JDF

Issue 7; April 2017

TEACHING/TRAINING

YOU SAID:.....

1. ED trainees reported that the role was felt to be service provision of 90% with training 10%. It was specifically said that there was not enough time in minors to gain technical expertise, and it was felt that within the 11 week block in ED there should be some protected time in resus and minors. It was also felt that there was very rarely direct clinical supervision by consultants in ED.
2. Trainees reported that there was a lack of supervision in General Surgery and Cardiology, in particular that there is very little direct consultant clinical teaching.
3. There was also concern about the quality of the protected Thursday afternoon teaching which was felt to be of variable value. The trainees commented that sessions are often cancelled and they would appreciate a more structured approach to what goes into the teaching programme, with input from them. They do provide feedback on the sessions but they are unsure of actions actually taken on this. An FY2 commented that the ALS lectures were superb, and that lectures about clinical management would be valuable.
4. Trainees commented on the ability to get to protected teaching, with the four FY doctors ranging from 14 – 35 out of 70 teachings actually attended. This is thought to be largely due to the on call pattern which also is felt to affect the continuity of care on the wards
5. The histopathology trainees commented that they feel there is very good consultant led training in their specialty
6. GP trainees commented on the very good consultant led training in their specialty
7. Cell Pathology trainees commented that there was very good consultant led training in their specialty
8. JCF's and SCF's on Stroke reported that they were all supervised and had 2/3 sessions each week with a Consultant
9. Trust Grades doctors on Stroke felt that study leave was not defined, it was case by case, they have no allocated budget and felt it was not consistent
10. Trust Grades on Stroke stated that protected time is only disrupted if they are short on the ward; if this is the case it is reallocated
11. Paediatric trainees commented that they feel there is very good consultant led training in their specialty
12. Concerns were expressed in one area about the lack of consultant support when concerns about patient care were raised – the Deputy Medical Director asked that these concerns were directly reported to her
13. It was reported that SAU and the other assessment units are very good for teaching, as they are allowed to clerk patients as an FY1 and they get immediate feedback
14. SCFs/JCFs confirmed that their rota was ok compared to other departments and that the balance between education and service was good
15. SCFs/JCFs confirmed that they had received a full induction upon commencing at the Trust

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16. SCFs/JCFs on Stroke reported that the clinical feedback was not always formal, but they were able to get SLEs completed at Consultant Learning meetings/ward rounds. They reported that they were never asked to perform tasks above their competence and stated that the Consultants were approachable
17. FY2 trainees reported that they had received a local induction when they changed over
18. FY2 trainees reported that the Paediatric Induction they received at changeover was good
19. FY2 trainee in Urology asked about the possibility of having formal time in theatres
20. FY2 Trainees advised that they had undertaken an audit in Medicine, but said nothing had changed. The audit has since been re-done and the trainees queried what had happened with it
21. FY2 trainees reported that the Psychiatry placement was good and the induction was good. Dr Powersmith was reported to be a good supervisor
22. ICU was reported to be a good placement. The senior doctors acknowledged the trainee capabilities and provided good support
23. FY2 trainees reported that they did not receive formal training on how to cannulate a baby – it was reported that you are shown but then left to do it
24. Paediatric trainees reported that the paeds protocols were really good and easily accessible on the intranet
25. Acute feedback and ACATs in Acute Medicine—trainees felt that they did not get sufficient feedback as it was too busy. Trainees acknowledged that they needed to be proactive, but felt the Consultant on call should be aware of the trainees needs

WE DID:.....

1. There is now a consultant solely with educational responsibilities who wears a different uniform 3.5 days/week, who provides education/training for all grades of trainees. There is always a resus doctor during the day to ensure resus exposure and the dept are trying to have a minors doctor.
2. Cardiology— there is a weekly 'Heart Hour' teaching session on a Tuesday lunch, in addition to this the Cardiology Lead has requested all Consultants encourage the juniors to go on the ward rounds to ensure they receive teaching. When the COW model is implemented it is felt this will improve further as a Consultant will be ward based each day. Please can specific teaching requests be fed back to Dr Viswesvaraiah so that these can be action. Making junior attendance on ward rounds mandatory is also being considered.
   General Surgery—Fed back to the Clinical Director for Surgery and a response has been chased
3. This has been fed back to the FY team who will respond
4. The FY team are currently looking in to this with the rota teams and will be addressed
5. Fed back to the specialty Lead

Cont...

TEACHING/TRAINING

WE DID:.....

6. Fed back to the GP Training Programme Director and HEE NW GP Associate Dean
7. Fed back to the Specialty Lead
8. Fed back to the Stroke Clinical Director
9. Study leave is authorised as per contract and taking into consideration individual needs and appraisal PDPs as well as taking into consideration whether the request fulfils their career or skills and competency requirements. The SAS Tutor is aware of the issue regarding the budget and is currently working to address this promptly.
10. Fed back to the Stroke Clinical Director
11. Fed back to the Paediatric Clinical Director
12. Trainees are advised to report any patient safety concerns directly to the Deputy Medical Director; Dr G Burrows
13. Fed back to the Surgical Clinical Director
14. Fed back to the appropriate Speciality Leads
15. Fed back to the appropriate Speciality Leads
16. Fed back to the Stroke Clinical Director
17. Fed back to the FY team
18. Fed back to the Paediatric Clinical Director
19. The Urology Clinical Director has reported that the Urology rota master will try to ensure that the FY2 doctor in Urology get posted to theatre at least once a fortnight—this will be dependent on ward cover, safe levels of Juniors on the wards need to be maintained
20. Director of Medical Education is currently looking in to this further and a follow-up audit is taking place, updates will be available in due course
21. Fed back to the DME for Pennine
22. Fed back to the Anaesthetics College Tutor
23. This is something that the department consider a generic skill. The department have never been asked for specific teaching on this—the Clinical Director is going to raise this at the next consultant and ward communication meeting to see what trainees feel they need and will ask the SAS doctors to be supportive and present for their initial attempts
24. Reported back to the Paediatric Clinical Director
25. The Acute Medicine and Medicine Clinical Directors have asked if more information could please be supplied to Medical Education so that this can be addressed; is the lack of feedback from the POD or the hot consultant, when on nights or at weekends? The Medicine Clinical Director is hoping to attend the June forum to get further details for attendees

INDUCTION

YOU SAID:.....

1. Induction process for Pennine Care was felt to be excessive and very time consuming. It was recognised that both the Trust and local induction is necessary, but there is a general feeling that it ought to be more flexible, with trainees being given information that is pertinent for their role. It was reported that Bolton had a very flexible approach to induction for junior doctors.
2. Histopathology trainees said that their local induction had been excellent with a folder which they could use as a manual.
3. It was reported that there was a lack of clarity about whether taster sessions could be taken in FY1/FY2 or both, and how much time is available for this. All of the trainees would welcome clarity about taster sessions.
4. A CT1 reported that they started yesterday but didn't receive any starting instructions other than notification of Induction on Friday. This meant no badge, bleep or IT access etc was in place

WE DID:.....

1. Pennine Care Response—Unfortunately we are mandated to provide a lot of the things we do at Induction. We have taken anything out over the years that isn't necessary and will continue to review the programme following each induction .
2. Fed back to the Specialty Lead
3. The FY team emailed all FY trainees with the Study Leave and Taster user guide and the FY Tutors have explained the process at the 1.45pm joint teaching sessions. Any trainees still unsure should contact one of the FY team
4. This was fed back to the Medical team and they have reported that they will ensure there is a more definite line of communication for the trainee. Trainees joining on a Wednesday will always be booked in to IT training to ensure they have the relevant training and can receive their username and passwords

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ROTAs

YOU SAID:.....

1. There was a clear request from the FY1 doctors that they did not want to do on call whilst in their GP placement in FY2
2. There was recognition that ED had a very demanding rota but that the rota had improved with no 7 consecutive night rota, longer shifts and zero days.
3. A trainee in General Surgery reported that the working hours on a Bank Holiday are different; they had received not communication on these hours so this resulted in the trainee being late for their bank holiday shift
4. FY1s moving to FY2 from August had heard a rumour that they would be expected to undertake on call on AMU while on their GP placement – it was felt that this would take them away from their GP experience – the trainees asked for confirmation on this
5. Medicine ST1/2 rota has a zero day before 3 long days and none after. It was felt it was not logical as tired after a long day not before. 2 zero days after nights but the first isn't a zero day as worked 9.5 hours already

WE DID:.....

1. The FY team have contacted all F1 trainees and have reported to the Joint Medical Education and Foundation Board that they do not wish to undertake on call whilst on their 4 month GP placement. Any trainees wishing to undertake on call should contact Dr Bonnici directly
2. Fed back to the Educational Lead in Emergency Medicine
3. Feb back to the Clinical Directors in surgery; a response has been chased
4. See response; point number 1 above
5. Awaiting a response from Medical Staffing

iBLEEP

YOU SAID:.....

1. It was reported that as a result of the recent changes – minimal information is provided eg; no patient name, just a number, so trainees have to refer to a separate system for these details
2. Trainees reported that they liked the fact that patients are ordered by ward
3. It was reported that there was a prioritisation list previously – this meant they could scroll down, but this is no longer possible
4. iBleep - names are not used on the new system, just number. It should be case note number but that is regularly mistyped or NHS number used in place. The doctor then needs to access patient care to look up the name of the patient. Screen layout is improved. Training on new system was not sufficient and the ibleep co-ordinators are not yet au fait with it.
5. Chance of picking the wrong patient is high and there have been errors. Trainee confirmed they had raised this with a member of the team

iBLEEP

WE DID:.....

Points 1—5 have been discussed with the iBleep team and we are currently awaiting a formalised response. To ascertain further information and trainee feedback, a member of the iBleep team attended the FY1 teaching last month and to get feedback from the trainees as to positive and negative points of the system. To further ascertain feedback ,Medical Education has emailed 5 questions to all FY1 trainees requesting direct feedback on the iBleep system to ensure changes implemented are making a difference. Trainees are strongly encouraged to respond to the email sent asap, so any issues can be addressed promptly.

Dates for your diary

- **Junior Doctors Forum:**
  13th September 2017

Hot Lunch will be available from 12.30pm.
All meetings will take place in lecture theatre B in Pinewood House.

DME Meetings with Trainees;

These are currently being scheduled throughout June; please ensure that you make every effort to attend. Your feedback is of great value to us.

If you are not aware of your specialties meeting with Dr Baxter please contact Medical Education on Ext 4684

NEXT MEETING:
???? 2016;
12.30pm

WORKING LIVES

YOU SAID:.....

1. It was reported that some trainees were having problems with their access cards; some reported that they were not working at all
2. Trainees requested information on the arrangements around cremation forms, specific clarity was asked around the following;
   - Do they complete them in our of hours time?
   - Are juniors covered by our indemnity insurance?
   - If they are paid separately, need to clarify that it is part of normal working hours and responsibilities
3. It was suggested that the GPs cover the medical on call for additional pay, it was felt that this would save on the usage of locums/agency staff
4. SCFs/JCFs on Stroke confirmed that they had direct access to Consultants to raise any patient safety issues and had not witnessed any undermining behaviour
5. Trainees queried whether the cash floor would stick with the trainees if they move out of the training programme and then re-enter
6. A trainee reported not being paid a locum claim in Psychiatry – it was reported that it had been going on for a few months
7. Trainees reported that they got paid more doing agency locums with the Trust than internal, they also don't receive payments until at least a month later, whereas with agencies, they get paid weekly
8. FY2 trainees felt that when they were on GP placements they should come back in to the hospital to help reduce the pressure on the FY1 trainees
9. FY2 trainee reported staffing issues in ED. It was felt that internal locums would be better than external ones as they do not know the hospital. It was also felt that in house bank for ED would be cheaper – trainees advised that they had seen shifts filled that had not been circulated internally
10. Relationships in ED between nursing staff and medics was reported to be good
11. Medical ST3+s reported that the 'Med Reg' rota was hard and intense
12. ST3+s in Surgery reported that the rotas were good
13. FY1 trainees queried where the monitoring was up to
14. FY2 trainees reported that their placements were good. It was queried why they were not able to go out to assess acute patients in their home – they can only see chronic patients
15. Two trainees reported that they had their cash flow calculated on un-banded post as per terms and conditions. NHS employers guidance on 31st March advised to change this and uplift the nil banding to 40% for the purpose of cash floor. The trainees had their cash floor uplifted as advised, however they are sharing a rota with a trainee who had their cash floor calculated on 50%, the trainees felt it was unfair to do the same job for less money

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WORKING LIVES

YOU SAID:.....

16. Orthopaedics - there are too many FY1's on orthopaedics (6) and one should be moved to gastroenterology
17. Smartcard updates - FY1 wanted to change information on his smartcard and going onto the microsite there is no information about who/where to go to change details.
18. FY1 advised they needed a smartcard but no-one could advise how to get one

WE DID:.....

1. This has been fed back to the relevant area; please can those trainees having problems ensure they are reported to Medical Education or the Specialty Clinical Director so that the issues can be addressed promptly
2. All trainees were emailed the necessary information directly after the April Forum—please contact Medical Education if you did not receive the information (room G24 Pinewood House or Ext. 4684)
3. FY2 trainees in GP are allowed to do up to 8 hours per week locum work with the written agreement of their educational supervisor. It is not allowed to impact on their GP attachment in any way i.e. Can't miss any of their main employment time for any time off following locum work etc.
4. Fed back to the Stroke Clinical Director
5. Awaiting response from Medical Staffing
6. Awaiting response from Medical Staffing
7. Awaiting response from Medical Staffing
8. Please see response to point 3 above
9. ED response—We have an internal bank. We have a number of external people who do regular locums for us but this number is now relatively small compared to a few years ago. The rota pressure is severe, so much so that several consultants are having to cover night shifts as there is no one else. If trainees want to do extra shifts then they should contact our rota master, but of course the scope to do extra shifts is small to be compliant with the EWTD.
10. Fed back to the Educational Lead for Emergency Medicine
11. Fed back to the Acute Medicine CD and Medicine CD
12. Fed back to the Surgical Medical Director
13. Awaiting a response from Medical Staffing
14. FY trainees in GP are not able to visit acutely unwell patients unwell outside the practice. The reason for this is following coroner inquest into patients deaths it was deemed by the coroner as too risky. Trainees are encouraged to gain supervised experience of acute home visits and also non-acute home visits for chronic disease reviews, post discharge reviews etc.
15. Awaiting response from Medical Staffing
16. Fed back to the FY team
17. SMART card team has been in attendance prior to F1 teaching on two occasions—this was to supply cards and help answer queries. Please contact Aaron Fox or Dr Catania if you have further problems
18. Please see response to point 17 above.