NHS
Health Education England

Directorate of Education and Quality

Postgraduate School of Paediatrics Visit

Cambridge University Hospital NHS Foundation Trust (Addenbrooke's Hospital)

Wednesday 27th July 2016

Visit Report

Visiting Team:	**Trust Team:**
Dr Nisha Nathwani, Regional Advisor for Paediatrics Dr Andrea Turner, Training Programme Director ST3-5 Dr Vipan Datta, Training programme Director ST 6-8 Dr Jonathan Waller, Deputy Postgraduate Dean Ms Susan Agger, Senior Quality Improvement Manager	Mr Richard Millar, Deputy Medical Director Dr Shazia Hoodbhoy, College Tutor, NICU Dr Gautam Ambegaonkar, College Tutor, Paediatrics Mrs Mary Archibald, Medical Education Manager Miss Hannah Weeks, Senior Medical staffing Advisor Mrs Sue East, Deputy Medical Education Manager Dr Louise Selby, Chief Resident trainee for Paediatrics Miss Hannah Bavalia, Speciality Administrator for Paediatrics

Purpose of visit:

The purpose of the visit was:

- To review progress made in the department since the last School visit on 25th August 2011 and the QPR visit on 24th February 2015, and following the appointment of dual paediatric tutors, Dr Shazia Hoodbhoy in the neonatal intensive care unit and Dr Gautam Ambegaonkar in paediatrics.
- To review progress against the Trust's action plan following the QPR recommendations for the department.
- To discuss the 2016 GMC Survey which identified CUH as a red outlier in NNU for workload and in Paediatrics for Handover. NNU was also Pink for supportive environment and Paediatrics was Pink for adequate experience.

Meeting with Paediatric Tutors:

Dr Hoodbhoy updated us on progress in supporting training across both areas of the department over the last year. She presented a well thought out presentation summarising the trainee numbers, placements, educational supervisor details and the training experience. The presentation covered both areas and confirmed the progress that has been made within the faculty group, meetings with trainees, the role of the Senior Resident trainee and the teaching programme in place. The presentation also identified the work that had taken place following the last visit (2011) and the recent QPR visit (2015).

They confirmed that they both meet regularly and have regular meetings with the senior trainees and the wider trainee group to discuss training issues. They also have worked hard to accommodate and help the integration of the Academic trainees. They identified fundamental differences between training on the neonatal unit and in general paediatrics.

Dr Hoodbhoy highlighted that they have made progress in the neonatal unit with the learning environment for

trainees and that the trainees report to feeling well supported. She was clear that this work needed to continue and that she continues to review the situation. The teaching programme has changed with the introduction of trainee led teaching and formal Consultant led teaching. The teaching is time protected although not bleep free.

Dr Hoodbhoy then went on to talk through the action plan that was created to address the issues in paediatrics identified in the QPR visit. They have had various meetings with the management team to try and look at the Consultant rota and to improve the support consultants are able to provide trainees during working hours but especially out of hours. They are aware that although a discussion has been had with the consultants the trainees report no change in the support provided or an improvement in the availability of the consultants after 5pm. Some specialities are able to provide high quality training and educational opportunities and support but still a significant proportion have demonstrated no improvement. This they feel for a unit such as CUH with its tertiary status and complex speciality admissions is making the environment unsafe for trainees.

When asked whether they had adequate support and time in their job plan both felt that for the number of trainees, the number of Educational supervisors and the differing educational needs of the trainees that 0.5pas in their individual jobs didn't reflect the time they spent supporting the trainees placements. Both have raised this at their job plan meetings since appointment 1 year ago.

Meeting with trainees:

The visiting team met a representative group of trainees at level 1 and 2, this included academic trainees at level 1, and the senior resident trainee. Although there was no foundation trainee at the meeting we were given feedback that they had shared to the trainee reps. Some of the trainees had rotated across both paediatric and the neonatal unit and they were able to reflect and give feedback of their experience in the two areas. The senior resident trainee and the trainee's rep presented collated feedback from all trainees following discussions prior to the visit. We were also able to receive constructive individual feedback from the high number of trainees present at the visit. The trainees were clear that their placements in CUH provide a rich environment for learning and that there was a variety and complexity in the patient case mix. They felt that there is ample opportunity to learn and to develop both clinical and technical skills. Within individual departments there is the opportunity to take part in teaching, audit and various projects. The main concern raised by both, level 1 and 2 trainees related to the significant difference in the learning and supportive environment between the paediatric placement and the neonatal unit. This also extended to different speciality placements within paediatrics. The feedback from trainees outlined below has been divided into the two clinical areas i.e. paediatric and neonates to help focus on the significant difference.

Feedback from trainees on NNU

Generally the feedback from the neonatal was very positive. They felt very supported by the consultants and they were clear that they received appropriate training and experience. There were some concerns raised by level 1 trainees' concerning the current difficulties with the rota due to sickness levels. The working relationship on the unit is noted to be generally good and only occasionally did the trainees feel that there was tension with the relationships between trainees themselves, or with ANP and senior nurses. However, the trainees did not feel this was a significant problem. Trainees were positive that the consultants were always present onsite, until 10pm, and they were all very accessible. There is also good consultant support at the weekends. All the trainees felt that the consultants were very supportive, that they were keen to teach and were very visible on the unit. The trainees fed back that they were given opportunities to be involved in teaching, audit and guideline development. Trainees were also supported in developing leadership roles. Trainees felt that there was always opportunity to complete WBAs and even with the

problem with eportfolio they were supported by consultants in completing their ARCP requirements. There was opportunity given to complete procedures with support and guidance.

The rota was reported as having no fixed pattern and this could be difficult for the trainees, which for the level 1 currently has been an issue due to gaps in the rota numbers. Currently they have 2-3gaps on the level 1 rota due to sickness and unfilled posts. Being a level 3 unit there is sometimes a struggle to get appropriate locums so this means the level 1 trainees are doing more of the cover and feel sometimes the 1 in 3 w/e cover can be difficult. But due to the flexibility of the rota it is then possible for them to be given a break later within the rota cycle.

The level 1 trainees are aware that the current issues were unpredictable and the tutor is trying to support the trainees but to find locums who are prepared to work in the busy level 3 NNU is hard. In view of this the trainees are short of 1 person on most days.

Level 2 trainees also felt that there was no pattern to their rota but with this there is then the potential for flexibility so they were able to take annual and study level when needed.

There is weekly Consultant led teaching on the unit which is time protected, which all trainees felt was very good and they were positive about the standard and content. There is also trainee led teaching which is generally good but if there was consistent consultant presence the trainees felt this would be better.

Level 2 trainees were able to attend regional teaching but level 1 due to the rota were not always able to.

When asked - Would they recommend the training on NNU?

All said yes but the Level 1 trainees feel the current rota situation has made their placement difficult.

Feedback from trainees on Paediatrics

Unfortunately the training environment and support for trainees in paediatrics raised significant concerns at both Level 1 & 2 trainees. The rota means that after 5pm there is usually only one level 1 trainee on duty with one level 2 trainee – they are expected to cover the busy wards with complex speciality patients and all the medical admissions presenting to the emergency department. They described problems with the level 1 and level 2 rotas with high service pressure and very poor support from the majority of consultants out of hours. They felt the on going pressure and expectation to support and review all medical paediatric attendance in the Emergency department significantly affecting the trainee's ability to provide cover on the wards for the complex speciality patients. The emergency department has no paediatric area to review patients or an area that could be used as an assessment unit where patients could be observed. The trainees described being "pulled in all directions". They talked about being "harassed" by bed managers in the emergency department to review patients quickly so that they didn't breach the 4hr target. The trainees clearly voiced their concerns about the consultant support provided after 5pm and felt increasingly concerned about patient safety. The statement made was "if it hadn't been for the PICU team they would have been many significant events". They informed the visiting team that a large proportion of consultants didn't attend the 4.30pm hand over and on some occasions they were not even aware of who was on call. They felt anxious about ringing consultants after hours and felt on the majority of cases when rung the consultants would direct them to speciality guidelines that were scanty, unstructured and difficult to access. Although we were unable to meet the FY2 and GPVTS the feedback that we received via the trainee reps outlined how the FY2 and GPVTS felt anxious and stressed being on call. The level 2 trainees were also concerned that when busy in the emergency department they were trying to support FY2s and GPVTS with difficult complex cases on the ward. The level 2 trainees felt vulnerable at leaving the FY2 and GPVTS unsupported on the wards. More often than not in these situations the PICU team were contacted to support the level 1 trainee and the wards. One level 1 trainee was

anxious that on two occasions she was on with one level 2 trainee who went to bed and refused to support her even though she was busy between rushing between the emergency department and the wards. She has escalated this to her educational supervisor and the college tutor. The concern she had was what would happen if the level 2 trainee had gone to bed when on call with the FY2. The weekend support for trainees was also minimal with no clear process of reviewing complex patients on the ward. The majority of on call consultant over a weekend would review the new admissions but not the complex speciality patients. The only exception to this was PICU consultants and the Oncology consultants who reviewed all cases under their care.

All the trainees felt that the service demands were always paramount and that as trainees they were being pulled out teaching, admin time or from speciality outpatient clinics. Level 1 trainees were not able to attend any specialty clinics, and they found it difficult to focus on working towards their exams. They were often unable to attend teaching, which is rarely consultant facilitated.

Trainees at both levels felt that they wanted to emphasise that within hours they received very good teaching and support from some departments and consultants. The Oncology consultants particularly were highly rated and all the trainees felt supported within oncology, that there was very good teaching and that the consultants were approachable and helpful within working hours and out of hours. Trainees also felt that they were well supported in PICU, Neurology and respiratory medicine.

There is regular teaching from 08.30 to 9.30, which trainees are encouraged to attend, but due to pressures on the service trainees always have to return to the ward in the busy specialities. The trainee have not been able to attend the weekly departmental teaching and the trainees feel that this is wasted opportunity as there is such opportunity to learn from the different specialities but this opportunity is not being developed for the trainees.

The level 2 trainees are able to attend the regional teaching but the attendance for level 1 trainees is variable and service pressure dependent.

<u>When asked - Would they recommend the paediatric training?</u>

The trainee said yes to the speciality training but no to the paediatric training and the out of hours service.

Strengths:

1. Trainees feel that CUH offered excellent clinical training opportunities for all levels of training in paediatrics.
2. Since the appointment of Dr Hoodbhoy and Ambegaonkar trainees feel that there is a significant improvement in the support and communication the current tutors provide to the trainees. There are now regular meetings and opportunities to discuss training issues. Making the role of the senior resident trainee clear has also resulted in improved channels of communication.
3. There is visible consultant presence and leadership on the NICU 24 hours a day, 7 days a week.
4. There has been a clear improvement in the working environment on the neonatal intensive care unit.
5. In the paediatric department some specialities have very strong consultant leadership and these departments are able to support and create and environment that supports trainees.
6. No specific concerns were raised about bullying or undermining.

Significant concerns:

The visit and trainee feedback raised some significant concerns in the paediatric department. These were highlighted in the QPR visit and the GMC survey. It is clear that there needs to a significant change in the approach and culture within the general paediatric department in particular with the consultant support provided to trainees out of hours.

It was disappointing to hear how unsupported, stressed and stretched the trainees in paediatrics have felt when on call. Whilst there are excellent role models in paediatrics within some specialities the inconsistent practice is damaging for the reputation of the department and the Trust. None of the trainees would recommend their training in the general paediatric department in CUH but they would recommend the speciality and neonatal training.

- The training environment is perceived to be unsupportive and significantly challenged by service pressures and support needed for complex speciality admissions and the Emergency department.
- This has had a negative impact on trainee morale, physical and emotional wellbeing, for trainees at both Level 1 and 2.
- There is a concern that the on call consultants are not interested in supporting the trainees and in turn the safety and management of paediatric admissions out of hours.
- There are serious concerns around the running of the wards when the level 2 trainees are busy in the emergency department. This leaves one level 1 trainee supporting the busy wards where the list of patients could extend onto 6-7pages. CUH is a tertiary referral unit for multiple specialities and hence has admission of complex patients from across the region. Leaving one Level 1 trainee to support these patients without senior input has implications for patient safety and trainee wellbeing.

Areas for Development:

1. CUH supports trainees at Level 1, including FY2, GPVTS, academic trainees, ST3 and extending to level 2/3 trainees. Some of the level 2/3 trainees are on a Grid or SPIN speciality rotation. To ensure that trainees receive appropriate support and training specific to their needs the visiting team don't feel that it is possible for all 54 consultants to be able to understand the wide ranging curricular requirements for the spread of trainees outlined above. To be effective educational supervisors the visiting team feel a selected number of motivated consultants should be appointed and then allocated trainees at specific levels so that they are better able to understand the curricular requirements and effectively support the trainees' requirements.
2. Trainees at Level 1/2 and 3 should have within their rota the flexibility to attend teaching and speciality clinics as required for their level of training.
3. The teaching programme needs increased consultant leadership and the opportunity to learn from the various specialities. Trainee attendance at all teaching sessions must be supported and complex speciality cases from the various teams should be shared and presented to support learning for all trainees with the department.
4. The trust needs to look at better consultant presence at weekends and at the night time handover to support patient safety and trainees as recommended by 'Facing the Future" document published by RCPCH. This is in addition to the requirement outlined for OOHs support below.

Requirements:

HEE (EoE) expressed significant concern of the issues raised in relation to the training environment and trainee support in paediatrics. They are concerned the implication this has on trainee wellbeing and patient safety.
There was not sufficient evidence at this visit to recommend that trainees be immediately withdrawn from the Trust. However, the consequence of not successfully addressing these concerns prior to a follow up visit by the School of Paediatrics in three months' time will be for our concerns to be escalated to the GMC Enhanced Monitoring process. This may lead to the withdrawal of GMC recognition for these posts and paediatric trainees being removed from the Trust.

Therefore prior to the initial re-visit the Trust must:

- Immediately remove of FY2 trainees from the OOHs and weekend rotas.

- Ensure that consultant on call always attends the 4.30pm handover during the weekdays.
- Address the culture within the paediatric consultant group. Some of the consultants are perceived as unsupportive and inaccessible.
- Review trainee staffing levels for the out of hour shifts after the 4.30pm handover and over the weekend. The visiting team found this to be inadequate in the current model of supporting all medical walk-ins attending the emergency department.
- Support the college tutors and work with them to achieve and improve the training environment for trainee over the next few months. The time in their job plan needs review so that they are able to fully support the number of trainees within the department, as the range is so wide from FY2, academic trainees, core, SPIN and GRID speciality trainees. It is not possible to do this within the current pas allocation.
- Reduce the workload and pressure that is currently being displaced on trainees from the emergency department. Trainees can't be "harassed" by managers to meet the 4hr A+E target. Consideration needs to be given to whether all medical walk-in into the emergency department need paediatric input.
- Enable the department of Paediatrics to bring about change in the consultant engagement to support the trainees out of hours for paediatric admissions. The trust must not solely rely on the PICU to support patient safety and the complex speciality admissions.
- Be proactive in reviewing the rota at level 1 and 2 to safeguard adequate trainee numbers to cover admissions and the ward out of hours and at weekends for a Paediatric department the size of CUH.
- Rectify the inadequate supervision and support of trainees out of hours and at weekends. The current arrangements for consultant cover must be reviewed to ensure more consistent 7day support in out of hours for paediatric trainees.
- Effectively ensure that trainees are facilitated to attend weekly teaching, which should have greater consultant facilitation.
- Ensure that trainees are facilitated to attend their special interest clinics, and specifically those trainees requiring specialist experience as part of their curriculum.

Recommendations:

- The visiting team recommended the paediatric management team to liaise with a similar sized tertiary unit which also services a busy emergency department and acute admissions on top of speciality referrals. This may help in looking at whether to support speciality team activity the trust needs to consider an 'Acute consultant' model that would support the acute admissions and the wards out of hours.
- The trust needs to consider the development of the acute admission pathway for paediatric admissions from the Emergency department.
- Pathways for Trainee/Trainer communication should be further developed, building on the current faculty with forum trainee feedback and the senior resident trainee role. The tutors need adequate time allocation in job plans for face to face feedback this will help link communication between the consultant body and trainees.
- The paediatric department should consider 'human factors' or similar training to raise awareness about the concerns raised from trainees re-the supportive environment. This will also help to develop the consultant group and help focus on the impact of current practise both on trainees but also patient safety.

Conclusions:

The neonatal unit has made good steady progress with trainees reporting a good training environment with a supportive approach to training. Unfortunately the paediatric department continues to have problems in providing support to trainees at and after the 4.30pm handover and at weekends.
The trainee feedback at this visit triangulates with the GMC trainees survey and the finding at the QPR visit in June

2015. The number of trainees on duty after 4.30pm and at weekends needs review and consideration.
HEE (EoE) has serious concerns regarding the trainee experience in CUH. This will be discussed fully with the Dean and escalated to the GMC, with the anticipation that the Trust will be placed in enhanced monitoring for paediatrics. The department must address these training issues particularly relating to the culture, the high service demands placed on trainees due the admissions/reviews in the emergency department on the background of the complex case mix of patients on the wards and inconsistent consultant support.
The Trust has been advised that if these issues are not resolved then consideration will be given to the removal of trainees in paediatrics from CUH, including specialty, foundation and GP trainees.

Action Plan and further visits:	
Departmental action plan within 6 weeks.	
Action Plan	30th September 2016
Revisit:	Anticipated late October/early November 2016 with visiting team to include Royal College of Paediatrics and Child Health externality.