NHS

Health Education East of England
Directorate of Education and Quality

Postgraduate School of Paediatrics Visit to

Mid Essex Hospital Services NHS Trust (Broomfield Hospital)

Visit Report

Monday 28th September 2015

HEEoE Representatives:	**Visiting Team**: Dr Wilf Kelsall, Head of School of Paediatrics Dr Samudra Mukherjee, Consultant Paediatrician and Unit Training Programme Director, Basildon and Thurrock University Hospital Trust

Purpose of visit:
This visit was arranged primarily to interview a replacement paediatric tutor to take over from Dr Manas Datta. We also reviewed progress made since the last school visit in September 2014 and actions put in place following the 2015 GMC Survey. We also took the opportunity to meet trainees.

Feedback from Dr Manas Datta outgoing Paediatric Tutor with Dr Hywel Jones Director of Postgraduate Medical Education
Dr Datta gave feedback on the nine recommendations that we made following the visit in September 2014. He indicated that the Trust has supported the Paediatric Department with a further appointment at consultant level to strengthen the neonatal service. Additional funds have been identified to increase the level 2 tier to nine doctors. Work is ongoing to develop a tenth post in the burns and cleft service. Level one staffing has been improved with the conversion of clinical fellow posts to GP training posts. The department has been successful in having two of the level 2 training posts recognised for the RCPCH MTI programme with an interest in education and cardiology. There has also been some progress made with midwives performing the NIPE baby check. Handovers are thought to be more organised and less disrupted by consultant discussions. Office facilities on the neonatal unit have been provided. We discussed the issue raised in the most recent GMC Survey around undermining. Both Dr Datta and Dr Jones were confident that this was a one-off, it has been appropriately investigated. Both highlighted the pressure that paediatric trainees were under particularly in the early evening due to the workload on the paediatric assessment unit. These difficulties are compounded by problems with staffing and recruitment in the emergency department.

Meeting with trainees:

We met with a representative group of trainees that included general practice and paediatric trainees. The paediatric trainees range from ST1 to ST8. In addition, we had received email feedback from a number of trainees prior to the meeting and also during their ARCPs. Although the current trainees had only been in the department for only a short time they were able to confirm that all the consultants were approachable as individuals, there were good working relationships between medical, nursing and midwifery staff. They were all aware of who their educational supervisor is. They confirmed that induction had taken place appropriately at the Trust level but the departmental induction was erratic and less well organised. They highlighted ongoing concerns regarding the handover process. There are still multiple consultant inputs which prolong the handovers making them inefficient and regularly over run. They raise concerns about neonatal nursing support at resuscitations particularly when inexperienced medical staff were involved, this is important given the geographic spread of the department. They were not aware of any communication pathways through a senior trainee to the consultant body and tutor. They were not aware of how their thoughts to improve the clinical service and training could be cascaded across the department. They have particular anxieties about the level 1 rolling rota which always commences with three nights at a weekend; this is problematic for the most inexperienced trainees.

Conclusions:

1. Chelmsford is a busy department that offers good clinical training.

2. All the consultants are individually approachable and all are easily contactable.

3. There has been good progress in extending the roles of nurses and midwives. The nurses on the neonatal unit perform blood gases and the midwives have started to do a small number of baby checks.

4. There are good relationships between all staff members and there are no issues of intimidation.

5. There is a good teaching programme with good consultant input. Safeguarding teaching is well developed.

6. Office space with computer access has been identified on the neonatal unit.

7. We were pleased to appoint Dr Sharmila Nambiar to the role of paediatric tutor, we are grateful for all the work done previously by Dr Datta.

Recommendations:

1. The role of the senior trainee must be established. This appears to have lapsed with this incoming group of trainees.

2. There needs to be regular meetings between the tutor, the senior trainee and the trainees to discuss training issues. The development of a faculty group to formally discuss training issues should be introduced and minuted at consultant meetings. Trainees have important suggestions to make regarding rotas and service developments that can enhance both their training and patient care.

3. The paediatric rotas need further review particularly for the level one trainees in the neonatal service. Currently the rotas are managed by the HR department. It would beneficial for the department for a consultant to take ta more hands-on role supported by a senior trainee. This would allow the rotas to be developed to enhance training and improve service, also introducing a degree of flexibility that is often not fully appreciated by managers. The current rolling rota for the level 1 trainees on the neonatal unit must be reviewed. It is inappropriate and unsafe for level one trainees with limited experience to start with three nights on the neonatal unit.

4. Whilst progress has been made with the midwives in introducing NIPE assessments relatively speaking only a small number of baby checks are performed by midwives. Their role must be expanded. It is important that the Trust look to support trainees particularly at weekends. It is inappropriate that trainees start these examinations at 06:00amin the morning often waking mothers and babies.

5. Practise on the neonatal unit must be reviewed. The appointment of a consultant with an interest in neonatology has been identified as a priority for the Trust. Once this appointee is in post the department must review the handover process. It is inappropriate and inefficient that prolonged handovers take place across the whole department. The neonatal service also needs to review its "historic practice", head circumferences need to be measured and recorded but not a Sunday evening when staffing numbers are limited. Similarly, routine weekly blood tests should not be performed on all babies on a Sunday evening. The whole practise of routine blood tests needs review. I would suggest that a trainee takes this on as a Cost Improvement Project, in many units extended bllod gas monitoring has reduced the need for laboratory based testing.

6. Handovers remain problematic. I am aware that the department feels that they cannot yet split the neonatal and paediatric handovers. This must happen when a consultant with a neonatal interest is appointed. It would appear that there are still multiple consultants participating in handovers offering opinions. For the efficiency of the unit this does not seem appropriate. It is important that handovers do not over run and trainees do not stay beyond their working hours.

7. Consultant cover of the neonatal service requires review. Once a neonatal consultant with an interest is appointed the way the service is led must be changed. The previously noted historic inconsistencies between multiple consultants attending are still practiced. This must change.

8. Staffing across the Paediatric Department must be reviewed. The option to increase training numbers simply does not exist. The department must look to meeting the RCPCH facing the future guidelines through other strategies. The only robust way of achieving this would be to appoint more consultants. The department needs increased consultant leadership and presence in the paediatric assessment unit particularly in the early evenings. The whole process of referring patients to be seen in PAU for urgent review (when no outpatient is available) needs clarifying. Patients attending PAU sometimes do so without notes or clear plans or requesting consultant availability. This unsatisfactory for trainees and the patients. The consultants need to review their working practices to have an increased presence in the evenings perhaps until 10 o'clock at night; they also will need to increase their presence at weekends perhaps to 5pm. This change in practise will improve training opportunities and service delivery. Again I would suggest that colleagues in the department speak to local units such as Basildon or Colchester where successful models have been introduced with great effect.

Action Plan and further visits:	
I would be grateful to receive an action plan regarding these recommendations by 4th December 2015.	
Action Plan	4th December 2015.
Revisit:	Summer 2016

Report prepared by Dr Wilf Kelsall, Head of School of Paediatrics, and agreed with Dr Samudra Mukherjee September 2015.

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