Scotland Deanery
Quality Management Visit Report

Date of visit	17th June 2021	Level(s)	FY/GP/ST
Type of visit	Revisit	Hospital	Dumfries & Galloway Royal Infirmary
Specialty(s)	Paediatrics	Board	NHS Dumfries & Galloway

Visit panel	
Dr Peter MacDonald	Visit Lead - Associate Postgraduate Dean – Quality
Dr Marie Mathers	Associate Postgraduate Dean – Quality
Dr Katherine Quiohilag	Trainee Associate
Ms Marie Cerinus	Lay Representative
Ms Fiona Paterson	Quality Improvement Manager
In attendance	
Ms Susan Muir	Quality Improvement Administrator

Specialty Group Information	
Specialty Group	Obstetrics & Gynaecology and Paediatrics
Lead Dean/Director	Professor Alan Denison
Quality Lead(s)	Dr Peter MacDonald & Dr Alastair Campbell
Quality Improvement Manager(s)	Ms Fiona Paterson

Unit/Site Information									
Non-medical staff in attendance	3								
Trainers in attendance	8								
Trainees in attendance	1 x FY2, 2 x GPST, 5 x ST1-7								
Feedback session: Managers in attendance	Chief Executive		DME	X	ADME		Medical Director		Other	X

Date report approved by Lead Visitor	26th June 2021

1. Principal issues arising from pre-visit review:

Paediatrics was first visited in 2015 and then subsequently in 2018 as part of the 5-year visit schedule and as part of a new site visit. During the 2018 visit it was noted that some areas of concern flagged up at the previous visit were still unresolved and that ST trainees in particular, were not gaining an adequate experience from the post with regards to access to outpatient clinics. At the 2019 visit there had been clear improvements and a significant amount of work undertaken to address the previous requirements. 2 areas of concern remained around the delivery of feedback and inconsistent clinical practice with lack of adherence to guidelines. The SQMG reviewed the action plan and felt that 7.4 required further input. They suggested the department undertook an audit of guideline compliance in regard to a few of the commonest conditions in both Paediatrics and Neonates and that it shares the results with the visit team at its next visit. A planned visit for October 2020 was postponed due to the pandemic.

Requirements from 2019 visit:

- Allegations of undermining behaviour must be investigated, and if upheld, put in place an appropriate action plan must be instigated to address them.
- There must be a process that ensures trainees understand, and are able to articulate, arrangements regarding Educational Governance at both site and board level.
- FY2 and GP trainee cohorts should be made aware of CIRG meetings and when they happen
- Measures must be implemented to address the (ongoing) patient safety concerns described in this report regarding guidelines and patient management plans.
- There must be active planning of attendance of doctors in training at teaching events to ensure that workload does not prevent attendance. This includes bleep-free teaching attendance.

The visit commenced with a detailed presentation from Dr Peter Armstrong & Dr Ben Rayen which provided an update highlighting the improvements made within the department since the last visit. Specific examples were given in relation to:

- Culture – Process in place to ensure any allegations of undermining are investigated by the senior team within the paediatric department. Team working/psychology teaching sessions delivered and a pro-social model of working now in place.

- Feedback -The clinical director meets with trainees on a regular basis to monitor for any issues or concerns. Introduction of the 'Greatix' award system to encourage a positive atmosphere where trainees, senior staff and nursing staff can appreciate each other's contribution.
- Patient Safety – Changes to acute paediatric and neonatal guidelines to reflect West of Scotland practices. If no WoS guideline exists, the department have their own. This is highlighted at induction. A recent audit demonstrated excellent progress with guideline adherence.
- Educational Governance – The governance structure within the organisation and NES has been documented and is shared with trainees prior to starting in post. All trainees are aware of Critical Incident Review Group (CIRG) meetings and learning points are shared with trainees.
- Teaching – All Thursday morning teaching sessions are bleep free, this includes departmental grand rounds and CME sessions.

2.1 Induction (R1.13):

Trainers: Trainers reported that all trainees receive a hospital induction which at present has been delivered virtually via MS teams due to the pandemic. They told us trainees receive a bespoke departmental induction which provides detail on the geography of the department and a guide to day to day working. The rota is coordinated to ensure trainees are not scheduled for ward work until they have completed induction. Trainers told us that ST2 trainees stepping up onto the more senior on call rota are supported to ensure they feel comfortable in doing so.

Trainees: All trainees reported that they received induction. Trainees previously in post had provided feedback on how to improve the induction which had been implemented. Trainees currently in post told us that an IT issue delayed the provision of certain passwords but, that this was acknowledged as an issue by the site.

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

Trainers: Trainers told us that departmental teaching takes place on Thursdays and that this is bleep free. They reported that, at induction, they inform trainees that teaching is scheduled into their rota and a staff grade doctor is scheduled to cover duties during this time. Trainees are encouraged to pass their phones to the ward clerk or place them in a designated box in the doctors' room.

Departmental teaching is mapped to the trainees' curricula providing a mix of topics such as common presentations, child protection and X-rays. Trainers reported there are no issues in allowing access to regional teaching.

Trainees: Local teaching is delivered on Thursday mornings and is bleep free. Occasionally there are informal sessions delivered on Wednesdays. Previous trainees told us that teaching was case-oriented and mainly driven by trainees with a lack of consultant input. Trainees in the unit at the first wave of Covid had an extensive teaching programme which was manageable due to service restrictions. Current trainees reported that they received good departmental teaching. To further enhance the teaching programme it was suggested more community-focused teaching would be beneficial for the GP trainees.

2.3 Study Leave (R3.12): Not covered. No concerns raised in pre-visit information.

2.4 Formal Supervision (R1.21, 2.15, 2.20, 4.1, 4.2, 4.3, 4.4, 4.6): Not covered. No concerns raised in pre-visit information.

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 felt due to the size of the unit they were able to work closely with trainees and learn individual competence levels. During induction all staff members are introduced and within the education centre there is a photo board displaying all junior doctors. They told us that there are clear escalation policies for clinical governance and pastoral support which are all detailed at induction. When starting within the unit junior doctors are required to gain supervised sign-off for basic clinical skills such as, baby checks and cannulations. Trainers reported they were not aware of any instances where a trainee had been left to cope with a situation beyond their competence. Trainers felt that all consultants are approachable and accessible at any time.

Trainees: Trainees reported that they know who to contact for supervision during the day and out of hours. When seeking support from the consultant body trainees felt the majority to be approachable, although on occasions the response was less positive. None of the trainees felt they have had to cope with a situation beyond their competence. Trainees confirmed that guidelines when managing a patient are clear and easily accessible. Trainees told us that there has been a recent drive to improve

the consistency of the use of clinical guidelines and reported that the department are now following NICE (National Institute for Health and Care Excellence) and West of Scotland guidelines. Trainees confirmed that although initial steps are followed well, on occasions further steps were inconsistent dependent on the consultant. Trainees noted that although there was deviation from the guidelines the practices were not unsafe and trainees previously in place stated there had clearly been improvements made since they were in post.

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

Trainers: Trainers reported that they are aware of the curricular needs of each trainee cohort. GP and ST trainees have clinic experience scheduled into their rota. They reported that trainees can discuss any patient with the consultant during their clinic and all patients are discussed and reviewed at the end of the clinic. Locum cover is well provided to ensure that trainees access to clinics is protected.

Trainees: Trainees told us that they can attend a variety of outpatient clinics and that for GP and ST trainees this is scheduled into their rota. They confirmed the post has allowed them to develop their skills and competencies in managing acutely unwell patients. They noted the balance of non-educational tasks vs medical work is on par with other placements.

2.7 Adequate Experience (assessment) (R1.18, 5.9, 5.10, 5.11): Not covered. No concerns raised in pre-visit information.

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: Trainers reported that all ST trainees are encouraged to undertake an audit whilst in post. There are continuous re-audits or trainees have the opportunity, to complete one of their own interest. Audits have remained ongoing throughout the pandemic and the most recent audit on the management of Bronchiolitis was shared with the visit team.

Trainees: All trainees confirmed that they were able to participate in quality improvement projects.

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: We were told that trainees are given regular informal feedback and that where possible this is delivered on a 1 to 1 basis. Acknowledging the importance of providing feedback in a positive way, trainers ensure to adapt the style of feedback depending on circumstances. Trainers listed a variety of ways in which they provide feedback to trainees such as:

- Immediate debriefs
- Handover
- Greatix system
- Educational supervisor meetings

Trainees: Trainees reported that they receive regular informal feedback. They told us that due to the small size of the department there is a high level of continuity of care which is conducive to informal discussions. Trainees highlighted handover as a source of positive feedback.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: Following on from the Deanery visits the department routinely seek feedback from trainees. Dr Ben Rayen, Clinical Director, meets with trainees at the start of their post, mid-point and end to discuss and receive feedback. Dr Peter Armstrong, Director for Medical Education also sends out an online survey for trainees to complete. Any issues raised from feedback are discussed amongst the consultant body and steps taken to address.

Trainees – Not asked

2.12 Culture & undermining (R3.3)

Trainers: Trainers told us that they have continued work to enhance a positive team culture within the department, participating in team working/psychology teaching sessions. Weekly senior team meetings provide a forum to discuss any issues raised. The panel were provided examples of

concerns which had been adequately addressed such as providing bleep boxes to ensure trainees can attend training interruption free. Trainers acknowledged there may still be a perception of undermining behaviours but that as a consultant body they have awareness of this. They reported that there is a policy in place for reporting bullying or undermining concerns. Any allegation will be investigated by the senior team within the department (Clinical Director, General Manager and Associate Medical Director)

Trainees: Trainees reported that they worked in a very supportive department with approachable consultants. They told us that at times feedback can feel unnecessarily negative particularly for the junior (Tier 1) doctors who have very limited paediatric experience. When on duty, varying inter-consultant expectations regarding communication and decision making has the potential to make trainees feel undervalued. All trainees confirmed they had met with Dr Rayen during their placement and this was a highly valued meeting. They reported that if needed, they would raise concerns regarding bullying or undermining behaviours with the clinical lead, educational supervisor or training programme director.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Trainers reported that outpatient clinics and teaching sessions are built into the rota for trainees. They acknowledged the remote location of the hospital may have a negative impact on a trainee’s family life however, trainees have reported positive experiences at the site. To help address the low patient case numbers during the pandemic, enhanced training sessions were set up.

Trainees: Trainees told us that their rota is very well balanced and accommodates good access to learning opportunities. They reported that rota gaps are well managed, and they did not feel pressured to cover any additional shifts. Specialty trainees were not aware that the primary expectations from this placement beyond transitioning to middle-grade working were to allow them to focus on outpatient experience in a remote and rural context and to provide the opportunity for quality improvement projects. They felt it would be helpful if this was highlighted to them. Trainees raised concern over the joint obstetrics & gynaecology and paediatrics OOH cover on the tier 1 rota. O&G dominates the cover needed and trainees felt that should there be a paediatric resuscitation required, whilst the tier 1 doctor is committed to obstetric care, this would result in a lack of vital junior support

for the paediatric registrar. Junior trainees reported recent delays in receiving their rota which left planning life outside of work challenging.

2.14 Handover (R1.14):

Trainers: Trainers reported that there is a structured and effective handover three times per day. In addition, they have an informal meeting after completion of the ward rounds and the nursing staff safety brief which trainees can also attend.

Trainees: Trainees reported that there is a good, structured handover in place, which allows for discussion of all patients.

2.15 Educational Resources (R1.19):

Trainers: Trainees described a variety of educational resources available to trainees including:

- Education Centre
- Online resources
- West of Scotland paediatric guidelines
- Library
- Neonatal and paediatric simulation.

Trainees: Trainees reported there are adequate facilities and resources to support their learning. Not all trainees had experienced simulation training but those that had, found it to be a valuable exercise.

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

Trainees: All trainees reported that support is available to them if they were struggling with the job or personally. They provided an example of tailored support for a previous trainee.

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: Trainers reported that there is a structured educational governance team at the site. Prior to starting trainees are sent flow charts detailing the structure within the hospital and NES.

Trainees: All trainees would raise any concerns about the quality of training in the post through the feedback meetings held with Dr Rayen. The trainees previously in post had made suggestions to improve induction which had been implemented for the next cohort of trainees. Specialty trainees have the opportunity, to attend critical incident review groups (CIRG).

2.18 Raising concerns (R1.1, 2.7):

Trainers: Trainers encourage trainees to raise any concerns through the open culture of the department and the escalation policy is detailed at induction. Risk management meetings provide the opportunity to formally review cases and share learning from incidents.

Trainees: Trainees advised they would raise any patient safety concerns with the consultant on call or with their educational supervisor. They felt any concerns would be adequately addressed.

2.19 Patient safety (R1.2)

Trainees: Trainees reported that they would have no concerns about the quality and safety of care a relative or friend would receive if admitted to the department. However, trainees did report some residual inconsistencies in guideline application (see previous comments under Clinical supervision (day to day) paragraph 2.5).

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

Trainers: Trainers reported that adverse incidents are reported through the Datix system and reviewed at the risk management meetings. An immediate debrief and full review would follow any major incident. Learning points from adverse incidents are shared with trainees either via meeting or email.

Trainees: Trainees reported that adverse incidents are reported through the Datix system. They reported they were aware of the CIRG meetings and are encouraged to attend.

2.21 Other

We noted that both consultants and trainee groups often used the term “SHO”. It appeared that this term is in common usage throughout the department.

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:

- Foundation & General Practice – Range 7-9 Average 8
- Specialty Trainees – Range 7-9 Average 8

3. Summary

Is a revisit required?	Yes	No	Highly Likely	Highly unlikely

The visit panel noted the ongoing commitment of the clinical team and NHS board in improving the educational environment for trainees. There has been substantial ongoing progress made over the past 2 years. The application of guidelines is now much more consistent than in the past however, there is still some element of individual variation. There has also been clear progress in relation to the issues of perceived undermining behaviour however, there remain occasions when interactions with some consultants can be perceived as undervaluing or being unrealistically critical of the junior trainees. Both of these issues have been substantially improved but in order to maintain improvement and prevent relapse we would encourage ongoing future audits of guideline adherence and expansion of the regular DME trainee survey to specifically enquire about how corrective feedback is conveyed.

The positive aspects of the visit were:

- Significant ongoing progress in addressing concerns was noted. Very engaged clinical team and NHS board

- Handover was reported as excellent and provides a source for positive feedback
- Outpatient clinics are built into the rota for both GP and ST trainees and effectively delivered as an educational experience.
- There are opportunities for Quality Improvement activities and valuable involvement in the Critical Incident Review Group meeting for specialty trainees
- Clinical supervision and support within the department is good and trainees always know who to contact
- Good use of simulation training, which we encourage to be continued
- Example provided of tailoring support to individual trainee circumstances
- The introduction of consistent WOS guidelines over recent months, though there is still some individual variation in application. We recommend ongoing audit over the coming months
- The rota is well planned out and there is a clear effort made to address gaps which ensures the trainees are not pressurised or over stretched.
- The teaching programme delivered is good and trainees can attend bleep free sessions
- There is a focus on listening to trainee experience and adapting when required. The clinical lead holds regular meetings with the trainees as individuals.

The less positive aspects of the visit were:

- Delays in sending out the junior rota leaves planning life outside of work more challenging for trainees
- There is a degree of risk associated with the joint overnight cover of O&G and paediatrics by the tier 1 rota. O&G dominates the cover provided and trainees raised concerns should there be a paediatric resuscitation required whilst the tier 1 doctor is committed to obstetric care and a lack of junior support for the paediatric registrar. Although not flagged at the most recent visit in 2019, this issue was raised at the previous Deanery visits to O&G and Paediatrics in 2018, and it is an ongoing concern for trainees. See 6.1
- Progress has been made in addressing the historical undermining issues however, there remains a perception of undermining type behaviour within the department. At times day to day communication can be perceived as unsupportive by the junior doctors. Some correction and criticism can be perceived as unfair and expectations of the junior tier doctors from some consultants can at times feel unrealistic given that these trainees have no previous Paediatric experience. See 6.2

- Persistent use of SHO terminology amongst consultants and trainees

Review of previous requirements from 2019:

Ref	Visit requirement from 2019	Progress in 2021 visit
7.1	Allegations of undermining behaviour must be investigated, and if upheld, put in place an appropriate action plan must be instigated to address them.	Technically this requirement has been met as systems are in place. However, occasional interactions continue to be perceived as potentially undermining even if not raised as allegations. (see 2.12)
7.2	There must be a process that ensures trainees understand, and are able to articulate, arrangements regarding Educational Governance at both site and board level.	Addressed
7.3	FY2 and GP trainee cohorts should be made aware of CIRG meetings and when they happen	Addressed
7.4	Measures must be implemented to address the (ongoing) patient safety concerns described in this report regarding guidelines and patient management plans.	Partially (largely) met (see 2.5)
7.5	There must be active planning of attendance of doctors in training at teaching events to ensure that workload does not prevent attendance. This includes bleep-free teaching attendance.	Addressed

4. Areas of Good Practice

Ref	Item	Action
4.1	Adequate experience	Outpatient clinics built into rota for GP & ST trainees
4.2	Feedback	The clinical director has regular meetings with trainees to seek feedback

4.3	Feedback	Greatix system to recognise when something has gone well

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	Teaching	To further enhance teaching sessions for GP trainees it would be beneficial to include more community focused sessions (i.e. how should this issue be managed in primary care?)
5.2	Guidelines	Continue to audit the application of guidelines to ensure ongoing and improving adherence.
5.3	Curriculum Opportunities	It would be helpful to make clear to Paediatric ST trainees at the beginning of their placement that the primary objectives of their placement in Dumfries are: • Transitioning to middle-grade working • Obtaining good remote and rural OPD experience • To access opportunities for clinical governance & quality improvement work.
5.4	SHO Terminology	All references to “SHOs” and “SHO Rotas” should be actively discouraged.
5.5	Rotas	Rotas should be consistently issued in a timely manner, usually 6 weeks in advance.
5.6	Induction	All trainees should have timely access to IT passwords and system training through their induction programme. This appears to have been a one-off issue at the last induction, but it should be ensured that issues that caused the problem on that occasion have been corrected.

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	The Board & Department should address the double jeopardy issue that arises when there is a Neonatal (or Paediatric) resuscitation whilst the tier 1 trainee is committed to an Obstetric surgical procedure. Clear guidance should be produced about this which should be communicated to all Paediatric and O&G trainees at the beginning of their placement.	17th March 2022	
6.2	The Board must ensure that staff (including non-medical staff) behave with dignity, respect, care and compassion towards each other.	17th March 2022	

7. DME Action Plan: to be returned to QIM on 17th August 2021 fiona.paterson14@nhs.net

Ref	Issue	By when	Owner	Action(s)	Date Completed
6.1	The Board & Department should address the double jeopardy issue that arises when there is a Neonatal (or Paediatric) resuscitation whilst the tier 1 trainee is committed to an Obstetric surgical procedure. Clear guidance should be produced about this which should be communicated to all Paediatric and O&G trainees at the beginning of their placement.	**17th March 2022**			
6.2	The Board must ensure that staff (including non-medical staff) behave with dignity, respect, care and compassion towards each other.	17th March 2022			