NHS
Health Education England

Learner/Educator Meeting Findings Form

Section 1: Details of the meeting

Trust/Site:	**Harrogate & District NHS Foundation Trust**
Speciality Reviewed:	**Gastroenterology**
Date of Meeting:	**23 May 2017**

Section 2: Findings from the meeting

Summary

The meeting was arranged to obtain feedback from the trainees and trainers within gastroenterology. There have been concerns expressed periodically, over several years, about lack of support, supervision, educational opportunities and/or lack of engagement with the department. We noted that since 2012 Medicine as a whole has been allocated two additional F1 doctors and 2 additional CMT trainees.

The meeting was well organised with good engagement from the trainees and the trainers.

Findings

The gastroenterology service is busy; it is managed within the Planned & Surgical Care Directorate, with their inpatients being located on two surgical wards. We speculate whether this may result in the senior team being more isolated professionally from the rest of the medical specialty teams. One consultant covers the patients on each ward, and on average there are ~25 patients on the two wards (reported range 10 – 35) - Mondays are always potentially busier due to medical boarders moving to surgery during the weekend – these medical outliers also fall under the responsibility of the gastroenterology team. There may also be additional outliers to manage on one of the orthopaedic wards.

It is perceived by all staff that the workload/patient intensity per available doctor is greater than on other wards. Late finishes are common, especially when there are afternoon ward rounds. However apart from occasional one day snapshot audits of patient numbers there was no data available to prove this assertion, and it would be useful for the Trust to generate hard comparative data on inpatient workload (both patient numbers and bed days occupied would be informative) for all the medical specialty teams. If the gastroenterology team is under undue pressure this should be considered in discussions with Trust management.

There had previously been an additional locum Trust doctor appointed for two periods (colloquially called the ‘F3’) earlier in the year; this had been helpful to all the trainees. This post is not continuing at present, and we heard that financial constraint had previously prevented it being filled.

There have also been 2 recent Medical Training Initiative (MTI) appointments to the team, intended

to provide more middle grade support. Unfortunately there appears to have been lack of clarity over the expectations and working patterns of these doctors, and so far they have not improved the trainee working patterns significantly.

The DME expressed concerns over the engagement from the gastroenterology consultants. With 1 long term locum consultant, and 1 other consultant not undertaking ward duties this impacts on the senior team's resilience, with the 3 ward based consultants always having inpatient responsibilities while also working off site running various peripheral outreach clinics and endoscopy sessions. Trainees may not know who is available to cover them on the ward, and finding a senior doctor for advice has on occasions been difficult. One clinical incident was described related to this, and this dispersal of senior staff is a central factor causing the supervision concerns.

The option of introducing a consultant of the week arrangement has been accepted by the consultants, who are willing to move their clinical commitments to do this, but this is not fully supported so far by Trust management – the expected loss of outpatient capacity and income was mentioned.

The trainees denied any concerns about undermining behaviour. The consultants were described as being approachable, but the trainees were quite reticent when asked to expand on the team dynamics, leaving the impression that the team as a whole is not working happily.

HEE has no part in determining service design, but discussion with the trainers did not reveal a clear short or long term strategy for the gastroenterology service; this is a priority for Trust management, as a relatively small service sitting between two large neighbour Trusts, needs a clear development plan, otherwise there is a risk of losing rather than improving future training opportunities, which may impact on future recruitment.

Areas of strength

- The trainees reported that the nursing staff on the surgical wards are excellent; they are very supportive and happy to help out with tasks where they can.
- The surgical trainees on the ward also help their gastroenterology colleagues during busy periods.
- The phlebotomy service here is reported as excellent, and operates twice daily rounds during the week and a morning round at the weekends. The service also provides clinical support undertaking ECGs, cannulas etc.

Section 3: Outcome (please detail what action is required following the meeting)

No further action required – no issues identified	
Conditions Set (see appendix A):	X

Section 4: Approval

Name:	Dr David Eadington
Title:	Deputy Dean
Date:	30 May 2017

Disclaimer:

Any issues that have been escalated to a condition will be included on the Quality Database and managed by the Quality Manager through the Monitoring the Learning Environment meetings.

Appendix A

Conditions

HEE Domain	1 and 3	
HEE Standard	1.1, 3.1, 3.2	
Condition Number	1	
Trainee Level	Foundation	
Concern	Foundation trainees are not continually provided with on-site support from a senior colleague during the day time.	
Evidence for Concern	On-site supervision during day time hours is sporadic. The current arrangements involve consultants covering the ward on a monthly basis while they also undertake outreach sessions off site e.g. Wetherby, Ripon, Otley. This impacts on the supervision of the F1 trainees having no on-site support and being unclear who they can escalate issues to. The RMO is too often the default for a go-to person. There have been 2 potential patient safety incidents/near misses - one was a variceal haemorrhage when all consultants were off-site and an ICU consultant dealt with it. A consultant of the week model would deliver the supervision required. Since two consultants are ward based at present there would not automatically be a loss of outpatient activity if outreach roles are job planned effectively.	
Action 1	The Trust must introduce named senior on-site day time support.	**30 June 2017**
Action 2	Provide trainees with clear guidance/an escalation policy that details who should be contacted.	**31 July 2017**
Action 3	Consider other models of consultant working e.g. consultant of the week.	**31 August 2017**
Evidence for 1	Written confirmation of on-site day time senior support.	**30 June 2017**
Evidence for 2	Copy of guidance/escalation policy.	**31 July 2017**
Evidence for 3	Confirmation of the outcome of the consultant working model discussions.	**30 September 2017**
RAG Rating		
LEP Requirements	• Copies of documents must be uploaded to the QM Database • Item must be reviewed and changes confirmed with HEE YH Quality Team	

HEE Domain	2, 3 and 6	
HEE Standard	2.3, 3.3, 6.3	
Condition Number	2	
Trainee Level	All	
Concern	Trainees report that there are regularly insufficient staff on duty to provide what they always feel as a safe level of patient care. The role of the MTI doctors is not clear enough; this is impacting both the service and the trainee supervision. Nursing support to trainees does not yet fully compensate.	
Evidence for Concern	Recently 2 MTIs have been appointed to work as middle grades and they are currently settling in. There are different expectations between the MTI doctors and the trainees. One is more willing than the other to undertake some of the supportive jobs and help the trainees. Their own induction and need to refresh skills may be contributing to this. The trainees reported examples of working with one of the MTIs where there have been a lot of patients and the MTI was not able to do some of the tasks required e.g. cannulas. At other times the trainees have been left to do all the jobs after the MTI has undertaken the ward round. The trainees are not sure if it has been explained to the MTIs what is expected of them; they have the impression that the MTIs were to start off at a more junior level, supporting them with some of the jobs rather than offering senior support, but the MTIs felt they were starting off at a registrar level. There is confusion over their position in the team. The trainees feel that as well as wanting more senior support, they need more clinical support with the tasks needed to run the ward. The trainers felt that although the MTIs are experienced doctors they are not used to working on a ward and this may have contributed to the differing impressions of them. They have been told that the place they work now is a team based approach rather than hierarchical and all team members are expected to step up or step down where necessary.	
Action 1	The role of the MTIs needs clarifying with both the trainees and the MTIs being clear what is expected.	**30 June 2017**
Action 2	MTIs to be provided with the relevant training to update their skills.	**30 June 2017**
Action 3	Support for the trainees to be provided by the MTIs.	**30 June 2017**
Evidence for Action 1	Written confirmation that staff have been informed of the MTIs' role and responsibilities.	**30 June 2017**
Evidence for Action 2	Written confirmation that required refresher training has been provided to the MTIs.	**31 July 2017**
Evidence for Action 3	Confirmation that support is provided by the MTIs.	**31 July 2017**
RAG Rating		
LEP Requirements	• Copies of documents must be uploaded to the QM Database • Item must be reviewed and changes confirmed with the HEE YH Quality Team	

HEE Domain	2, 3 and 6	
HEE Standard	2.3, 3.3, 6.4	
Condition Number	3	
Trainee Level	All	
Concern	The inpatient gastroenterology service relies too heavily on the trainees, to the detriment of their training delivery.	
Evidence for Concern	The Trust should consider what other forms of alternative workforce can reduce the over-dependence on the medical trainees. One option would be employing a Physicians Associate as F1 clinical support; another would be to develop an Advanced Nurse Practitioner role(s) to support junior doctors by providing more middle grade decision making. There are already nurse endoscopists employed – would they (or future nurse specialist staff) be interested in expanding their role? If the consultant of the week model is implemented one of the trainers thought that there could be a more blended approach to service delivery, which would give more opportunities to accommodate assessment needs within normal working, rather than setting separate time aside as they currently do.	
Action 1	Consider alternative workforce options	**30 September 2017**
Evidence for Action 1	Written confirmation that alternative workforce options are being developed, and their timescale.	**30 September 2017**
RAG Rating		
LEP Requirements	• Copies of documents must be uploaded to the QM Database • Item must be reviewed and changes confirmed with the HEE YH Quality Team	