Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	12 February 2020	**Level(s)**	Foundation, Core, General Practice and Specialty trainees
Type of visit	Triggered visit	**Hospital**	Glasgow Royal Infirmary
Specialty(s)	Gastroenterology	**Board**	NHS Greater Glasgow and Clyde

Visit panel	
Stephen Glen	Visit Chair – Associate Postgraduate Dean
Reem AlSoufi	Associate Postgraduate Dean – Quality
Rebecca Docea	Foundation Training Programme Director
Chris Summerton	College Representative
Joanne Jenkins	Trainee Associate
Neil Logue	Lay Representative
Heather Stronach	Quality Improvement Manager
In attendance	
Patriche McGuire	Quality Improvement Administrator

Specialty Group Information		
Specialty Group	Medicine	
Lead Dean/Director	Alastair McLellan	
Quality Lead(s)	Stephen Glen, Reem AlSoufi, Alan McKenzie	
Quality Improvement Manager(s)	Alex McCulloch and Heather Stronach	
Unit/Site Information		
Non-medical staff in attendance	1	
Trainers in attendance	3	
Trainees in attendance	10	2 Foundation 1 General practice trainee

		2 Core level trainees 5 Specialty level trainees

Feedback session: Managers in attendance	Chief Executive		DME	√	ADME	√	Medical Director	√	Other	√

Date report approved by Lead Visitor	16 September 2020

1. Principal issues arising from pre-visit review:

At its meeting in September 2019, following a review of the available data, the Deanery's specialty quality review panel (QRP) decided to trigger a visit to gastroenterology at the Glasgow Royal Infirmary.

Below is a broad summary of the data from the General Medical Council's (GMC's) national training survey (NTS) and the Deanery's Scottish training survey (STS).

	Foundation trainees	Core	Specialty trainees	(Post data)
Adequate Experience				
Clinical Supervision				NTS pink (3 consecutive)
Clinical Supervision out of hours			NTS pink	
Educational Supervision				
Feedback			NTS pink	
Handover	STS Red	STS Red	NTS red	NTS red (pink and red in consecutive years)
Induction			NTS red	
Local Teaching				
Overall Satisfaction				
Regional Teaching				
Study Leave				
Supportive environment			NTS red	
Work Load				NTS red
Reporting systems				
Teamwork			STS Pink, NTS red	
Curriculum Coverage			NTS red	NTS green
Educational Governance				
Rota Design				NTS red

Analysis of the qualitative data suggested that the main issue for trainees was around the general internal medicine (GIM) workload and rotas. Gastroenterology specific training opportunities appeared to be widely available at Glasgow Royal Infirmary; however, trainees were missing out on these due to their commitment to GIM. The data received did not express any concerns around the

approachability and supportiveness of seniors, therefore the flags around supportive environment and teamwork appeared to stem from this issue. The flag on handover raised by all cohorts was identified as an area that needed to be explored by the visiting panel.

The panel met with both trainers and trainees in gastroenterology. The trainees we met with were foundation year 1 (FY1 trainees), (no FY2 trainees were available on the day due to on call commitments), a core trainee (CT), a core-level clinical fellow, a general practice (GP) trainee who had only just started within the department so limited commentary can be provided, specialty trainees (ST), and a registrar level clinical fellow. We also met with one member of non-medical staff who, while able to provide general commentary about GIM and the GIM rota, was unable to make specific comment about the gastroenterology department which was the intended purpose of this visit.

A summary of the discussions has been compiled under the headings in section 2 below. This report is compiled with direct reference to the GMC's Promoting Excellence - Standards for Medical Education and Training. Each section heading below includes numeric reference to specific requirements listed within the standards.

Prior to the visit commencing, the visiting panel met with Gerard McKay, Associate Director of Medical Education, Brian Neilly, Clinical Director for Medicine, Dr Ravi Jamdar, Acute Medicine Lead, Kirsty May, Acute Services Manager and Michael McCrossan, Clinical Quality Manger, to gain a broad summary about what is happening in the gastroenterology department. They advised that a Deanery GIM visit had taken place in May 2019: 8 requirements had resulted from that visit including an item relating to handover. The 9-month action plan had just been completed and therefore it was likely that we would hear about some of the changes from trainees today. Changes had also been recently made to the GIM rota; while improving GIM cover and experience, it became apparent as early as August 2019 that the GIM rota changes were having unintended consequences on specialty training: for gastroenterology trainees could no longer access gastroenterology specific training on Mondays and Fridays.

We heard that Glasgow Royal Infirmary, like many sites, is facing an increasing volume of admissions and this requires innovative planning about how to manage patient flow to absorb this increase in demand with the available doctor staffing levels. Persistent gaps in the rota due to long term sickness

or shortage of GP trainees on the rota is frustrating the service in being able to meet these demands. Trainees deemed capable of doing so are being asked to act up on the rota to support service.

Gastroenterology consultants are keen to support specialty training but are aware of the dichotomy of maintaining the frontline service for acute medical admissions whilst trying to support training in the specialty of gastroenterology. The revised GIM rota has improved the patient experience for acute care. As a result, service leads consider that small changes could be made to improve the gastroenterology experience for trainees; however, major service changes could not be considered in face of what is needed for GIM.

2.1 Induction (R1.13):

Trainers: Trainers reported induction is led by Dr Lyn Smith and is effective. Induction is repeated again at the 4- and 6-month changeovers. If a trainee is unable to attend routine induction, Dr Smith provides a bespoke induction for them. Induction is supported by written materials available online. Feedback is sought from trainees about induction, but trainees had not had anything to report back.

Foundation and GP trainees: Trainees reported that they were emailed induction information 10 days before starting in gastroenterology. The email they received welcomed them to the department and there were documents attached containing useful practical information, such as what to expect on the wards, what to do to get training on ascitic taps, and when departmental teaching takes place.

On the day of changeover itself, Dr Lachlan gave a presentation and they did a tour of the ward. Trainees said their induction prepared them well for their FY role and they had no suggestions for improvement. On weekends, FY trainees sometimes cover their own wards but also other wards, and the GIM induction they received separately was good for explaining to them how the hospital runs out of hours. One trainee had not yet received the GIM induction, but was aware that the intention was to provide this before they do any out of hours working.

Not all trainees had received their passwords to the radiology Picture Archiving and Communication System (PACS) and access to the arterial-blood gas (ABG) machine.

Core trainees: Core trainees had received departmental induction. They confirmed the same information as the foundation trainees. They rated departmental induction highly and said it had clear information about their roles as a core trainee and had clear formal lines of escalation. All trainees had received their passwords and access to the ABG machine. Core trainees had no suggestions for improving induction.

Specialty trainees: All trainees had received departmental induction and had received their log ins without a problem. Trainees who had been out of programme had been given a refresher induction which they found useful. Trainees were clear about their role as the gastroenterology registrar after having received induction.

ST trainees felt that the hospital GIM induction for out of hours was not as good as it could be, because this information is provided online or electronically only and trainees do not receive anything face to face. Instead they feel that hospital induction is uncoordinated as they had received separate emails from the various teams. It was felt that a face-to-face induction is needed so that registrars can get to know who other team members are and who to contact. They said that escalating to the consultant on call was fine, but it was difficult for them knowing who their junior team are. If there had been a face to face induction, they could have found out.

2.2 Formal Teaching (R1.12, 1.16, 1.20)

Trainers: Trainers told us about the formal foundation, core and specialty training days. Regarding local departmental teaching, this is held weekly on the ward on a Tuesday lunchtime and lasts between 30 minutes and 1 hour. Morbidity and mortality meetings (M+Ms) take place once per month as part of the teaching programme. Teaching is usually led by core or specialty trainees, but sometimes it will be the consultant. Teaching is not bleep free; if a patient is unwell in the gastroenterology ward next door, the door will be knocked on and someone will attend to the unwell patient.

Foundation trainees: Foundation trainees said they can attend the Tuesday departmental teaching and do not get called out of teaching to attend the ward. Foundation trainees said that Tuesday teaching is not always specific to gastroenterology and would prefer more gastroenterology targeted teaching.

Core trainees: Core trainees also confirmed the Tuesday department teaching and also a grand round taking place on a Wednesdays. They said they usually receive about 1 hour of teaching per week at maximum. Overall trainees report that the teaching is varied and of a good standard and particularly enjoyed a session that where Jehovah's witnesses were present to talk about their beliefs and how this might affect the care they receive.

Core trainees confirmed their regional teaching but reported that it can be difficult to attend because of the tight GIM rota.

Specialty trainees: Specialty trainees also confirmed the Tuesday department teaching and Wednesday grand round taking place in the postgraduate centre. They said their attendance was variable as it depended on whether or not they were working at Stobhill Hospital. Working offsite at Stobhill Hospital meant they could not attend teaching due to being in a different physical location. On average, they estimated getting to about 30 minutes of teaching per week. Specialty trainees said that everyone in the department is given an opportunity to present at the Tuesday lunchtime meeting to try and make it as inclusive as possible. They report that the Tuesday teaching is a good case mix of things.

Regional teaching for specialty trainees usually takes place on a Thursday or Friday. Specialty trainees have had one regional training day so far and were aware of two upcoming Thursday sessions. They said that usually there are four training days, whereas this year it appears that there may only be three.

All trainees suggested that department induction could be improved with some consultant led, gastroenterology specific teaching.

2.3 Study Leave (R3.12)

Trainers: Trainers said they not aware of any issues. They said that trainees mostly get away to their training days, although acknowledged it can be challenging for the rota coordinator to approve study leave requests due to the gaps in the GIM rota. They said the two clinical fellows in the gastroenterology department provide extra resource given that there is no requirement for them to attend teaching. Trainers said that they are aware that when trainees are on call for GIM

(approximately 40% of their time), they might be unable to take study leave. However, trainees are usually granted the study leave they request.

Core and specialty trainees: Core and specialty trainees said that they can request and take study leave if they are not on call. Specialty trainees described having to make sure that one of them is available on site so that the request will be approved; however, this can be challenging at times because the GIM rota does not take into account which specialty ST trainees are coming from. Amongst the gastroenterology STs themselves, they try to be fair in their requests. Trainees describe getting a reasonable amount of study leave sufficient for their requirements.

2.4 Formal Supervision (R1.21, 2.15, 2.20, 4.1, 4.2, 4.3, 4.4, 4.6)

Trainers: Trainers said that educational and clinical supervisors are assigned to trainees at the start of the year and trainees are emailed who their supervisors are.

Because ST trainees rotate through a 5-year programme, there is wide knowledge amongst trainers about their individual training needs. Trainers reported that this can be more difficult for the other cohorts because there are different training portfolios and these can take time to navigate. Trainers said it might be better if trainers were allocated to the same group of trainee so they can familiarise themselves with this better; however these trainees are allocated centrally.

Trainers have time in their job plans for their supervisors roles (some with 2.5 supporting professional activity allocations). Supervisor training is assessed through the appraisal process.

Trainers had been passed on information about a trainee requiring additional support but would have preferred earlier notification about this.

All groups of trainees: Trainees reported no issues with respect to formal educational supervision. The GP trainee was not yet aware who their clinical supervisor was but had just started in post.

2.5 Clinical supervision (day to day) (R1.7, 1.8, 1.9, 1.10, 1.11, 1.12, 2.14, 4.1, 4.6)

Trainers: Trainers said that as a unit they work together cohesively and effectively. There are two gastroenterology wards each with regular consultant presence and a dedicated consultant on call for the week. This means there is 7 days a week consultant contact. At their initial meetings with trainees, trainers ask trainees where they are at in their training and what they need or want to achieve. Trainees are encouraged by trainers to present their learning, for example, at journal clubs or at Tuesday teaching. Trainers are not aware of any instances where trainees have felt they have had to cope with problems that were beyond their competence or experience because there is regular formal, and informal supervision.

Foundation, GP and core trainees: Foundation trainees said they always know who to contact during the day: there is always someone more senior on the ward who they can escalate matters to. Foundation trainees know to escalate to the registrar on call for senior support if they are working out of hours. They said they have never felt that they have had to cope with problems outwith their competence or experience: senior support is always easily accessible and available.

Specialty trainees: Specialty trainees also said they always know who to contact for senior support during the day and out of hours. The gastroenterology consultant on call can be reached via the switchboard, and they are also comfortable calling the consultant on call for other specialties, when required. Specialty trainees also did not feel that they have had to cope with problems outwith their competence or experience stating that senior support is always easily accessible and available.

2.6 Adequate Experience (opportunities) (R1.15, 1.19, 5.9)

Trainers: Trainers said that specialty trainees have a structured job plan. However, the frequency at which specialty trainees are on call is affecting the time they spend in specialty training. When trainees are on call for medicine, they are unable to do any specialty training and are unable to take annual leave or study leave. Trainees must take zero days after working weekends, meaning that trainees are missing out specialty training opportunities that take place on a Monday or Friday. ST trainees have a weekly timetable so that if they are rostered to be in the endoscopy clinic on Mondays, this means that they can attend the endoscopic clinic a maximum of 8 times per year once the GIM commitment has been factored in. In reality, this could be less if any endoscopy lists are

cancelled due to consultant absence. Some trainers reported having adjusted their job plans to move their clinics and endoscopy from a Monday to Tuesday to allow trainees better access to these training opportunities.

Trainers strongly feel that their current ST trainees are not able to get good gastroenterology training because of their GIM commitment. Trainers report feeling frustrated because there is a good breadth of gastroenterology opportunities available at Glasgow Royal Infirmary. Trainers reported that specialty trainees are having to voluntarily attend within their own time the gastroenterology bleeding list that takes place 7 days a week from 8am – 9am. Trainees are contracted to start work at 9am. If they start work before this they would be working outside of their contracted hours in order to obtain this mandatory competence.

There is an imbalance in the specialty training cohort at the moment; there are three ST7 trainees. The ST7 trainees have already been signed off for their GIM competencies meaning that their commitment to the GIM rota (they said approximately 30%) is purely service based and not needed for training. ST3 trainees and ST7 trainees have the same frequency of on call. Some of the ST7 trainees were unable to achieve some of their gastroenterology competencies in the earlier years of specialty training, and this means they are now all competing for their specialty competencies. Trainers do not consider that they are supported by management to offer solutions. They feel that the West of Scotland is unique in terms of the way the GIM component of training is managed.

Foundation, GP and core trainees: These trainees all felt they would be able to achieve their curriculum competencies. Foundation trainees are ward based and do not attend clinics or endoscopy. For core trainees, the gastroenterology rota does not formally allocate clinic time for them but they have been told that they are welcome to attend clinic. The perception was this might be difficult because the wards are busy. Some days trainees attend consultant led ward rounds and at other times their working days are more task focused. Clinics for core trainees are being achieved through general medicine via ambulatory care and day ward experiences.

Foundation trainees estimate that on average they spend 20-40% carrying out duties of little educational benefit. Phlebotomy has a cap of 8 patients on the wards. This means the FY1 are often busy taking bloods which then results in delays in other activities and also impacts what core trainees carry out day to day.

Specialty trainees: There are currently a high number of ST7 trainees who require procedural training and they report difficulty achieving the following competencies:

- Endoscopy in acute gastrointestinal bleeding: Trainees report having to voluntarily attend the gastroenterology bleeding list that takes place from 8am – 9am within their own time.
- Colonoscopy: Trainees reported that there are 8 lists in total, 4 of which are on a Friday (which ST trainees are unable to get to if they are on the medicine rota). Some trainees report having to come in on their days off to achieve colonoscopy experience. It was noted that the current ST3 had done Structured Programme of Induction and Training (SPRINT) training in upper GI endoscopy and this might be a solution for trainees in future. This was not the case for some of the ST7 trainees who were unable to complete colonoscopy in their earlier years of training and now report feeling that the general medicine commitment in the West of Scotland has taken precedence over their specialty training.
- Nutritional training: ST trainees reported that there is a surgically led nutrition team at the Glasgow Royal Infirmary which they attend when then can, but they perceive this needs to be 3 months consistent experience. Trainees have organised a session at the University Hospital Monklands on a Tues afternoon which they share.

Trainees report being unable to take part in the bowel cancer screening lists and trainers confirm that they can only attend bowel screening lists once signed off as provisionally accredited in colonoscopy as it is not believed to be reasonable for patients identified through a national screening programme to have their procedures undertaken by inexperienced endoscopists, even under supervision. Trainees consider that an effort needs to be made to identify which trainees may be interested in colonoscopy at consultant level. The return of colonoscopy as a mandatory curricular procedural skill in the future will have an impact on this.

2.7 Adequate Experience (assessment) (R1.18, 5.9, 5.10, 5.11)

Trainers: Trainers reported that they have all received training in completing workplace-based assessment. Trainers are not aware of any trainees not being able to achieve their mandatory assessments. Trainers said that despite the known difficulties with endoscopy, trainees are all meeting their competencies.

All trainees: All trainees were happy with assessment reporting that they are fair and consistent.

2.8 Adequate Experience (multi-professional learning) (R1.17)

All trainers and trainees described the multidisciplinary meeting that takes place on a Wednesday amongst doctors, pharmacists, nurses, dietitians and palliative care specialists.

2.9 Adequate Experience (quality improvement) (R1.22)

Trainers: Trainers reported that trainees are actively encouraged to take part in quality improvement projects and present their findings regionally and nationally.

Foundation and GP trainees: Foundation trainees were not aware of any quality improvement projects specifically for gastroenterology.

Core and specialty trainees: Core and specialty trainees described active engagement with quality improvement projects and good support from seniors with this.

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: Trainers described feeding back to trainees frequently both formally and informally, such as at supervisor meetings or at clinic. They said that out of hours this can be more challenging, but it still takes place. They said that both trainers and trainees are proactive in giving and getting feedback.

Foundation and core trainees: Foundation and core trainees said they receive feedback primarily through case-based discussions with seniors. When feedback is received, it is delivered in a constructive and meaningful way; however, core and foundation trainees would appreciate receiving more proactive feedback.

Specialty trainees: Specialty trainees would also appreciate receiving more proactive feedback They said that if they do a ward round and this is followed by a consultant led ward round the next day, then feedback will take place.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: Trainers said that they often hear from trainees if there are any issues at lunchtime meetings or after ward rounds. The consultant group meets twice a year for general business matters and the progress of ST3+ trainees is discussed at these meetings. Trainers advised that their offices are right beside each other so that there are informal chats taking place all the time.

Foundation and core trainees: Foundation and core trainees said they would be comfortable speaking to their educational supervisors if they wished to feed back anything about their training.

Specialty trainees: Specialty trainees confirmed having contacted management and described a meeting with the gastroenterology TPD, the Acute Services Lead and Acute Services Manager about their ongoing concerns with the medicine rota and the impact of this on specialty training. The partial solution to this was the revision of some consultants' job plans to reallocate Monday lists to the middle of the week (as previously described in this report).

2.12 Culture & undermining (R3.3)

Trainers: Trainers described several steps they undertake to create a team culture including social and sport activities. Trainees receive funding to go to gastroenterology conferences. They regularly attend British Society for Gastroenterology meetings.

Trainers were not aware of any instances of bullying or undermining within the department. Trainers advised that there is a trainee representation on the gastroenterology specialty training committee (STC) and issues can also be fed back there.

All trainees: All trainees described working with supportive and approachable consultants. No trainees had experienced any bullying or undermining behaviours and would feel comfortable reporting such behaviours.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Trainers said that the GIM rota is centrally managed and outside control of the gastroenterology department. There is no separate gastroenterology trainee rota.

Trainers said there are no gaps at ST3+ level for gastroenterology. Sometimes there are gaps at core or FY level due to gaps and sickness.

Trainers could not remember the last time the junior rotas were at full complement, but they did not consider there are any implications for patient safety as the site proactively manages the gaps to the best of their ability. Occasionally trainers cancel elective services if there are large gaps.

Foundation and GP trainees: Foundation trainees were not sure about rota gaps but were aware of a locum FY doctor. Foundation trainees did not consider there were any patient safety issues due to staff shortages. Foundation trainees are not rostered to clinics (and there are no plans for this). Foundation trainees did not think the rota organisers would be open to any of their suggestions for improving the rota if they had any.

Core and specialty trainees: Core trainees and specialty trainees were aware of several gaps in the middle grade medicine rota. They said that this was a result of sickness, but they were also aware of some GPST positions that had not been filled. They said that providing there are no GIM rota gaps, the two acute wards and the day unit should be covered by three middle grade doctors. In their experience this has usually been just two with an ST trainee having to fill the third gap. On the GIM ST rota, there are also three to four gaps; and this then reduces the number of STs available in specialty and reduces the number of training opportunities that can be attended by STs.

Trainees said the rotas are often given at short notice and they perceived that the rotas that are issued to them are often incorrect. We heard of an instance where the GIM rota circulated to them indicated that there would be five doctors covering the weekend shift. Amongst trainees themselves they knew that two of the doctors listed were on long term absence, so in reality there were only three doctors covering the weekend shift. Trainees could not understand why such names appear on the rota. We also heard that CT2s are often asked to act up (which is good experience); however, there

had been at least one instance where a CT2 had stepped up to fill two absent registrar roles and this was felt to be a stretch. This too impacts on the ability of core trainees to attend clinics and teaching.

Trainees did not consider that the gaps were leading to any patient safety issues but reported that things can feel stretched. The impression from trainees is that the known shortages do not feel well planned for and they believe that the medicine rota team find it difficult to keep up with last minute changes. Trainees report often receiving emails, without any context, instructing them to cover another area than what they were initially rostered to. Trainees felt that the service did not understand how busy they are and do not have realistic expectations about what we they can deliver for service when taking into consideration their own training needs.

2.14 Handover (R1.14)

Trainers: Trainers advised that hospital handover for medicine is at 8:30am led by senior trainees. For evening handover, trainers said that any sick patients on the downstream wards are handed over by the middle grade doctor to the hospital at night team. Trainers were also aware of a handover at weekends for downstream cover. Trakcare for handover is utilised at weekends to pass on information about unwell patients.

Trainers said that a lot of work had been undertaken to improve handover since the GIM visit. Consultants undertake their endoscopy lists for acute gastrointestinal bleeding at 8am and carry out a ward round from 9am and are not involved in handover. They suggested that questions about handover would be better directed at trainees. They advised that the day consultant is then on call for gastrointestinal bleeding throughout the night. Handover between consultants is verbal.

Foundation, GP and core trainees: Foundation and core trainees confirmed the 8:30am medicine handover. They said that foundation trainees and the downstream medical registrar attend morning handover, where information is passed on from the hospital at night team and foundation trainees disseminate this information to the various wards they are covering. At 4:45pm the on call foundation trainees receive handovers from day shift FY1. There is a room on the gastroenterology wards where this takes place. At 8:30pm, foundation trainees handover to night team and the hospital at night team feed back again at the 8:30 morning handover.

Morning handover was felt to follow a formal structure. It takes place in the junior doctor's mess and there is a laminated sheet with a proforma. Handover is not documented. If there are outstanding tasks such as bloods, the form will be handed over to the ward doctor. Handover was not felt to be used as a learning opportunity with there reportedly being not much time for that

Foundation trainees find it difficult if they are covering a ward at one end of the hospital and have to handover to a ward at the opposite end of the hospital by telephone because they are not always able to get through to someone on the telephone. They find this stressful because they then have to come off their own ward to ensure that handover takes place. This was reportedly felt by several trainees.

Specialty trainees: Specialty trainees said they would phone the downstream medical registrar on call or ask the middle grade who is doing the handover to find out any information about sick patients. STs also felt that morning handover had become much more structured since August and is now working well.

By contrast, evening handover was not felt to be working well. It was described as informal and unstructured, with a lot of 1 to 1 conversations taking place. Trainees said that attendance at handover to the hospital at night team is variable because day shift staff can be dealing with medical emergencies. Registrars were unclear about attending evening handover on the wards as they are supposed to be attending the Acute Assessment Unit. Some trainees grab the page and go back to the handover but advise that there is not always time to do this. Others did not follow this pattern. They felt that evening handover would benefit from a registrar being present.

2.15 Educational Resources (R1.19)

Educational resources were reported to be adequate. New computers were starting to be installed, and trainees feel this will have a positive impact.

2.16 Support (R2.16, 2.17, 3.2, 3.4, 3.5, 3.10, 3.11, 3.13, 3.16, 5.12)

Trainers: Trainers said that as supervisors they often discuss with trainees what they want to achieve and if there is anything we can support them with (for example, should trainees wish to do

some palliative care experience trainers help to provide guidance and support) Trainers also reported that trainees do taster days, which they enjoy.

All trainees: Overall, trainees felt that the gastroenterology department is supportive.

2.17 Educational governance (R1.6, 1.19, 2.1, 2.2, 2.4, 2.6, 2.10, 2.11, 2.12, 3.1)

Foundation, GP and core trainees: Foundation and core trainees were not aware who the Director of Medical Education is for Greater Glasgow and Clyde. However, trainees were aware of a junior doctor's forum meeting monthly and a chief resident who sits at that forum. Items such as the rota gaps had been raised and were ongoing with no resolution as yet.

Specialty trainees: Specialty trainees were not aware of a junior doctor's forum but of a medical staffing association. One of the specialty trainees was able to identify the Director of Medical Education.

2.18 Raising concerns (R1.1, 2.7)

Trainers: Trainers said that concerns can be raised quickly by trainees because senior support is always available. Educational supervisors and clinical supervisors work together as a team and try to ensure that trainees feel well supported and able to raise any concerns they might have.

All trainees: All trainees said that their seniors are contactable and approachable and are comfortable raising concerns with them.

2.19 Patient safety (R1.2)

Trainers: Trainers said that the gastroenterology department is a safe environment for patients. Trainers stated that there is a lot of consultant support for trainees and trainees have fed back positively about this. Trainers acknowledged that rota gaps could be improved.

All trainees: All trainees said that there were no concerns relating to patient safety in the gastroenterology department. Trainees can sometimes feel pressured by bed management to board

patients they do not feel are appropriate to be boarded. This has been raised with consultants who responded to ensure that patients are not to be boarded without prior discussion with a consultant in the department and this was felt to be effective.

2.20 Adverse incidents & Duty of Candour (R1.3 & R1.4)

Trainers: Trainers said that registrars lead the morbidity and mortality (M&M) meetings and collect any data for it. M&Ms take place monthly on a Tuesday.

All trainees: All trainees were aware of the Datix system for reporting adverse incidents and would feel supported raising incidents using Datix. They said that trainers would be very sympathetic if trainees were involved an adverse incident. Trainees also described the monthly gastroenterology M&M meetings. They said both trainees and consultants attend this and the meeting is very valuable. Some trainees had received specific feedback on the incidents they had raised using Datix whereas others had not. Trainees were aware how M+M meetings fed back into the wider hospital governance.

2.21 Other

The visit panel met with one member of non-medical staff who, while able to provide general commentary about GIM and the rota arrangements, was unable to make specific comment about the gastroenterology department and therefore this commentary is unable to be included within this report.

It is worthwhile noting in this report that there was clear awareness of the ‘Say No to SHO’ campaign with coloured badges in place; although unfortunately foundation trainees continued to use the term SHO.

All groups of doctors were asked to rate their overall satisfaction with their placement and the average scores are presented below:

- **Foundation and core trainees** Average = 7 out of 10
- **ST trainees:** Range = 5 - 8, Average = 6.8 out of 10

3. Summary

Is a revisit required?	Yes	No	Highly Likely	Highly unlikely

Overall the gastroenterology department was found to be supportive with dedicated and approachable consultants. Good gastroenterology opportunities at Glasgow Royal Infirmary are taking place, but the ability for trainees to attend such opportunities is compromised due to gaps in the GIM rota. This was seen to be largely affecting the three ST7 trainees.

FY and core trainees would like to see better support with non educational tasks such as taking bloods. which are preventing them from accessing learning opportunities.

ST trainees considered that accessing the endoscopy lists in acute gastrointestinal bleeding should be achievable within their working hours. Overall, they considered there needs to be a greater understanding that prioritising service provision for GIM will impact on their ability to achieve their mandatory outcomes for specialty training.

All trainees would like some consultant led, gastroenterology specific teaching.

Positive aspects of the visit:

- All trainees advised that they had supportive, approachable and easily accessible consultants with clear examples of good leadership including around procedural session access and boarding decisions.
- Gastroenterology induction was effective with bespoke catch up inductions in place for those who had missed out on routine induction. Trainees were satisfied with the written induction materials provided.

- Both educational and clinical supervision was in place and reported to be good.
- There was clear awareness of the 'Say No to SHO' campaign with coloured badges in place; although unfortunately foundation trainees continued to use the term SHO.
- M+M meetings run monthly. Trainees are actively involved in these meetings and receive feedback on cases.
- Morning handover (including dissemination of information to the downstream wards) was noted by trainees to have improved since the GIM visit and was structured.

Less positive aspects of the visit

- Afternoon handover at 4:45 was reported to be variable and dependent on individuals, leading to cause for concern about potential patient safety concerns.
- The GIM rota management is having unintended knock on effects for trainees. Trainees report that known gaps are not being filled and are unable to understand why trainees known to be on long term absence appear on rotas. Trainees reported instances where they came to work on the weekends to find out that the hospital was not as well staffed as they were led to believe with the rota that was issued. We also heard of an instance where a CT2 had stepped up to cover a registrar gap in the rota to then find out they were required to fill two registrar gaps. There was confusion about changes in the published rota with multiple versions in circulation.
- The capping of phlebotomy to 8 patients on the wards is having a negative impact. Foundation trainees report feeling burdened carrying out non educational tasks affecting their ability to take part in ward round. This is also having a knock on effect to core and ST trainees.
- Foundation trainees would like some gastroenterology teaching that is more relevant to them.
- Core trainees are not rostered to attend gastroenterology clinics. Clinics are being achieved through general medicine via ambulatory care and day ward experiences.
- There are currently a high number of ST7 trainees who require procedural training and they report difficulty achieving the following competencies:
  - endoscopy in acute gastrointestinal bleeding
  - colonoscopy
  - nutritional training.

Trainees report having to voluntarily attend the gastroenterology bleeding list that takes place from 8am – 9am within their own time.

- All trainees would appreciate receiving more proactive feedback.

4. Areas of Good Practice

Ref	Item	Action
4.1	Monthly M+M meetings. Trainees are actively involved in these meetings.	

5. Areas for Improvement

Areas for Improvement are not explicitly linked to GMC standards but are shared to encourage ongoing improvement and excellence within the training environment. The Deanery do not require any further information in regard to these items.

Ref	Item	Action
5.1	Teaching	More gastroenterology specific teaching led by consultants.
5.2	Feedback	More regular feedback opportunities.
5.3	Rota	Improved communication around the GIM rota.

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	Handover arrangements, especially evening 4:45pm handover, must be reviewed and improved to ensure there is a safe, robust handover of patient care with adequate documentation of patient issues.	Immediately	All trainees
6.2	The board must continue to review the GIM rota and the management of this rota in order to eliminate the frequent, short notice filling of gaps	12 November 2020	All trainees

	and to reduce the unintended adverse consequences this has on specialty training.		
6.3	The Board must design rotas to provide learning opportunities that allow doctors in training to meet the requirements of their curriculum and training programme.	12 November 2020	Core, specialty trainees
6.4	Tasks that do not support educational and professional development and that compromise access to formal learning opportunities (for example, taking bloods) must be reduced.	12 November 2020	Foundation, Core
6.5	Trainees must have access to the appropriate procedures, including endoscopy, to enable them to meet the requirements of the curriculum.	12 November 2020	Core, specialty trainees