School of Postgraduate Paediatrics Visit to

Princess Alexandra Hospital NHS Trust

Visit Report

Tuesday 7th October 2014

HEEoE representatives:	Dr Wilf Kelsall, Head of School of Paediatrics Dr Richard Brown, Consultant Paediatrician, Peterborough Dr Nadeem Abdullah, Consultant Paediatrician, Cambridge Dr Andrea Turner, Training Programme Director Mrs Liz Houghton, Lay representative Dr Shanthi Shanmugalingam, Training Programme Director, North Thames Dr Amjad Khan, Trainee Representative - ST8

Purpose of visit:

In accordance with the review of the delivery of training in all Trusts in the HEEoE, a visit was undertaken on 7th October.

This meeting was arranged to review progress with respect to training in Harlow following the School visit in January 2014 that identified a number of concerns. Ongoing issues were highlighted by both East of England and London trainees in their ARCP's and Harlow was the least popular hospital in the recent GMC survey, with 6 negative outliers in overall satisfaction, clinical supervision, workload, experience, regional teaching, and study leave.

Feedback from Paediatric Tutor - Dr Thambapillai and DME – Dr Refson

We received an update on current progress in the department and feedback from Dr Refson and Dr Thambapillai regarding their meetings with trainees. We heard that there had been strategies put in place to improve the working relationship between medical and nursing staff on the neonatal unit and postnatal wards. We were updated on forthcoming changes in consultant staffing. They highlighted problems caused by vacancies in the junior doctor rotas, both at core and levels two/three. They highlighted how the department had worked with trainees to improve teaching and induction programmes. They also provided figures which showed the increased paediatric activity on the neonatal unit, paediatric ward and emergency department. The birth rate is now approaching 4,500 deliveries in a unit that was designed for 2,500.

Meeting with trainees:

We met a representative group of General practice, Foundation, and Paediatric Trainees. The Paediatric trainees were from St1-St5 levels. The senior trainee was able to attend and was able to share her feedback from other trainees. In addition, the Trust Doctor was able to share his experience over the last two years. Trainees were also able to reflect on how the department has changed as they have progressed through the training system. It is clear that the department is extremely busy. The Paediatric wards and emergency department are well organised and

there are very good relationships with nursing staff. There has been a significant improvement in the working relations between nurses and trainees on the neonatal unit. The postnatal wards are challenging in terms of their organisation and clinical throughput. Consultant supervision with the single consultant of the week covering the paediatric wards and neonatal unit is not satisfactory. It does not fulfil the RCPCH requirements of "Facing the Future", nor does it deliver appropriate training. Particularly on the neonatal unit it often leaves inexperienced very junior level 2 trainees conducting ward rounds. Because of their lack of experience the neonatal ward rounds are slow and management decisions are delayed or often deferred. The transitional care unit on the postnatal ward has very little senior input with the most junior trainees often left to make management decisions. This then puts increasing pressure on other parts of the neonatal and obstetric service. This pressure causes tension between staff and with parents. The trainees were very positive about the departmental induction and they all know who their educational supervisors are. The trust induction remains problematic as previously identified with delays in the issuing of passwords and ID badges despite this information being supplied in advance of the start date by trainees.

Conclusions:

1. Harlow is a busy unit with excellent potential training opportunities in paediatrics, Emergency care, and neonates/postnatal wards.
2. Activity in all areas of the department continues to increase.
3. Consultants are all seen as approachable and supportive of junior doctors.
4. There is an excellent working relationship between trainees and nursing staff. It is particularly positive to note the improvement on the neonatal unit.
5. Trainees are actively involved in developing the teaching programme and feel that they can present ideas that will be listened to.
6. The department has reflected on the School of Paediatrics visit in January and the GMC trainee survey, and are determined to improve training opportunities.
7. The department has an excellent teaching programme with sessions in cranial ultrasound, echocardiography, and simulation being particularly positive.

Recommendations:

1. The department should continue to develop the role of the senior trainee. The senior trainee should meet with the paediatric tutor and should be encouraged to attend consultant faculty group meetings.
2. The paediatric tutor should attend consultant paediatric meetings to strengthen paediatric faculty groups and ensure that training issues are properly addressed and minuted in the department.
3. Staffing across the service needs urgent review. There are currently too few consultants and too few doctors on the level one (core) and level two/three (middle grade) rotas. Combined with the increased activity across

the whole service and pressures on capacity, this leads to difficulties in patient care and difficulties in patient flow. The single consultant of the week is too stretched who cannot be in several places at one time. All of these represent a significant patient safety challenge for the Trust and certainly would call into question the quality of care.

4. Supervision of trainees is inadequate and they are having to make management decisions that are inappropriate. This creates tension between trainees and staff and tension between staff/trainees and parents. This has to be addressed as a matter of urgency.

5. The department needs to review consultant numbers and consultant working practice. A business case has been made for two additional consultants which would allow the department to develop a dual consultant of the week service which would improve patient care, efficiency and increase training opportunities. The most serious problem remains the neontal unit and postnatal wards. Particularly transitional care which we highlighted as a major issue back in January. The supervision of somewhat complicated babies on antibiotics is not appropriate; the decision making on the management of these babies is left to the most junior doctors who have very little paediatric experience. There is inadequate consultant provision and very infrequent registrar support in the transitional care unit. This has to be changed. This is a significant risk issue for the Trust. Simply "throwing money" at the department to employ additional consultants will not work alone. The success last winter around the appointment of additional middle grade staff with "winter pressure" monies improved patient and staff experience. The working practices of all staff needs review, consultants extended hours working, and the appointment of hybrid consultants to support the middle grade rotas would strengthen the Department. This would give more security to the middle grade rotas, reducing the dependence on clinical fellows who are extremely difficult to recruit. As suggested before we would urge the department to work with other hospitals where these innovations and changes of practice have worked such as Colchester and Luton.

6. The neonatal unit should work closely with the ODN to review service arrangements which would enhance training and the clinical service.

7. The postnatal and transitional care service needs urgent review. The Trust currently has relatively few midwives who can perform baby checks. We are conscious that there is also a shortage of midwives so simply saying that midwives should undertake these tasks will not alleviate the problem. The paediatric, midwifery, and obstetric departments must work closely together to tackle this problem. The workload of the most junior trainees on the postnatal wards needs urgent review. They describe the wards as being chaotic , this is due to the rapid throughput of the mothers in a unit that was not designed for this level of activity. The processes around performing baby checks could be smoothed with perhaps more healthcare assistants to support trainees. Shift patterns must be reviewed as trainees shift can overrun by up to 2 hours. The administration of BCGs and Hepatitis B vaccinations needs to be reviewed. Many departments have moved away from trainees administering BCGs on the postnatal wards. This needs to be discussed. There are duplications of tasks with trainees completing a computerised 'cosmic discharge form' and then separately writing in the handheld community red book. This is unnecessary duplication and we do not believe it occurs in any other department in the East of England. We would suggest that duplication could be simplified by if necessary printing the computerised form and filing this in the red book, this is something that a ward clerk could do. Reducing this duplication would significantly improve the quality of the trainees experience on the

postnatal wards and reduce their inappropriate need to stay beyond shift finish times

8. The department should review doctor attendance at elective caesarean sections. Again there should be regional guidelines regarding this. Many units have moved away from trainees attending low risk normal caesarean sections.

9. The department needs to move away from a dependence on locums to provide cover. The Trust should work with the School of General Practice to discuss converting the Core clinical fellow post to a GP training post. This though can only happen if the overall quality of training for the core trainees is improved.

10. Handovers are currently joint for the paediatric and neonatal services. This needs to be reviewed. The handovers are often disorganised, starting and finishing late. This needs to be addressed. Poor handovers then set the tone for the rest of the working day.

11. The departmental induction was thought adequate by the trainees. There should be more emphasis to provide appropriate neonatal training for the newest and most inexperienced doctors and similarly provide training in their competence to perform baby checks.

12. The hospital induction needs further review. This was highlighted as a serious problem in January and persists. This is a patient safety issue which also compromises trainees and the department in terms of IT governance. The trust had asked trainees to attend several months before their start date to provide details and take pictures to supply them with ID badges. Many of the trainees did not receive their ID badges until seven days after their start time. This is unsatisfactory and must be addressed.

13. All the trainees were very supportive of the department and very loyal to the consultants. All of them think that Harlow has great potential for training. None of them would currently recommend Harlow for training as it currently is. The department needs more secure staffing at all levels. It needs good consultant leadership to introduce new working models and reduce its dependence on locums. The issues raised in this visit are challenging and raise significant patient safety concerns. Many of the issues we noted today were similar to those identified in hospitals that have struggled over the last two years. We were convinced that the consultants are committed to delivering a high quality service. We hope that they will be supported by the Trust to strengthen the existing service and manage the activity. Failure to do this will result in significant patient safety episodes. It will result in ongoing poor trainee morale and increased staff sickness.

Action Plan and further visits:	
We were disappointed to see so little progress on a number of significant areas that were highlighted in January 2014. These must be addressed as a matter of urgency. Failure to improve the training environment is likely to result in the removal of trainees which would have significant consequences for the Trust. I am pleased that Dr Vikas Satwik has taken on the role of paediatric tutor at a very difficult time. I know that he will work with his paediatric colleagues to tackle some of the issues raised and he will work closely with the education department. I would like to receive an action plan regarding the issues raised in this report. We will revisit the department in February 2015 to review progress.	
Revisit:	**February 2015**

Visit Lead: Dr Wilf Kelsall, Head of School of Paediatrics **Date: 31 October 2014**

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