NHS Education for Scotland

Scotland **Deanery** News

Issue 18 | Winter 2019

In this issue:

Welcome to the Winter edition of the Scotland Deanery Newsletter and some more news of what is going on in your Deanery.

Hot on the coat tails of the very successful Developing Excellence in Medical Education Conference (DEMEC) that we co-hosted recently, in Manchester, we are delighted to host the 10th National Scottish Medical Education Conference (SMEC) in Edinburgh, this Spring. A fantastic opportunity to hear directly from noted speakers and network with other educators and trainees. Ahead of the event, poster submissions are now invited.

Patient safety is a key strand of what we do in NES Medical Directorate and in an article about their work, concerning the role of human factors in patient safety, Professor Paul Bowie and Dr Duncan McNab, challenge those involved in providing care to think differently about patient safety. A thought provoking read that may cause you to examine the impact of human factors in your own practise.

Deanery Quality Management visits to hospitals and practices, as part of the GMC's Quality Assurance Framework, are often misunderstood and met with apprehension by both trainees and their trainers. Helpfully in this edition, Dr Euan Harris, Scottish Clinical Leadership Fellow, summarises work he and colleagues in the Deanery Quality Team have done to explain the purpose and process of a typical visit. Links to the new resources are provided. Related to this feature, we are pleased to present the Scotland Deanery Annual Quality Report which pulls together a summary of all of the quality activity we have undertaken over the past year. A comprehensive report that highlights the breadth and depth of our work in this important area.

Practice Nurses are key members of the primary care team and we give you some insight into the NES team that supports Practice Nursing across Scotland, giving you a flavour of the initiatives and schemes run in support of this important group. Lastly, we feature the NES Annual Report 2018-19 where you can read more about the wide range of work NES does to ensure that NHS Scotland has a skilled and sustainable workforce, for now and the future.

I hope you enjoy the read.

Professor Rowan Parks

Prof. Rowan Parks
Medical Director

SAVE THE DATE!

When: Thursday 30 April & Friday 1 May 2020
Where: Edinburgh International Conference Centre

Following on the growing success of this event, NES is delighted to confirm that it will be hosting the 10th National Scottish Medical Education Conference as a two-day event at the Edinburgh International Conference Centre.

This meeting will be of interest to all those involved in medical education and training, including students, trainees, trainers, managers, those working in primary care, secondary care, Universities, Deaneries and Medical Royal Colleges.

The meeting will aim to outline recent developments and explore the many challenges facing undergraduate and postgraduate medical education and training, in a time of tightening resources and evolving regulatory requirements.

There will be a number of parallel conferences hosted by other health professional groups and an opportunity for joint sessions highlighting interprofessional learning.

SUBMIT YOUR POSTER ABSTRACTS!

Deadline: Midnight Sun 16 February 2020

We invite submissions in the following categories:

- Training Delivery
- Simulated & Online Learning
- New Perspectives and Novel Methods in Medical Education and Training
- Medical Careers – Structure & Support
- Interprofessional Education
- Miscellaneous

The poster submission form is available from:
medicalconf@nes.scot.nhs.uk

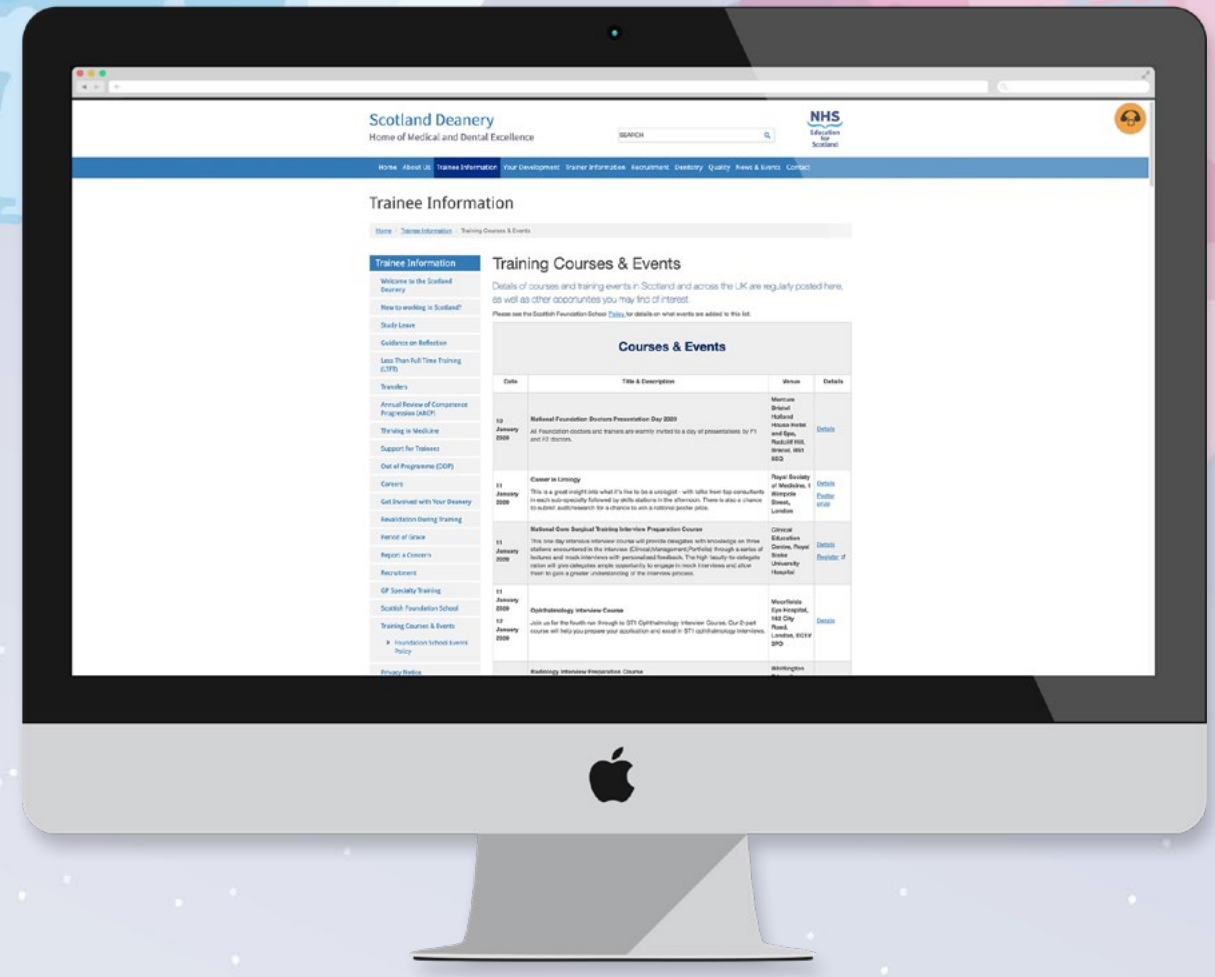
Successful abstracts will be announced week commencing 16 March 2020.

The meeting is sponsored by NHS Education for Scotland, and there will be no charge for participation. Further details on the programme and how to register will follow in January 2020. CPD credits to be confirmed.

For queries and further information please contact:
medicalconf@nes.scot.nhs.uk

Prizes:

- **The top three highest scoring abstracts will be selected for a short oral presentation at the conference.**
- **The three highest scoring posters in each category will be awarded "Poster of Distinction".**
- **One poster from each category will be awarded "Best Poster" following judging panel discussion during the conference.**



Courses and Events aimed at trainees and trainers are available on the Scotland Deanery website here:

scotlanddeanery.nhs.scot/trainee-information/training-courses-events/

PAUL BOWIE AND DUNCAN MCNAB

In this Article, Paul Bowie and Duncan McNab, adopt a Human Factors perspective in challenging NHS leaders, care teams, educators and policymakers to think differently about patient safety.

In safety science perhaps the most obvious question to ask when people are unintentionally but avoidably harmed is: why did things go wrong?

But an alternative and equally intriguing question is possible: why do things go right most of the time? And we might further add: …most especially in our highly complex healthcare systems?

Healthcare is being challenged to think differently about patient safety. Traditionally, related goals are to learn from when things go wrong and (re)design care delivery to minimise the risk of patient (and staff) harm as much as practicable. Our efforts, therefore, tend to focus on reporting, quantifying and learning from 'incidents'.

When we seek, with hindsight, to learn we often try to detect deviations from 'ideal' or 'best' practice and then design improvements to prevent or minimise the risk of future incidents – this is a 'find and fix' mentality that aims to isolate specific 'causal' events (e.g. failure to communicate a test result) and rectify them so the identified incident trajectory should not re-occur.

The assumption is that unreliable technology and fallible clinicians, executives, managers and others should be treated as one in the same – as problematic system elements that either function as intended (e.g. follow protocols rigidly) or do not function (e.g. 'deviate' from expected practices).

Simplistically, we believe that if all system elements, including us, behave as expected then things will not go wrong.

In recent years a 'new safety movement' has gradually emerged. This perspective introduces the contrasting but compelling concepts of Safety-I and Safety-II as ways to explain why things go wrong sometimes, but also go right in the great majority of cases.

In Safety-I thinking, safety is defined almost completely by the absence of something – the point where as few things as possible go wrong. To get to this reductionist state we examine why these 'wrong things' happen and attempt to repair them, often with limited success.

Safety-II thinking, however, aims to increase safety by maximising the number of events with a successful outcome. To achieve this means going beyond the study of adverse events to understand how things happen – good and not so good– under different conditions in everyday healthcare work. A more sophisticated understanding of our work systems should emerge, better informing efforts to improve patient care.

Below are some practical pointers related to updating our thinking and approach which should be of interest to those with a patient safety role:

- **Appreciate healthcare is a complex (sociotechnical) system:** Healthcare performance is achieved through interactions (successful or otherwise) between human, technical, social, organisational economics and regulatory system components, which are rarely simple or linear – we need, therefore, to move away from linear 'cause and effect' thinking and tools (i.e. A + B led to C) because it is largely unsuited to appreciating healthcare complexity (Figure 1).
- **Recognise that outcomes are 'emergent:** In complex care systems outcomes such as patient safety or workforce wellbeing emerge as a result of the interactions described above. Patient safety is not an inherent feature of the system – we cannot state with certainty that a system is safe at any one time (e.g. the operating theatre or outpatient clinic); it is people who largely create safety through everyday practice.
- **Rethink 'medical error':** Despite widespread use, perhaps avoid employing this unhelpful term uncritically. It is problematic because, amongst many other issues, it unintentionally focuses on the personal and foments blame, and is fundamentally inaccurate, self-harming and educationally backward, especially when it is viewed as a 'cause'.
- **Reconcile work-as-done (WAD) and work-as-imagined (WAI):** WAD and WAI are important concepts (Figure 2). WAD refers to how everyday work is really done i.e. how people adapt and adjust what they do to keep patients safe and 'get the job done'. WAI refers to the imagined assumptions of how work should be done by those – often detached from sharp-end reality – who design care

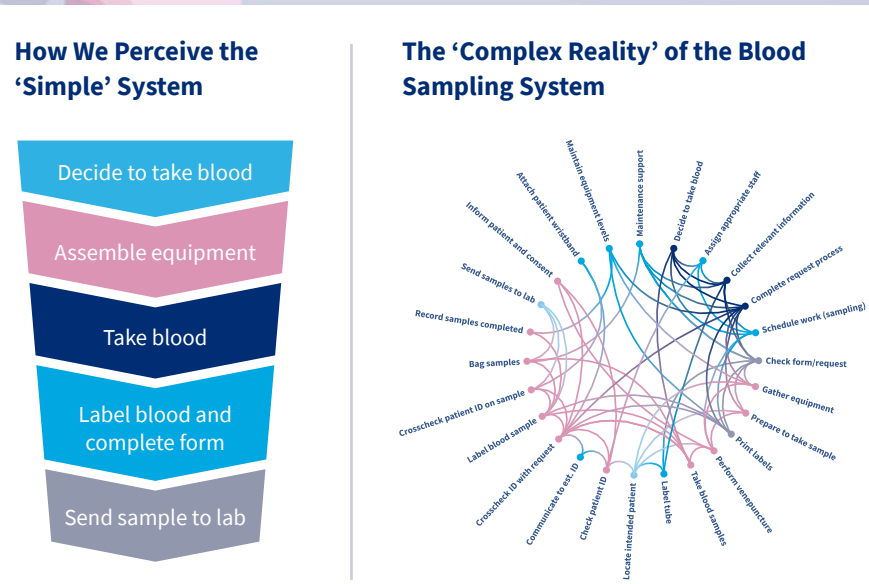


Figure 1. Blood sampling example: simple linear versus complex system model. Pickup L, Hollnagel E, Bowie P et al. Blood sampling - Two sides to the story. Applied Ergonomics. 2017; 59, 234–242

processes or guidelines, manage organisations, or formulate policy.

- **Consider local rationality:** When looking back at the decisions of others, seek to understand why decisions made sense based on the system situation and context they faced (local rationality). People do not go to work to do a bad job, but at the time their decisions made sense to them, otherwise they wouldn't have made them, so why was this and how can we learn from it?
- **Efficiency-Thoroughness-Trade-Offs (ETTOs):** Again, when looking back at decisions and outcomes consider and learn from the ETTOs that people made. In complex systems, conditions are dynamic and people adjust what they do, which often involves making necessary trade-offs between being efficient and being thorough.
- **Learning from events:** Before trying to answer why something went wrong, ask what does successful everyday 'work-as-done' normally look like in this situation? In this way, you can begin to reconcile both perspectives to get a more informed picture of the system of care you potentially wish to change and improve.

A longer version of this Article is published on the Human Factors Scotland online Blog here: knowledge.scot.nhs.uk/hfe/hfsblogs.aspx

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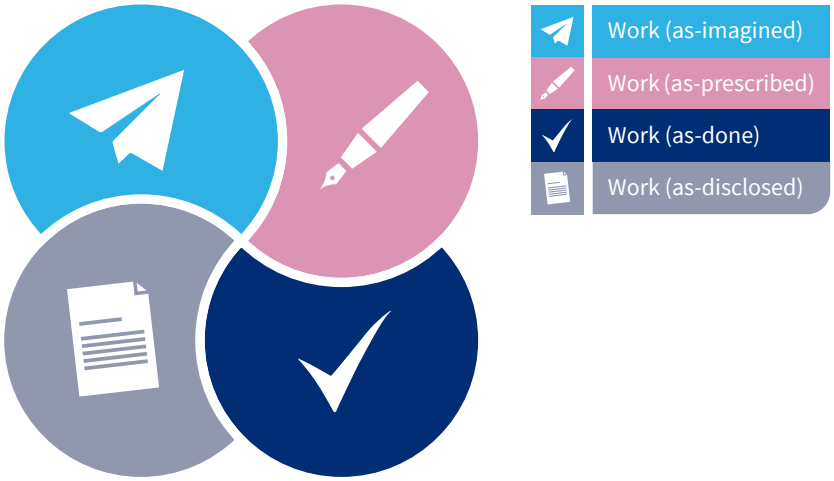


Figure 2. Shorrock S. The varieties of Human Work. https://www.safetydifferently.com/the-varieties-of-human-work/

Further reading

Hollnagel E & Wears R. From Safety-I to Safety-II

NES Systems Thinking for Everyday Work (STEW) Cards

McNab D, Bowie P, Morrison J, Ross A. Understanding patient safety performance and educational needs using the 'Safety-II' approach for complex systems. Educ Prim Care. 2016 Nov;27(6):443-450.

DR EUAN HARRIS

During the last year, whilst undertaking the Scottish Clinical Leadership Fellowship Programme hosted by the NHS Education for Scotland Quality Workstream, I have been working closely with the Quality Management Improvement Group.

Recognising that there remains some uncertainty and misperception surrounding the purpose of Quality Management Visits, which can cause a degree of apprehension amongst trainees when they are invited to attend, the Quality Management Improvement Group have been exploring ways to better engage with trainees and trainers. This has involved ensuring participants have a more detailed understanding of the visit process, as well as greater awareness of how data and intelligence is collected and used. Most significantly, the Group wanted to stress that the purpose of Quality Management Visits was communicated to trainees, namely, to provide a supportive and confidential environment for them to discuss their experience of medical education and training.

To help address this a new dedicated Quality Management Visit section within the Trainee Information webpages on the Scotland Deanery website was developed, with the aim of outlining to trainees what to expect on a visit if asked to attend. The content describes the timeline of a Quality Management Visit, explaining what happens before, during and after a visit. It highlights several key elements including the Pre-Visit Teleconference, the importance placed on the Pre-Visit Questionnaire, the structure of the Question Sets, how the visit report is written and where to access the report subsequently. A further aspect orientates trainees to the visit panel, explaining the individual roles and responsibilities of those taking part, as well as detailing why and how sites are selected to be visited.

> *"The unifying theme throughout all of the material is a desire to stress the opportunity Quality Management visits present for trainees to engage constructively in influencing and developing their own training, by highlighting what is working well, and what could be improved.*

To compliment this information in May 2019 a contingent of burgeoning thespians made up of trainees, trainers and many of the NHS Education for Scotland Quality Team came together to film a series of short instructive videos documenting a mock Quality Management Visit. Whilst the Royal Shakespeare Company can count themselves safe, through the course of filming a variety of scenarios we definitely discovered some hidden talents! We trust the videos accurately illustrate so many of the stories that panels often hear from trainees and trainers when conducting visits and provide an honest account of the visit process. A special message of thanks needs to go to the NHS Education for Scotland Digital Team who kindly (and patiently) helped film throughout the day.

The unifying theme throughout all of the material is a desire to stress the opportunity Quality Management visits present for trainees to engage constructively in influencing and developing their own training, by highlighting what is working well, and what could be improved. We also wish to recognise the need to assist and support trainers in continuing to provide high quality, excellent training.

The Quality Management Improvement Group hope that the new webpages, and notably some outstanding acting talent, offers an entertaining insight into the Quality Management visit process, and reflects the commitment of NHS Education for Scotland in promoting an understanding and supportive environment in which the challenges faced by trainees and trainers can be discussed, as well as offering a means to share best practice, and ultimately advance postgraduate medical education and training in Scotland.

Dr Euan Harris, Scottish Clinical Leadership Fellow 2018-2019 (hosted by the Quality Workstream, NHS Education for Scotland) & Quality Management Trainee Associate

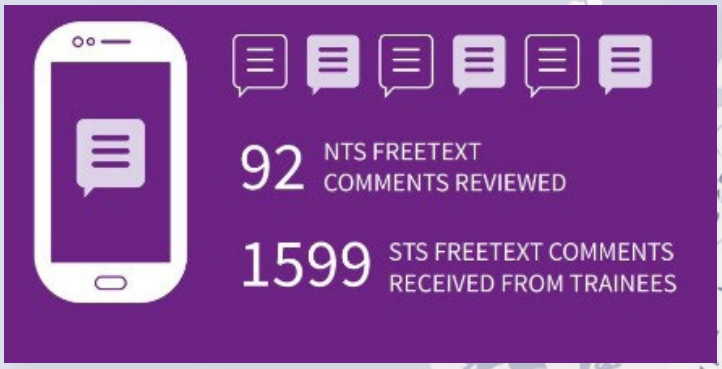
For further information please find the link to the Quality Management Trainee Information webpages here:
scotlanddeanery.nhs.scot/trainee-information/quality-management-visits/

The Scotland Deanery Annual Quality Report in which we give a round-up of our Quality Management and Improvement activities over the course of the 2018-19 training year is now available to view. The report yet again reveals the extent our Deanery staff and colleagues in Health Boards go to, to continually monitor and improve the standard of medical education and training in Scotland.

Our pan Scotland Quality Management approach is now well established and the in-depth knowledge we have built-up around each specialty is reflected in the reports provided by each specialty grouping. In each case we provide a summary of what has happened and been actioned, where we found good practice and what are the main issues for consideration in the coming year Importantly, we reflect our work around sites included within the GMC's Enhanced Monitoring process and report on an overall reduction in Enhanced Monitoring sites from 9 to 7. Clear evidence that partners are working collaboratively to bring about sustained improvement.

Improving what we do within the Deanery is also important and working with doctors in training to make our process better is key to making sure doctors in training in Scotland have real influence over how training is delivered. The report highlights our commitment to working with our Trainee Associates and Clinical Leadership Fellows to make this happen. I trust you will gain great insight from the 2019 report.

The Scotland Deanery Quality Report 2019



We would like to introduce ourselves, we are both General Practice Nurses (GPNs) who have joined the NES GPN Programme lead by Lynne Innes, NES National Coordinator for General Practice Nursing and Vicki Waqa, Specialist Lead GPN CPD Connect. Lynne and Vicki each lead different workstreams within the GPN Programme, however work closely with a shared passion and vision.

Lynne leads the workstream for registered nurses new to general practice, either newly qualified or new to general practice. The Queen Margaret University credit rated GPN Programme has gone from strength to strength, not only in academic quality but also with its increase in learner capacity with Lynne's dynamic and forward thinking committed approach to support nurses in primary care. Lynne is also involved within many strategic areas of NES and works collaboratively in many groups, including Cervical Screening Education standards and British Heart Foundation to name only a few.

Vicki leads CPD Connect which supports further education for GPNs. The number of courses developed and delivered has increased dramatically over the last 23 months with the waiting list testament to the quality of the learning opportunities. The official feedback from each course provides evidence of Vicki's incredible success. Vicki was able to engage with nurses in General Practice to discover what education the GPNs were hoping for and allow GPNs across Scotland to learn within a networking and supported environment.

As GPN Programme Officers we work alongside these two incredible nurses. We support their quite literally, ground-breaking developments for the future of General Practice Nursing. The team is not only person centred and kind, but Lynne and Vicki have the most friendly and supportive way of working that genuine relationships have formed. We feel lucky to be a part of their team and proud to be part of the fantastic and exciting future of GPNs.

The recognition of their tireless and outstanding commitment to nurses, and the future of Primary Care nursing was recognised 'officially' in November 2019, when Lynne and Vicki received a NES STAR for their creative and passionate approach to education. To be awarded a NES STAR is to be recognised for working exceptionally well, based on NES values, and going that 'extra mile'. These ladies have gone more than the extra mile – and they continue to do so with unrelenting enthusiasm and passion.

Karen Beattie and Diane MacMichael

Lynne Innes, NES GPN Programme Leader, and Vicki Waqa, Specialist Educator GPN CPD

THE NHS EDUCATION FOR SCOTLAND ANNUAL REPORT 2018–19

This is the fifth and final year of our refreshed strategic framework, Quality Education for a Healthier Scotland, to deliver the Scottish Government's Everyone Matters: 2020 Workforce Vision.

Our role

We have a Scotland-wide role in undergraduate, postgraduate and continuing professional development. Our mission is to provide education that enables excellence in health and care for the people of Scotland.

What we've achieved

Over the last year we have continued to provide opportunities for undergraduate students and the recruitment and management of postgraduate training; create and commission educational materials, resources and learning opportunities; and improve the physical and digital infrastructure.

The report features:

- **NES Annual Report 2018-19 Review**
- **NES Annual Report 2018-19 Fast Fact Animations** showcasing some of our achievements
- **NES Annual Report 2018-19 Clear Perspectives** video case studies from staff and trainees working in health and social care; each describes how NES education, training and resources have helped them in their roles

CREATED SPECIFICALLY FOR THE NEEDS OF SCOTLAND'S MEDICAL TRAINEES AND TRAINERS, ARE THE FOLLOWING RESOURCES:

The Scotland Deanery Website

The Scotland Deanery, along with our Local Education Providers, is responsible for managing **Medical Training and Training Programmes across the four Scottish regions**. Here you'll also find details of the Deanery's Quality Management activities, its key staff and locations plus information on Professional Development for doctors.

www.scotlanddeanery.nhs.scot

Scottish Medical Training

This site is the principal resource to **learn more about how to apply for Foundation, Core and Specialty Medical Training in Scotland**. Here you'll find regularly updated information about application windows (how and when to apply), a directory of 50+ GMC-approved medical specialty programmes and first -hand accounts about training from trainees and trainers. There are also useful insights on career direction and what it's like training and working in Scotland.

www.scotmt.scot.nhs.uk

SOAR

Designed for doctors (in both Primary and Secondary Care) working and training in Scotland, for their **Appraisal and Revalidation needs**. SOAR is used by Appraisers and Appraisees to aid the appraisal process, and for Trainees to complete their self-declarations. Here you'll also find a SOAR user guide, handy FAQ's and examples of Quality Improvement Activities.

www.appraisal.nes.scot.nhs.uk

Please contact us with newsletter feedback and ideas for articles at:
www.scotlanddeanery.nhs.scot/contact

Social
Join the conversation

This resource may be made available, in full or summary form, in alternative formats and community languages. Please contact us on **0131 656 3200** or email **altformats@nes.scot.nhs.uk** to discuss how we can best meet your requirements.

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NESD1045 Scotland Deanery Newsletter Autumn 2019 | Designed by the NES Design Team