relations with other staff. Consideration should be given to expanding the mentor roles to help embed trainees into the wider team more effectively.

4. Areas of Good Practice

Ref	Item	Action
4.1	The college tutor is very dedicated and hardworking covering induction and clinical supervision.	n/a
4.2	The pain team works well with a robust handover and a multi-disciplinary team culture	n/a
4.3	There are clear escalation policies in place for contacting senior staff and for adverse incidents.	n/a
4.4	Trainees are able to provide feedback via their end of block survey	n/a

5. Areas for Improvement

Ref	Item	Action
5.1	The short length of the attachment is a concern for trainers and trainees.	n/a
5.2	The mentoring program is in place but could be utilised more to improve trainee welfare.	n/a

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	Rota patterns must ensure sufficient rest time for trainees in transition from night to day working and must avoid patterns which result in excessive fatigue.	7 February 2020	all
6.2	A programme of formal teaching with particular days & times should be maintained.	7 February 2020	all
6.3	There must be active planning of attendance of doctors in training at teaching to ensure that workload does not prevent attendance. This includes bleep-free teaching attendance.	7 February 2020	all