Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	25th & 28th October 2022	**Level(s)**	FY/GP/ST
Type of visit	New Site Visit	**Hospital**	Royal Hospital for Children & Young People
Specialty(s)	Paediatrics	**Board**	NHS Lothian

Visit panel	
Dr Peter MacDonald	Visit Chair - Associate Postgraduate Dean – Quality
Dr Mandy Hunter	Associate Postgraduate Dean – Specialty
Dr Lisa Black	Foundation Training Programme Director
Mr Ian McDonough	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	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		
Trainers in attendance	24	
Trainees in attendance	3 x FY1, 3x FY2, 8x GPST, 8 x ST1-3, 15 x ST4-7	

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

Date report approved by Lead Visitor	November 2022

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 new site visit has been arranged to the Royal Hospital for Children & Young People in Edinburgh. The visit team will take the opportunity to gain a broad picture of how training is carried out within the hospital and to identify any areas of innovation or good practice for sharing more widely. The visit will provide an opportunity for trainees and staff within the unit/departments 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.

2.1 Induction (R1.13):

General Paediatrics: All trainees receive site and specific departmental inductions. Trainees receive a protected full day on site induction which includes:

- Common presentations,
- Introduction to South-East Teams site,
- Useful apps for guidelines,
- IT, and
- Orientation tour.

Those unable to attend the main induction will be sent log in details for the South-East website which hosts all presentations and a bespoke induction provided. Feedback is sought on induction programme from trainees and responded too.

Community Child Health (CCH) Trainers: Trainers are encouraged to link in with their allocated trainees at the start of their post. As trainees will work split sites during their placement, induction is also provided for St John's Hospital. Further induction topics and themes are covered within the departmental teaching programme over the subsequent weeks. They regularly seek feedback and review the induction content accordingly.

Emergency Medicine (EM) Trainers: Prior to starting trainees are sent out details of their rota, supervisors, and an online handbook. Departmental induction consists of tutorials, presentations, and escalation policies. Trainees are rostered to be available for this.

Paediatric Intensive Care Unit (PICU) Trainers: A 2-day comprehensive protected induction is provided acknowledging this is a new environment for many trainees. Cover on the ward is provided by advanced nurse practitioners (ANP's) or clinical fellows (CF). An online handbook is sent to trainees prior to starting. Handover encompasses a wide range of topics including:

- Use of specialist equipment,
- SIM sessions,
- Tour of department, and
- Talks from allied health professionals.

To provide further support to junior trainees and those new to the unit the department aim to schedule more senior trainees or those who have worked within the unit previously to the initial out-of-hour shifts (OOH).

Specialty Trainers: Each sub-specialty department provides comprehensive induction. Handbooks are routinely updated by trainees. They also receive information about how the department works, have a tour of the site, and meet staff. Some departments record induction via MS Teams which allows those unable to attend to review later.

Bespoke inductions are provided for trainees unable to attend the specific departmental sessions.

ST1-3 Trainees Admissions Unit: All trainees present received a 2-day induction which they felt equipped them well to work in the unit. Trainees felt that there were a few minor additions that might be worth considering, however they reported that this is the subject of a current QI project.

ST4-7 Trainees Emergency Medicine & Intensive Care (EM & PICU): Trainees told us that they received adequate induction to their units. Those working in emergency medicine received a half day induction and were supernumerary on the rota for clinical work. Within intensive care, trainees completed a 2-day induction, they felt well prepared for their role and did not suggest any improvements required.

Community Child Health Trainees: Trainees received extensive inductions to both general paediatrics and community child health (CCH). To further enhance the CCH induction, it was suggested a trainee handbook would be beneficial.

FY 1 & 2 Trainees: All trainees present received induction which they felt adequately prepared them for their roles however, they told us it would be beneficial if more practical aspects of the job were shared with them in the form of a FY doctor handbook. FY1 trainees advised that their shadowing week had been disorganised and they had not all been allocated named individuals to shadow. IT access had also been delayed until mid-week which hindered their ability to fully participate. Some Trakcare shortcuts are useful but they could be better flagged rather than discovered on the job.

GPST Trainees: 1 trainee who started out of step did not receive a formal induction but was provided with ad-hoc training on the wards. All other trainees described induction as good, those working within the emergency department told us they would like more detailed information on their roles and responsibilities.

Sub-Specialty Trainees: All received site induction but told us a more defined cohort tailored induction would be preferred. The tour of the hospital was delivered by a volunteer who did not have access to clinical areas therefore trainees were unable to visit these units which greatly devalued the tour. For trainees returning to the hospital a targeted site induction focusing on need-to-know information that has changed would be desirable. Trainees working within the respiratory team commended the online induction booklet.

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

All Trainers: Trainers reported that there are lots of teaching opportunities available within the site. GP and FY trainees have protected non-clinical time built into their rotas to facilitate attendance. Specialty teaching is delivered in person on Friday afternoons, these sessions are recorded using MS Teams and trainees are encouraged to track their attendance in their portfolio. We were told consultants take trainees pagers to allow them to attend teaching uninterrupted but acknowledged this was not always possible for trainees in the emergency department.

Although not timetabled, the department facilitates FY trainee attendance at centralised core teaching. The majority of GP curricular needs are met through the induction programme and trainees are encouraged to upload this to their portfolios.
Opportunities for informal teaching on ward rounds and during handover are utilised whenever possible. When service allows, those working is specialties can attend both their departmental teaching and general paediatric sessions.

EM Trainers: Whilst working within the emergency department trainees have the opportunity, to attend weekly departmental teaching, medical/trauma simulation sessions and trauma teaching. ST4-ST8 trainees are scheduled to attend regional teaching. ST3 trainees are not guaranteed this though the department do try to facilitate attendance if service levels allow. GP trainees are allocated clinical time to attend specific GP paediatric teaching once every 3 months.

PICU Trainers: Weekly department teaching is mostly trainee-led, however the initial first 6 sessions are dictated to cover essential topics. Sessions are linked with Glasgow and trainees have the option to attend both regions' teaching sessions.

Specialty trainers: All units provide weekly teaching sessions which are recorded. Trainee attendance is expected unless dealing with an emergency. Trainers told us it can be difficult to ensure those working less than full time attend sufficient teaching sessions. There are numerous opportunities to attend outpatient clinics, the 'First Fit' clinic proves popular with GP trainees as this enhances their learning for their future roles as GPs providing insights into the GP referral path and management of common complaints

ST1-3 Trainees Admission Unit: Trainees reported that there is weekly general paediatric teaching. They also have the opportunity to attend departmental teaching which is scheduled for 30 mins 3 times per week. They found it easy to attend the sessions unless holding the referrals bleep. Sessions are recorded, however due to workload the majority of trainees have had to watch sessions in their personal time.

ST4-7 Trainees EM & PICU: Teaching is supported within both departments and trainees told us they can attend weekly sessions. Within PICU trainees are paged to attend teaching and although not

bleep-free there is an awareness that, when teaching is happening, interruptions should be limited to emergencies only. Trainees said the sessions are relevant to their training.

CCH Trainees: Unless busy in clinics trainees can virtually attend the general paediatric teaching session, some trainees working LTFT will watch the sessions in their own time. They can also attend grand rounds and a variety of child protection meetings.

FY 1 & 2 Trainees: Trainees told us that the departmental teaching available to them was abundant and of a high standard. They do not get study time to review recorded sessions and most tend to watch these in their personal time. Attendance at regional teaching is facilitated, although not always bleep free.

GP: GPST's confirmed they could attend thrice weekly 30-minute teaching sessions which start at 08:30. For those working in subspecialty units it can be challenging to attend as they are scheduled to start work in the wards at this time. GP-specific teaching is delivered once per month within the hospital, trainees felt this was not adequate as shifts or LTFT working meant they could go some months without attending a session. Teaching within individual departments is not targeted and its usefulness to future GP practice is variable. 1 trainee had attended a NES teaching day and found this to be very good, they commented on the helpfulness of the rota coordinator.

Sub-Specialty Trainees: Trainees can attend departmental teaching although this is not always bleep free. Some departments lack consistent instruction for a designated person to take the pagers. Occasionally service pressures and staffing can also affect their ability to attend interruption free. General paediatric teaching takes place on Fridays (commonest non-working day for LTFT trainees) and trainees felt this could be moved or rotated to facilitate increased attendance.

2.3 Study Leave (R3.12):

Trainers: There are no issues supporting study leave. Trainees are asked to give as much notice as possible but changes to the rota can be made to support requests.

ALL: Study leave is supported.

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

All Trainers: Specialty trainees are allocated their educational supervisor (ES) at ST1, this remains their ES throughout training unless a request is made to swap. Clinical supervisors are allocated where possible based on trainee interests. To help ensure continuity and familiarity with the curricular requirements, trainers aim to work with the same level of trainees each rotation. Any known concerns regarding a trainee would be discussed and an appropriate support plan put in place. All trainers have time recognised within job plans and roles are considered during appraisal however some felt that the amount of time allocated was not sufficient to carry out all elements of the role. Trainers commented on the supportiveness of the TPD's specifically around the new curricula.

Trainees: All trainees had been allocated educational supervisors, met with them, and agreed learning plans. Trainees confirmed having good quality educational supervision.

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)

All Trainers: Trainers reported staff can differentiate between the different levels of trainees using colour coded lanyards. Both during the day and out of hours (OOH) there is a clear escalation policy for who to contact for support. The acute handover provides the opportunity for introductions and any absences for the day will be discussed ensuring trainees are aware who to always contact. Following feedback from previous trainees the emergency department have increased the number of advanced nurse practitioners (ANP's) working night shift to ensure adequate support.

Trainees: All trainees know who to contact for support and have never had to cope with problems beyond their competence. Trainees felt that their senior colleagues and nursing staff had been very approachable when support had been sought. Some very junior trainees have felt uncomfortable when asked to carry the specialty registrar bleep. Although not asked to act up as registrar some trainees perceive they have more responsibility than they actually do as consultants are always contactable to discuss any calls. GPST's told us that at times they can feel overly supervised and would like more autonomy in decision-making matching their skills and experience.

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

All Trainers: All are aware of trainee's various curriculum requirements. Maintaining responsibility for a specific cohort of trainees each year, ensures familiarity with requirements and e-portfolios.

General Paediatric Trainers: Clinics were scheduled into GPST's rota, tailoring to their personal learning needs where possible. Although not scheduled into their rota, FY trainees are welcomed and encouraged to attend clinics. ST2 trainees have a 4-week specialty block scheduled into their rota providing them with opportunities to attend sessions that they find most useful to their learning, 2 of these weeks the trainees are supernumerary on the rota. To help support areas of the curriculum that are harder to achieve such as paediatric gynaecology the unit plan to create a bank of presentations.

CCH Trainers: Trainees have access to a broad range of clinic experiences within the department and have the opportunity, to further enhance learning opportunities through various departmental meetings and quality improvement projects. Trainers advised areas of the curriculum which were more difficult to achieve were public health and child and adolescent mental health.

EM Trainers: Trainers reported many learning experiences for trainees whilst working on the shop floor. Trainees are encouraged to attend clinics and when suitable they provide the opportunity for trainees to act as the consultant in charge. As procedures such as catheter insertion and lumbar punctures are referred to the medical team the trainers hope to produce a practical skills box to address these competencies. GPST admin time has now been increased to help facilitate attendance at more outpatient clinics.

PICU Trainers: The department ensure all trainees receive adequate training opportunities. If specific trainee learning needs are identified the team would highlight opportunities to achieve these. GRID or adult ICM trainees are prioritised for certain competencies required in their curriculum. To help address any perceived imbalance of opportunity, the trainers set expectations as to what can be achieved from the role at induction.

GP Trainers: They told us that GPST's can at times feel they are not challenged enough and are more supervised than previous posts. Trainers encourage them to highlight their skills and experience to the team.

ST1-3 Trainees Admissions Unit: Clinics are not built into their rota, trainees said they would find it beneficial to attend when service allowed. ST2 trainees confirmed they get a 4-week specialty block but noted that these would be pulled to cover staff shortages or service pressures when necessary.

ST4-7 Trainees EM & PICU Trainees: These trainees were positive about their learning opportunities.

CCH Trainees: Trainees reported they could achieve the majority of their learning outcomes. Occasionally they have been asked to leave clinics due to the size of the room or sensitivity around the case. When this happens, they are always included in post discussions. They are always supported by their senior colleagues. There is a high level of administrative tasks associated with the role, but trainees felt these were useful learning experiences.

FY Trainees: Although not built into the FY1 rota, trainees can attend clinics when service allows. Not all FY2 trainees have scheduled clinic time however they felt that if they were to ask for clinic time this would be supported. All FY trainees rotate through the emergency department which enables them to develop and maintain their skills in managing acutely unwell patients.

GP Trainees: This post has potential to provide good training opportunities in the acute assessment unit and attending outpatient experiences. However, trainees spend most of their time working in sub-specialty departments which are of limited relevance to a future career in general practice. Whilst working on a rota alongside FY trainees their duties do not always map to their level of experience. Clinic allocation has been variable across the group with some trainees receiving 2 weeks and others 2 days.

Sub-Specialty Trainees – Trainees told us they had lots of opportunity to attend clinics but almost all described a lack of non-clinical time in their rota (for research, Q.I. and even simple administrative tasks). Those working within gastroenterology were allocated inpatient days and admin time. Not all trainees felt able to develop their skills in assessing and managing outpatients to the degree that they

felt was appropriate for their stage of training. Significant trainee time was committed to providing a phlebotomy service with even senior trainees describing being called to clinics simply to bleed patients.

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

All Trainers: Trainers reported that there are plenty of educational opportunities for trainees to achieve their assessments.

ST1-3 Trainees Admission Unit: Trainees reported no issues in completing their work-place based assessments (WPBAs). A weekly summary is provided, and they are encouraged to highlight any learning outcomes required.

GP Trainees: Trainees reported some difficulties in completing WPBA's as they had limited contribution to patient management.

All other trainees: All felt well supported, were able to complete WPBAs and have them signed off easily. CCH trainees complete their out of hours commitments within acute care and reported good scope to complete assessments.

2.8 Adequate Experience (multi-professional learning) (R1.17):

All Trainers: Trainers advised that most specialties had multi-disciplinary meetings on a regular basis, that all staff members were welcome to attend. Morbidity & Mortality (M&M) meetings were also multi-disciplinary, as were some of the teaching sessions. The flattened hierarchy culture within the department ensures all members of the team are respected and able to contribute their views.

All Trainees: Trainees told us they have several opportunities for multi-professional learning.

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

All Trainers: Trainers reported that they encourage all levels of trainees to take on a quality improvement project, ST3+ trainees are required to complete an audit whilst in post. There is a list of suggested projects but trainees also have the opportunity to complete a project of their own interest.

All Trainees: There are opportunities to get involved in projects, but the trainees have found there is not always enough time for them to complete the projects during their working hours. There is a lack of physical space with no doctors' room or library. The specialty trainees state that the trainers encourage them to participate in the projects alongside other clinicians. The FY trainees were unaware of any Quality Improvement lead within their department or the wider hospital.

2.10 Feedback to trainees (R1.15, 3.13)

Community Child Health Trainers: They meet with trainees before and after clinics and provide robust feedback. When working alongside the child protection team, trainees are always supported.

General Paediatric Trainers: Trainees receive regular feedback on their assessment and management plans on all new admissions following a senior review. They felt that feedback was also available to trainees during ward rounds, handover and on the job learning when clinical workload allowed. Some consultants summarise weekly learning points and disseminate these via email.

EM Trainers: Consultants encourage trainees to discuss every patient with them for the first few months as this may be their first paediatric post. This provides opportunity for informal feedback and teaching. Similar, to the general paediatric trainers, a thank you email is sent at the end of the week summarising learning, any areas requiring further discussion with a trainee would be delivered on a one-to-one basis or shared with the trainee's educational supervisor for further discussion.

PICU Trainers: Due to the high level of consultant involvement in patient care, informal feedback was regularly provided to trainees. Trainees are encouraged to assess patients, create a management plan, and discuss with consultants.

Specialty Trainers: Trainers recognise the importance of giving positive feedback and provide this both face to face and via email.

ST1-3 Trainees Admissions Unit: Trainees told us that feedback can be variable. They felt it would help to improve the continuity of work and feedback opportunities if their rotas were more sequential i.e. involving them in the review of new admissions on the day after they have been receiving.

PICU Trainees: Trainees can discuss management plans and receive feedback on them.

EM Trainees: Trainees reported they receive good levels of feedback particularly, when participating in an extended supervised learning event (ESLE) in which a consultant 'shadows' them for 2 hours with post event discussion.

Community Child Health Trainees: They confirmed they have ample opportunity to receive feedback both in the community and in their OOH acute work.

FY Trainees: Feedback received can be variable dependent on the team they are working with, although trainees said, if it was sought, it would be provided.

GP Trainees: When working in the admissions unit trainees report good levels of supportive feedback. Opportunities in other units were limited due to lack of decision-making opportunities.

Sub- Specialty Trainees: Trainees receive regular good and constructive feedback during the day, it can differ at night depending on whom the trainees are working alongside. They told us they feel their opinion is valued.

2.11 Feedback from trainees (R1.5, 2.3)

General Paediatric Trainers: A mid-term review is held with all specialty trainees seeking information on what they have gained and what challenges have presented in the post. There is a trainee forum which a representative from the training groups attends, meetings are summarised and sent to trainees via email. In addition, the TPD's have reinstated 'Tea with the TPD's' which provides an informal opportunity for trainees to meet with the TPD's.

EM & PICU Trainers: Specialty trainees working within the emergency department are sent an end of block survey however this is not currently sent to the FY trainees. Clinical Supervisors within PICU seek feedback from trainees at their end of post review.

Specialty Trainers: Due to the supportive culture within the department's trainers told us that there are lots of informal opportunities for trainees to feedback on their experience. They acknowledged a lack of formal mechanism for the GP and FY trainees to feedback.

ST1-3 Trainees Admissions Unit: Trainees had been able to attend Tea with TPD meetings and participated in a session regarding their rota.

EM Trainees: The senior registrar attends management meetings where they seek feedback and update the group. There is also a South-East trainee rep who can raise issues at the Specialty Training Committee although they try to resolve issues locally in the first instance.

PICU Trainees: Trainees would use their educational supervisor meetings to feedback on the quality of their training.

CCH Trainees: They would feel comfortable discussing with any consultant on call but noted it would be beneficial to create an anonymised feedback system.

FY Trainees: Trainees had not yet had the opportunity to provide any feedback to the management team. They felt they would be able to feedback on their training at their end of placement meeting.

GP Trainees: Similar, to their FY colleagues, they had not had the opportunity to feedback. They told us if they had any issues, they would feel comfortable raising them.

Sub-Specialty Trainees: A newly appointed trainee rep will seek to address issues raised. Trainees were aware the majority, of issues raised previously were related to the site and not individual departments were there is a general desire to improve training.

2.12 Culture & undermining (R3.3)

All Trainers: Trainers reported that from induction they embed the positive culture of the department, highlighting the openness of the multidisciplinary teams. They ensure trainees are aware of their expectations, the value of their role and what opportunities are available to them. The trust run active bystander sessions for all and there is a planned bullying and culture session scheduled for 2023. Each department has introduced various measures to ensure trainees feel part of the team such as:

- Afternoon tea for those working on the wards,
- Induction gift,
- Photo boards with fun facts,
- Newsletters,
- Super Sundays, and
- ST1-2 buddy system.

Instances of undermining had been escalated and adequately addressed. An equality, diversity and inclusion group has been implemented and trainees are encouraged to participate.

All Trainees: All trainees felt they worked in a very supportive unit, trainees within the ARU told us about an instance of undermining but that it had been dealt with appropriately. All are aware how to escalate any concerns. Trainees who had previously worked in the unit commented on the positive culture change and desire to improve training from the consultant body.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Both trainers and trainees described acute staffing pressures from May-August 2022.

All Trainers: They acknowledged the challenges of working in a new site post-pandemic and the demands of the rota, which have been exacerbated due to COVID-19. Gaps on the rota are put out to a select group of locums. Within the Emergency department gaps are absorbed by the consultants, other departments rely on trainees to provide cover and commended them on ensuring the rota is well staffed during these times. Trainee feedback is sought and responded to. The specialty rota is

currently well staffed although trainers highlighted the impact that maternity leave and less than full time working can have.
Dealing with certain cases such as child protection or mental health can be stressful for trainees but the team work hard to ensure trainees are fully supported during these times.

ST1-3 Trainees Admissions Unit: Trainees said gaps on the rota fall to them to cover, this has resulted in some trainees experiencing feelings of burnout. OOH shifts are generally covered but during the day the impact of gaps resulted in an increased workload for them. Unless working their ST2 specialty weeks, access to clinics was limited.

EM & PICU Trainees: These trainees told us their rotas are adequately staffed, any gaps are covered internally. Their current rota accommodates access to learning opportunities and within PICU trainees have assigned admin days on their rota.

CCH Trainees: There are currently no gaps on the rota and the hospital have employed a clinical fellow. On occasions, trainees can be pulled from their community post to cover the paediatric rota.

FY Trainees: Trainees are asked to back-fill sickness gaps on the rota and some trainees felt uncomfortable with the notification process. They felt the responsibility to ensure their shift was covered created unnecessary stress and pressure whilst being unwell. There is also a lack of guidance around how to access locum payment or time in lieu for those covering shifts.

GP Trainees: Trainees reported no issues with their rota.

Sub-Specialty Trainees: Trainees said their rota had improved since August. Gaps are managed via email, and some felt pressure to cover shifts. There are limited opportunities or adequate space for rest breaks both on call and after shift. Trainees can not access their rota unless in the hospital, but we heard of plans to store the rota on MS Teams which would resolve the issue.

2.14 Handover (R1.14):

All Trainers: The hospital wide safety huddle begins at 8am with medical, nursing and management representation. If a clinician requires to attend the CEPOD huddle it begins at 8.15am. The medical

handover between clinicians is at 9am. There is another handover at 4pm involving the doctors on the wards, senior nurses, and pharmacists. At 4.30pm the day team handover to the night team and at 9pm the evening to night team.

CCH have twice daily handovers within the child protection hub, all cases are discussed providing learning opportunities for trainees.
Trainers felt there was robust and effective handover in place for all departments providing safe continuity of care.

All trainees: Departmental handovers in the Acute Receiving Unit, Emergency Department and PICU are all described as being fit for purpose with no issues noted. The wider hospital handover process was described as following a good SBAR model and being consistent in practice but having excessive content and not succinct enough. Some trainees reported that there can be ambiguity as to which specialty is taking over responsibility for new admissions. There are times when there is a lack of communication about patients being transferred from surgical to medical care. Other trainees felt that there can be excessively detailed discussion in the handover meetings yet important information may be hidden in the detail. Trainees did have some ideas as to how this could be improved.

2.15 Educational Resources (R1.19):

All Trainers: Specialty trainees are provided with their own laptop and have access to an educational area called Sphere. There is no on-site library however trainees can access a shared drive for learning. Departments run regular simulation sessions which are multidisciplinary.
Telecommunications concerns with poor WIFI signal limited mobile and bleep drop out zones.

All Trainees: Each cohort of trainees reported a lack of available space to complete administrative or study tasks.

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

All Trainers: To help support trainees there is a dedicated wellbeing consultant within general paediatrics and peer support is provided for significant events.

All Trainees: No issues were raised around support

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

All Trainers: There is good communication with the TPD's and ADME which helps to improve training.

All Trainees: Trainees confirmed if they had any concerns about their training, they would raise them with either their Educational Supervisors, their Training Programme Director, or the trainee rep.

2.18 Raising concerns (R1.1, 2.7):

All Trainers: Trainees are encouraged to raise concerns through the open culture of the department.

All Trainees: All would feel comfortable raising any concern within the team however concerns relating to adverse incidents or patient safety would be raised through the Datix system.

2.19 Patient safety (R1.2)

All Trainers: No concerns around patient safety were raised. Capacity for child and adolescent mental health patients is limited which results in patients being boarded into acute paediatric wards which can be challenging although, not unsafe.

All trainees: Trainees have no concerns regarding patient safety and are confident any issues would be dealt with appropriately.

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

All Trainers: They advised that adverse incidents are reported through the Datix system and that if a trainee is involved, they receive support and feedback. 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 and those who had been involved in Datix incidents had received feedback on them. Some trainees were able to attend risk management meetings, but this was dependent on where they were working.

2.21 Other

Both the trainers and every group of trainees that we spoke with highlighted facilities issues relating to the site. A lack of available car parking/park-and-ride on site is causing significant upset amongst the workforce causing inconvenience, expense, personal safety, vulnerability, and time issues. Catering facilities in and out of hours are suboptimal.

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 – Range 6-8, Average 7.6
- General Practice Range 6-9, Average 7.1
- ST1-3 Admissions Unit – Range 6-7, Average 6.5
- CCH Range 8-9, Average 8.5
- PICU & PEM Trainees – Range 7-9, Average 8
- ST4-8 Sub Specialty Trainees – Range 6-9, Average 7.3

3. Summary

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

Overall, this was a positive new site visit with good levels of engagement across the trainee cohorts and trainers. There are lots of good training opportunities within the site and some areas requiring improvement which are reflected in the requirements and area for improvements.

The positive aspects of the visit were:

All levels of trainees detailed:

- Positive culture and flattened hierarchy

- Supportive, committed trainers who are working hard to optimise training at the site.
- There are lots of educational opportunities available including substantial clinic experience.
- Variety of teaching opportunities available both formally and informally.
- Multi-disciplinary working is embedded within the teams
- No patient safety concerns, and all trainees would be happy to have family or friends cared for within the hospital.
- FY2 trainees have opportunities to attend outpatient clinics
- Foundation and GP trainees were largely happier than many of their colleagues working in similar posts.

The less positive aspects of the visit were:

All trainees highlighted facility issues at the site which are out-with individual departments' control.

- A lack of available car parking/park-and-ride on site is causing significant upset amongst the workforce causing inconvenience and expense. However, issues of personal safety, vulnerability, and protracted travel time added to very long shifts are the major concerns.
- There are very limited non-clinical learning areas for study, research or QI activity.
- A lack of space for rest on down-time, or for rest prior to travel home after a long shift if trainees feel too tired to travel (some trainees may be have a placement on this site whose main programme placements and homes are in East or West of Scotland).
- Major staffing issues from February-August 2022 and although there has been improvement from August onwards these pressures will inevitably recur. Long term supplementation of the trainee workforce is needed to mitigate against future pressures. Trainees described issues of burnout during this time.
- The junior cohort of trainees felt the acute medical handover to be overly long and insufficiently focused.

Acute Receiving Unit:

- These trainees were most affected by workload and burnout issues during Feb-Aug 2022
- Safeguarding competencies can be difficult to achieve for junior trainees due to such cases being very much led by senior staff.

- Trainees felt it would help to improve continuity of work and feedback opportunities if their rotas were more sequential to allow review of new admissions the following day.

Intensive Care:

- Trainees felt it would be desirable to have more practical procedural opportunities. Whilst trainees recognise this is not an essential part of their curricular requirements many would consider it to be a desirable enhancement.

Emergency Medicine:

- This group of trainees were most positive about their departmental experience and had no suggestions for improvement.

Community Child Health:

- Trainees would benefit from more time and flexibility to attend subspecialty clinics to allow development of their own specialty interests.

FY Trainees:

- The FY1 shadowing week was disorganised and trainees were not allocated individuals to shadow. IT access was not provided until mid-week which impaired the value of the week.
- The notification process to back-fill gaps due to sickness can put an unhealthy pressure on some trainees and can leave the unwell individual feeling an inappropriate personal responsibility to source shift cover.
- Trainees have felt uncomfortable when asked to carry the specialty registrar bleep. Although not asked to act up as registrar some trainees may perceive they have more responsibility than they actually do. That perception may still be a source of stress.

GP Trainees:

- GP trainees come to the placement with varied levels of experience and require a level of responsibility that fits with their personal experience.
- The monthly GP focused teaching is limited and dependent on attending a certain day which means some trainees can go months without attending due to shifts/LTFT.

- Some clinical experiences are of limited relevance to a future career in general practice. Trainees told us working within the acute assessment unit and attending outpatient experiences are most beneficial to them and they would appreciate more of this experience and less subspecialty work.

Sub-Specialty Trainees:

- Handover is overly broad with too many patients discussed and can leave trainees unsure which patients require their attention.
- Lack of time for non-clinical activity scheduled into rota.
- Not all trainees felt able to develop their skills in assessing and managing outpatients to the degree that they felt was appropriate for their stage of training.
- Lack of (or insufficient) phlebotomy service for outpatients resulting in a significant amount of time committed to phlebotomy and senior trainee time being committed to non-educational activity (getting called to clinics simply to bleed patients).

4. Areas of Good Practice

Ref	Item	Action
4.1	FY trainees have scheduled clinic attendance	

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		Guidance on roles and responsibilities for the GP trainees' working within the emergency department.
5.2		FY and CCH trainees would benefit from having a handbook.
5.3		For specialty trainees returning to the hospital a more targeted induction would be preferred.

5.4		Organised FY1 shadowing week ensuring all trainees have IT access and named individual prior to starting.
5.5		The department should publicise the identity and function of the Quality Improvement lead.
5.6		Due to set teaching days, some trainees are regularly missing sessions and must catch up in their own time.
5.7		To facilitate attendance at sub-specialty teaching sessions it would be helpful to identify a recognised person for trainees to hand their bleep to.
5.8		Formalise in a protocol what is expected of FY doctors (in sub-specialties) when asked to hold the registrar bleep.
5.9		The department should explore mechanisms for building outpatient experiences for trainees working within in the admissions unit.
5.10		The dept could examine the admissions unit rota to see if there is potential to increase trainee involvement in ward round reviews following their receiving shifts.
5.11		Clarify expectation and responsibility of FY doctors when notifying sickness.

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
7.1	The Board must provide sufficient facilities to enable doctors in training to fulfil their duties at work efficiently and to support their learning needs. (*Relates to facilities for non-clinical work such as audit, research etc*)	**28th July 2023**	**All trainees**
7.2	Appropriate outpatient clinic experience must be provided for specialty trainees. Clinic experience must be active participation (rather than merely observing) as appropriate to the level of trainee.	**28th July 2023**	**Specialty**

7.3	Handovers must be reviewed and developed to be more effective.	**28th July 2023**	**All trainees**
7.4	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.	**28th July 2023**	**All trainees**
7.5	The training opportunities provided to GPSTs must be tailored to their needs	**28th July 2023**	**GPST's**
7.6	The FY1 shadowing week must be structured with named individuals for each trainee and sufficient access to IT systems.	**28th July 2023**	**FY**

7. DME Action Plan: to be returned to QIM on

Ref	Issue	By when	Owner	Smart Objective	Date Completed
7.1	The Board must provide sufficient facilities to enable doctors in training to fulfil their duties at work efficiently and to support their learning needs. (*Relates to facilities for non-clinical work such as audit, research etc*)	**28th July 2023**			
7.2	Appropriate outpatient clinic experience must be provided for specialty trainees. Clinic experience must be active participation (rather than merely observing) as appropriate to the level of trainee.	**28th July 2023**			
7.3	Handovers must be reviewed and developed to be more effective.	**28th July 2023**			
7.4	Tasks that do not support educational and professional development and that compromise access to formal learning	**28th July 2023**			

	opportunities for all cohorts of doctors should be reduced.				
7.5	The training opportunities provided to GPSTs must be tailored to their needs	**28th July 2023**			
7.6	The FY1 shadowing week must be structured with named individuals for each trainee and sufficient access to IT systems.	**28th July 2023**			