Impact of changes on junior doctor rotas and training

South West Senate: Question-12:
Q: Describe the model of the potential impact of changes at CGH on junior doctor supervision, training and rotas and the accreditation of these posts. Engagement with Deanery regarding the full scope of the proposed changes would be helpful to demonstrate given the reference to concerns with surgical trainees

Engagement with the Deanery

The overarching concerns from trainees are that historically there was a significant imbalance between CGH and GRH in surgical workload and opportunity. This meant less than ideal training experience for surgeons on either side – too much emergency work in GRH to get to theatre and too little surgical experience in CGH for the number of trainees placed there. Part of the aim of the EGS reconfiguration is to better manage the emergency workload and even out the opportunities for specialist surgical experience. The surgical clinical tutor and deanery representative have been in contact with the training programme director for surgery to discuss how we are responding to the concerns raised. Further work is ongoing with the Director of Medical Education, Training programme directors and Clinical Tutors to review the training opportunities that the future configuration of services and will provide. This will then be shared and discussed with the Programme Directors and Heads of School for Medicine and Surgery.

General advice from the Deanery:
It is important to maintain foundation trainee post numbers across the trust and all the work schedules for posts affected will be reviewed to ensure suitable learning opportunities are still open to them. There is potential to be offered further foundation posts next year, as the first cohort of the extra 1500 medical school places will be graduating however GP training programmes are changing the year after that to include less time in hospital posts so it is possible that there is little change in overall junior doctor numbers but a shift in trainee type.

- The learning objectives for foundation doctors are set through a national curriculum, overseen by the UK foundation programme office and the GMC
- Foundation year 1 doctors require immediately available support from people with the skills to manage problems they might face (so that could be the ACRT or DCC team).
- There is no precise specification for particular hours of the day or night but posts should provide opportunities for experience to achieve the learning outcomes.
- Foundation year 1 doctors require immediately available support from people with the skills to manage p F2s take on more responsibility for leading and managing patient care but still need to be able to access support for problems they might face (so that could be the ACRT or DCC team).
- If there are going to be big changes in foundation post rotas, we should discuss them with the Gloucestershire foundation programme directors (at one of their regular Tuesday meetings) and then make sure the Foundation school team at the deanery is aware.
- There is no rule that requires training to be provided on one site. Many trainees will need to work at several sites to achieve their learning outcomes. Moving between sites should be justified on training grounds rather than service grounds and doctors in training must have induction to all areas and appropriate clinical supervision at all times. If doctors need to move sites during a shift we need to think about how they will do that safely (and return back afterwards) and without interrupting continuity of patient care.
- Training posts must allow trainees to achieve the learning outcomes set in their curriculum. Colleges may set expectations for proportions of elective/emergency work but this isn't universal across programmes and will be a guide. If a college sets an expectation that is unachievable but we can demonstrate that trainees are able to meet their learning needs with a different pattern that would be fine. That's difficult to do prospectively though.
- The risk of prioritising service over training is the withdrawal of training posts and loss of trainees.

Model of Impact for each option on Out of hours Doctor rotas- Medical Division:

	Do Nothing baseline			Option 4.4 (CR- CGH Vas-GRH)			Option 5.4 (CR & Vas GRH)		
Specialty	Consultant	Registrars	Foundation / SHO	Consultant	Registrar	Foundation / SHO	Consultant	Registrar	Foundation / SHO
Gastro	On- call 1:9 consultant rota countywide	Combined rotas: CGH: one resident Registrar 24/7. GRH: Mon-Fri- 1 reg. 09.00-17.00, 1 reg. 17.00-21.00, 2 reg. 21.00-09.00 Sat & Sun- 2 reg. day & night Rotas: 1 in 8 nights, 1 in 13 days & 1 in 5 on call (days and nights)	AMIA (additional) 1X 13.00-23.00, 1X 17.00-21.30 Combined rotas CGH: weekday 1x 17.00-21.00 1x 21.00-09.00. Weekends 09.00-21.00 GRH: weekdays 2x 09.00-21.00, 1x 12.00-21.00, 1x 14.00-24.00 1 FY1 & 1 SHO 21.00-09.30 3 SHO for clerking (2 additional on Friday) Weekends: 1X 09.00-21.00 AMU, 2X 08.00 plus 2-3 specials. Clerking 09.00-21.30, 1x twilight	On- call 1:9 consultant rota countywide	Combined rotas: CGH: one resident Registrar 24/7. GRH: Mon-Fri- 1 reg. 09.00-17.00, 1 reg. 17.00-21.00, 2 reg. 21.00-09.00 Sat & Sun- 2 reg. day & night Rotas: 1 in 8 nights, 1 in 13 days & 1 in 5 on call (days and nights)	AMIA (additional) 1X 13.00-23.00, 1X 17.00-21.30 Combined rotas CGH: weekday 1x 17.00-21.00 1x 21.00-09.00. Weekends 09.00-21.00 GRH: weekdays 2x 09.00-21.00, 1x 12.00-21.00, 1x 14.00-24.00 1 FY1 & 1 SHO 21.00-09.30 3 SHO for clerking (2 additional on Friday) Weekends: 1X 09.00-21.00 AMU, 2X 08.00 plus 2-3 specials. Clerking 09.00-21.30, 1x twilight	On- call 1:9 consultant rota countywide	Combined rotas: CGH: one resident Registrar 24/7. GRH: Mon-Fri- 1 reg. 09.00-17.00, 1 reg. 17.00-21.00, 2 reg. 21.00-09.00 Sat & Sun- 2 reg. day & night Rotas: 1 in 8 nights, 1 in 13 days & 1 in 5 on call (days and nights)	AMIA (additional) 1X 13.00-23.00, 1X 17.00-21.30 Combined rotas CGH: weekday 1x 17.00-21.00 1x 21.00-09.00. Weekends 09.00-21.00 GRH: weekdays 2x 09.00-21.00, 1x 12.00-21.00, 1x 14.00-24.00 (1 FY1 & 1 SHO 21.00-09.30 3 SHO for clerking 2 additional on Friday) Weekends: 1X 09.00-21.00 AMU, 2X 08.00 plus 2-3 specials. Clerking 09.00-21.30, 1x twilight
Cardiology	On- call countywide 1 :13 to a split rota 1 in 6 for PPCI and 1:7 for others			On- call countywide 1 :13 to a split rota 1 in 6 for PPCI and 1:7 for others			On- call countywide 1 :13 to a split rota 1 in 6 for PPCI and 1:7 for others		
Care of the Elderly	On- call consultant rota countywide			On- call consultant rota countywide			On- call consultant rota countywide		
Acute Medicine									
Diabetes & Endocrine									
Neuro	On- call 1:6 consultant rota			On- call consultant rota			On- call consultant rota		
Renal	On- call 1:6 consultant rota			On- call consultant rota			On- call consultant rota		
Respiratory	On- call consultant rota countywide 1:8			On- call consultant rota countywide 1:8			On- call consultant rota countywide 1:8		
Stroke	On-call until 20.00 7 days wk. Plus specialist regional on call: thrombolysis queries			On-call until 20.00 7 days wk. Plus specialist regional on call: thrombolysis queries			On-call until 20.00 7 days wk. Plus specialist regional on call: thrombolysis queries		
ED	Consultant cover at GRH 08.00-00.00 hrs CGH 08.00-22.00	1: rota across both sites. Senior trainees working 4:10 WE, Trust working to reduce to 1:3 for compliance	24 doctors across both sites rota 1:2 over WE Trust working to reduce to 1:3 for compliance	Consultant cover at GRH 08.00-00.00 hrs CGH 08.00-22.00	1: rota across both sites. Senior trainees working 4:10 WE, Trust working to reduce to 1:3 for compliance	24 doctors across both sites rota 1:2 over WE Trust working to reduce to 1:3 for compliance	Consultant cover at GRH 08.00-00.00 hrs CGH 08.00-22.00	1: rota across both sites. Senior trainees working 4:10 WE, Trust working to reduce to 1:3 for compliance	24 doctors across both sites rota 1:2 over WE Trust working to reduce to 1:3 for compliance

Grey background denotes specialties in which no rota changes are to be made but in which there may be impact

Model of Impact for each option on out of hours Doctor rotas- Surgery:

Specialty	Do Nothing baseline			Option 4.4 (CR- CGH Vas-GRH)			Option 5.4 (CR & Vas GRH)		
	Consultant	Registrar	Foundation	Consultant	Registrar/CT	Foundation	Consultant	Registrar/ CT	Foundation
Breast	No consultant rota, covered by GS	Included in GS rota	OOH covered by EGS (both sites)	No change	DPM – escalate to cons	DPM – escalate to cons	No change	DPM – escalate to cons	DPM – escalate to cons
T&O	1:20 rota based at GRH	1:16 rota based at GRH	GRH Rota 1:10. CGH: OOH combined with EGS rota	No change	No change	CGH: DPM – escalate to registrar at GRH	No change	No change	CGH DPM – escalate to registrar at GRH
Gynae-oncology (elective)	CGH: Consultants cover inpatients, No acute admissions	All at GRH None at CGH	CGH reviewed by EGS rota & escalated to consultant	On call based GRH CGH – no change	DPM – escalate to cons	DPM – escalate to cons	On call based GRH CGH – no change	DPM – escalate to cons	DPM – escalate to cons
Urology	1:9 (1:10) based at CGH	1:5 based at CGH resident until 18.00 non- resident to 23.00. W/e Resident 08.00-12.00. Non- resident 12.00-20.00	Part of EGS rota in CGH	No change	1:8 non-resident all night rota required at CGH to provide assessment of admissions • 2 ST required	DPM – escalate to registrar	No change	1:8 non-resident all night rota required at CGH to provide assessment of admissions • 2 ST required	DPM – escalate to registrar
Colorectal-(elective)	OOH covered by EGS (both sites) Weekend planned review by EGS consultant	OOH covered by EGS resident registrar (both sites)	OOH covered by EGS (both sites)	Option A- OOH covered by EGS (2 consultants on call) *	DPM at CGH supported by non-resident registrar 2 ANP (Band 7)	DPM at CGH– escalate to registrar at GRH. Will work on split sites	OOH covered by EGS (2 consultants on call) Weekend planned review by EGS consultant (TBC)	OOH covered by on site EGS registrar	On site resident team
EGS	Separate rotas on both sites. . Most consultants contribute to both rotas	1:8 CGH 1:9 GRH But 3 vacancies (locum & agency)	GRH FY1 rota. CGH: EGS rota combined with T&O	2 consultants on call 24/7 to provide support to both sites	1:15- resident GRH & 1:15 non-resident CGH	Foundation rota at GRH	2 consultants on call 24/7 to provide support to both sites	1:15- resident GRH & 1:15 non-resident CGH	Foundation rota at GRH
Vascular	1:7 rota	1: 7 (non-res) but only 1 in post currently therefore picked up by GS rota 6:7	Part of EGS rota in CGH	1:7 based at GRH	1:7 (non-res)Only 1 in post but resident GS reg. could cover 6:7	As for EGS	1:7 based at GRH	1:7 (non-res)Only 1 in post but resident GS reg. could cover 6:7	As for EGS
additional Staffing required				Additional ST X2 required for urology rota.			Additional ST X2 required for urology rota.		
Total additional				2 ST doctors required for urology			2 ST doctors required for urology		

Key:
Requires additional resource

Summary of the Impact on trainee doctors for various options:

Key: level of training provided	❶ Poor	❷ Adequate	❸ Good

Services (Involved)	**Baseline (pre COVID)**		**Option 4.4** **CGH-CR, D/C GS, GRH- AMT, EGS, Vascular**		**Option 5.4** **CGH- D/C GS, GRH- AMT, EGS, CR, D/C GS, Vascular**	
	Registrars	Foundation	Registrars	Foundation	Registrars	Foundation
Acute Medical Take	❶	❶	❸	❸	❸	❸
Emergency General Surgery	❶	❶	❸	❷	❸	❸
Colorectal (elective)	❷/❸	❷	❸	❷	❸	❸
Gastroenterology	❷	❶	❸	❸	❸	❸
Trauma & Orthopaedics	❷	❶/❷	❸	❷/❸	❸	❷/❸
Vascular	❸	❷	❸	❸	❸	❸
Sub Total	11.5	8.5	18	15.5	18	17.5
ED	❷	❷	❷	❷	❷	❷
Urology	❸	❶	❸	❷	❸	❷
Sub Total	5	3	5	4	5	4
Overall Total	**14.5**	**11.5**	**23**	**19.5**	**23**	**21.5**

Grey indicates specialties that will not change but there may be an impact.
This assumes that for all models the additional doctors required can be recruited

Details of changes for trainee doctors:

Medical Division		
Specialty	Registrars	Foundation & SHO Doctors
Acute Medical take to GRH	There has always been an out of hours on-call registrar rota combined from trainees within acute medicine, care of the elderly, cardiology, gastroenterology, renal, respiratory, endocrinology and diabetes. In response to COVID-19 the COVID and non-COVID pathways were separated by site. The acute medical take and associated medical assessment unit beds were centralised to GRH. The overnight cover has subsequently changed with one registrar providing cover at CGH and increased from previously one to now two providing cover at GRH. It is anticipated that these changes will be of major benefit as prior recurring feedback was that having only one registrar at GRH was insufficient due to the very busy workload. Informal feedback so far following these changes has been positive.	The foundation year 1 rota has changed, from previously a separate out-of-hours rota for each site (pre-covid), to currently a combined cross-site rota. This has led to a more equalised and 'fairer' workload. All FY1's get exposure to the acute take as well as ward cover of specialty wards. Prior recurring feedback pre-covid was that the medical SHO out-of-hours rotas at GRH were very busy and stressful. Concerns had been expressed about patient safety and trainee burnout. The new changes have resulted in being able to significantly enhance the out-of-hours SHO staffing on the GRH site. As per the FY1 rota – SHO's do on-calls on both sites (although mostly GRH) and the workload is now more equalised and 'fairer'. The changes to the registrar rota have led to greater registrar access and support for the on-call SHO's and foundation doctors. This should improve learning opportunities and training. Informal feedback from the SHOs who have worked both the pre and post-covid rotas has been extremely positive.
Gastro to CGH	Gastroenterology pilot move was undertaken in Nov 2018. All trainees are aware jobs are based over at CGH. From the trainee feedback, we had a positive response post Gastro move to CGH. Previously training was rated poor when gastro was over at GRH, as the trainees were covering medical patients on 5th floor surgical wards. Prior to the move registrar clinics and endoscopy lists were often cancelled due to "service pressures" which had a detrimental impact on training; this no longer happens. There is also more time for training foundation doctors	The Gastroenterology pilot move was undertaken in Nov 2018. Previously the team covered a very large bed base with few juniors this led to reduced training opportunities at all levels. The juniors were doing 8am-7pm days, sometimes later. Since the change, it has been a dramatic improvement. There is a small bed-base but the more intensely sick gastro patients are co-located. This means that the patients are getting the care they should and much more experience for all levels of trainee doctors without feeling over-worked and unsafe.

ED no changes	1: 9 rota across both sites. Senior trainees working 4 in 10 over the weekends and the Trust is working to reduce rotas to a 1:3 to comply with the new junior doctor contract. However this is not affected by the changes tabled in the Fit for the Future programme.	There are 24 foundation doctors working in ED across both sites. The weekend rota is a 1:2 and the Trust is working to reduce rotas to a 1:3 to comply with the new junior doctor contract. However this is not affected by the changes tabled in the Fit for the Future programme.

Grey background denotes specialties in which no rota changes are to be made but in which there may be impact

Surgical Division		
Registrars	Registrars/ CT	Foundation Doctors
Emergency General Surgery to GRH	Currently (pre-COVID), registrars work a1:9 rota at GRH and a1:8 rota at CGH. There are insufficient doctors to fill the rotas which results in gaps filled by consultants acting down or with extra shifts from local trainees or agency doctors and this has resulted in an increase in sickness absence. The Deanery has highlighted EGS as a source of concern with respect to training. The proposed solution will improve this with all OOH based at GRH with a 1:15 resident and 1:15 non-resident rota , providing cover for CGH which is compliant and for which we will be fully staffed. During the COVID period EGS has been moved to GRH temporarily and already feedback from trainees is positive with better training opportunities and a more evenly distributed workload. It is believed that the proposed changes will offer more attractive job roles and training opportunities. Pre COVID the CT rota was 1:7 which provided incomplete cover during the week. The plan is to move to a 1:9 rota to provide 24/7 cover.	Currently (pre COVID), foundation doctors work either at GRH 1:8 or at CGH 1:8. At CGH surgical foundation doctors provide cover from 08.00-20.30 and this will continue. Foundation doctors currently provide a twilight rota combined with other specialties from 17.00 -24.00. This will not be required for EGS if moved to GRH. Deanery feedback was good for teaching but highlighted problems with high intensity emergency work. The plan is for 12 doctors to be part of a rota based in GRH with this will provide excellent teaching opportunities and a balanced between elective and emergency work.
Elective Colorectal centralised to CGH	Currently (pre-COVID), elective colorectal is covered out of hours by the EGS teams; rotas as above with a 1:9 rota at GRH and a 1:8 rota at CGH. One of the main drivers for change is that these rotas are not sustainable. If elective colorectal services centralise at CGH the first line of patient management will be the deteriorating patient team who can then refer to the non-resident on call registrar. Also includes 2 ANPs (band 7 support)	Currently (pre-COVID), foundation doctors work either in GRH 1:8 and or at CGH 1:8 as for EGS and out of hours cover of elective patients is provided by the EGS team. Option is that the foundation doctor rota at CGH will be replaced by the deteriorating patient team.
Elective Colorectal centralised to GRH	Currently (pre-COVID), elective colorectal is covered out of hours by the EGS teams: rotas, as above, with a 1:9 rota at GRH and a 1:8 rota at CGH. One of the main drivers for change is that these rotas are not sustainable.	Currently (pre COVID), foundation doctors work either at GRH 1:8 or at CGH 1:8. At CGH surgical foundation doctors provide cover from 08.00-20.30 and this will continue. Foundation doctors currently provide a

	If elective colorectal is centralised at GRH it will be covered by the resident General Surgery Registrar and CT as part of the EGS rota.	twilight rota combined with other specialties from 17.00 -24.00. This will not be required if EGS is moved to GRH. Elective colorectal and EGS work would be performed on the same site.
T&O split- Trauma to GRH most Elective to CGH	Prior to the changes ST feedback was good in both CGH and GRH. Since the changes in 2017 Registrar rotas changed from a 1:8 at CGH and 1:8 at GRH to a 1:16 based at GRH. This does mean that more trainees are undertaking elective work and trauma work on different sites although many did beforehand, but feedback has not highlighted this as a problem. Latest reports are good at both sites and it is believed that the dedicated consultant on trauma allows improved supervision and teaching. OOH work is busy but there is easy access to the on-call consultant with 7 day a week ward rounds and the registrar is now able to see new trauma patients in a timely way and the volume of trauma seen gives excellent training. Since the change there has been improved recruitment for specialty doctors and therefore less pressure on trainees. Trainees have also commented that there has been fewer cancellations for winter pressures and therefore the number of surgical procedures has been The potential changes to other services within the paper will not affect this group of trainees.	Prior to the changes Junior Doctors feedback from the deanery was poor in GRH due to heavy workload and patchy supervision. There is now a dedicated 1:10 rota at GRH and at CGH the OOH rota is a shared one with other surgical specialties and runs from 17.00- 24.00. This is unchanged apart from discontinuing the 'twilight' rota at CGH to replace with the deteriorating patient model. At GRH there are CT1 and x F2s the latest reports are good and it is believed that the dedicated consultant on trauma allows vastly improved supervision and teaching. There is also enhanced junior doctor support and teaching experience which has been recognised by the Severn Deanery At CGH there is 1 CT1 who takes part in the GRH trauma rota and 3 F2s who take part in an out of hours surgical rota to provide a service to the orthopaedic wards 7 days a week and a night rota for combined surgical specialties from 17.00 to 24.00. The feedback from this rota is good there is dedicated regular teaching and a ward round but no access to trauma patients. This rota may require change if the twilight evening rota is removed or altered.
Vascular (GRH)	Currently (pre COVID), there are 2 ST doctors, who work in the vascular surgery; one general surgery themed and one vascular themed. The general surgery themed ST undertakes out of hours work as part of the EGS rota and this would continue. The other vascular themed doctor works a 1:7 non-resident rota. However as a designated vascular rota is not possible the rota is supported 6 nights out of 7 by the EGS rota. If co-located in GRH the out of hours can continue to be covered by the EGS rota There is also funding for two fellows but it has not been possible to fill these posts. Feedback for registrar training has been very good and it is anticipated that this would continue.	Currently (pre COVID), foundation doctors work either at GRH 1:8 or at CGH 1:8. At CGH surgical foundation doctors provide cover from 08.00-20.30 and this will continue. Foundation doctors currently provide a twilight rota combined with other specialties from 17.00 -24.00. This will not be required if EGS is moved to GRH. If vascular work was based at GRH, foundation doctors would continue to be part of the EGS rota in GRH and vascular work would be covered by the EGS team based on site in GRH.

Urology (remain in CGH) but affected by alteration of shared GS rota	Currently (pre COVID), there is a 1:5 non-resident rota with protected sleep after 23.00 during the week and 20.00 at weekends. After this urology is supported by EGS rota. If EGS moves to GRH this will no longer be possible and a up to further 3 registrars (one already appointed) will be required to form a 1:6 (ideally 1:8) non-resident rota for 24/7 cover. If a resident CT rota could be established in CGH, registrar rotas are more likely to be compliant with non-resident requirements. Feedback from the Deanery is that training is very good but the on-call period tends to overrun. This is due to the urgent patients being operated on late in the evening which is due to lack of emergency theatre capacity at CGH. In all options EGS will move to GRH and the plan is for emergency cases to be carried out on extended routine lists earlier in the day. This will provide capacity for these patients within a more compliant timescale.	Currently (pre-COVID), foundation doctors work either in CGH 1:8 in the general surgical rota. At CGH the foundation doctors provided cover from 08.00-20.30 which will continue and a twilight rota combined with other specialties from 17.00 -24.00 is also in place; this will be replaced by the deteriorating patient model if EGS moves to GRH.