Placement Quality (PQ) Review Foundation Year 1

REPORT MAY 2019

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Executive Summary

This report describes the review of the quality of training placements in the Northern Ireland (N.I) Foundation Year 1 (F1) Training Programme. This review was carried out by the NIMDTA Placement Quality Improvement Team and commenced in October 2018.

The ***first section*** of the report describes the background to this F1 Placement Quality Review including the Foundation Programme educational framework and the GMC National Training Survey (NTS) evidence regarding the quality of F1 training placements. The steady decline in the proportion of Foundation Year 2 (F2) doctors entering directly into GP or specialty training programmes in N.I is outlined (31.8% in August 2018) and reasons given by NI F2 doctors for taking a post-Foundation break from training considered.

The ***second section*** analyses the trainee feedback received from the Placement Quality Survey of Training in F1 and the associated Focus Groups (November 2018 –January 2019) and outlines the key recommendations to enable improvement in the quality of F1 placements.

The results are discussed under six headings.

I. Shadowing and Induction
II. Clinical Duties and Workload
III. Clinical Supervision and Feedback
IV. Educational Opportunities and Formal Teaching
V. Supportive Environment, Teams and Facilities
VI. Overall Opinions

The key recommendations for HSC Trusts are to:

1. Provide all new F1 doctors with ward-based F1 **shadowing** all day for **2 full days**;
2. Deliver a formal **induction** for all* F1 doctors to their clinical team **at the start of each placement;**
3. Fully involve F1 doctors in planned **patient reviews on a daily basis;**
4. Necessitate the participation of F1 doctors in the **clerking-in of patients** on average **at least twice a week**;
5. Require the active participation of F1 doctors on **ward rounds** on average ***at least twice a week***;
6. Limit the time spent by F1 doctors on routine **tasks of limited educational value** to **no more than 50% of their time**;**
7. Ensure F1 doctors are **aware of who the senior doctor** is (and how to contact them) for advice **for each shift;**
8. Provide **feedback** to all F1 doctors through their trained Clinical Supervisors on average on a **weekly** basis;
9. Enable all F1 doctors to **attend 3 hours** of on-site, bleep-free, **formal teaching*** per week**;
10. **Assign** F1 doctors **to a clinical team** as opposed to a clinical area;
11. Ensure that F1 doctors working **out of hours'** shifts have **access to hot food** and an area to take rest breaks;
12. Provide **rooms** where F1 doctors can **rest after a night shift before travelling home;**

including F1 doctors who are commencing on out of hours or who have a late start date

*** Examples include venepuncture, IV cannulation, peripheral blood cultures, preparing and administering IV medication/injections, performing ECGs. F1 doctors should complete no more than 5 discharge letters per day*

**** 50% formal teaching should be based on the Foundation Curriculum*

The ***third section*** summarises HSC Trust and Regional actions proposed by delegates at the "Redefining F1" Summit held on 1st April 2019. The aim of this Summit was to identify how the F1 experience in NI might be redefined through a collaborative approach involving key stakeholders. The appendices provide greater detail on the HSC Trust and Regional proposed initiatives/solutions.

Foundation year 1 doctors are the most junior, inexperienced and vulnerable medical members of the HSC workforce. If these doctors are not provided with adequate inductions, well-organised rotas, appropriate workloads and educationally rewarding work which utilises their medical skills and provides them with opportunities to learn in a supportive environment, there is a significant risk that the pattern of increasing burnout, non-progression into GP/specialty training, and disillusionment with medicine as a career will continue.

The ***fourth and final section*** sets out the key recommendations that this report makes in response to the evidence presented at the "Redefining F1" Summit (Foundation GMC NTS data; UKFPO Foundation rankings; NIMDTA Placement Quality Review of Foundation year 1 training) and the actions proposed by delegates at the Summit.

Quick fixes:

These are actions identified as output from the Summit which could and should be acted on as a matter of urgency:

- Provide all new F1 doctors with ward-based F1 **shadowing** all day for 2 full days (Recommendation 1)
- Deliver a formal **induction** for all F1 doctors to their clinical team at the start of each placement (Recommendation 2)
- Fully involve F1 doctors in planned **patient reviews** on a daily basis (Recommendation 3)
- Necessitate the participation of F1 doctors in the **clerking-in** of patients on average at least twice a week; (Recommendation 4)
- Require the active participation of F1 doctors on **ward rounds** on average at least twice a week; (Recommendation 5)
- Ensure F1 doctors are aware of who the senior doctor is (and how to contact them) for **advice for each shift** (Recommendation 7)
- Provide **feedback** to all F1 doctors through their trained Clinical Supervisors on average on a weekly basis (Recommendation 8)
- Enable all F1 doctors to attend 3 hours of on-site, bleep-free, **formal teaching** per week; (Recommendation 9)

Key actions proposed:

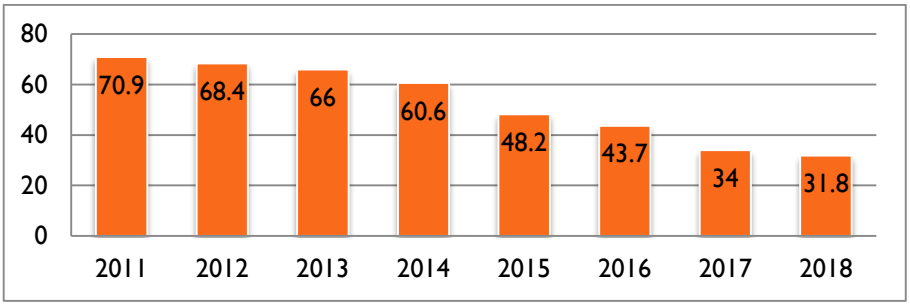
These key actions were proposed to ensure that progress is made in addressing the concerns raised about F1 training:

- Production of a ***Foundation Placement Quality Report*** based on the background information presented at the Foundation Summit and on the proposals generated during the Summit.
- Arrangement of individual ***meetings*** between the NIMDTA Placement Quality Team and each HSC Trust to
    - Share data for each site within the Trust
    - Implement quick fixes
    - Agree local action plans
- Identification by HSC Trusts of the ***local actions*** that are within their power/control to change to improve F1 experiences and what initiatives need to be taken forward at a system level.
- Discussion with the DoH regarding ***system-wide solutions*** that need to be introduced.
- ***Follow up*** through meetings, surveys and focus groups to monitor implementation of actions, to identify improvements and to enable reporting of progress

Section 1: Background Information

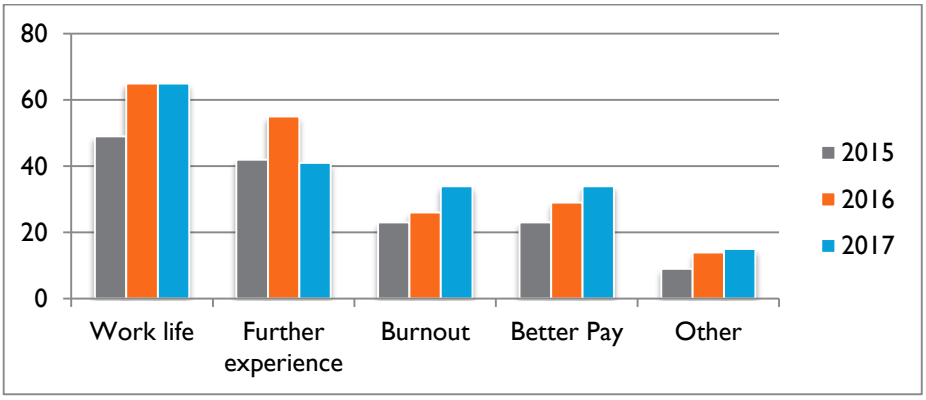
Since 2011, there has been a progressive decrease in the proportion of F2 doctors moving directly from the Foundation Programme into GP or specialty training in the UK. In Northern Ireland, the percentage entering directly into GP/specialty training post-Foundation has fallen from 70.9% in 2011 to 31.8% in 2018 (Figure 1).

Figure 1: % Progression of N.I Foundation Doctors (F2) into GP/Specialty Training



During the same time period, there has been an increasing number of doctors choosing to take a service post, a career break or work outside the UK post-Foundation. Reasons given include a desire for an improved work-life balance, further clinical experience, burnout and better pay (Figure 2).

Figure 2: Reasons given by N.I F2 Doctors for taking a post-Foundation break from training – GMC Survey 2015-17



Progression into specialty training is influenced by many factors including whether the doctor has made a definitive career choice or whether a post is available in the doctor's chosen specialty and/or geographical location. While the experience of some Foundation trainees in NI is very good, GMC National Training Surveys [1] indicate that Foundation doctors often

- do not receive a satisfactory induction to their training unit or adequate notice of their rota;
- are subjected to excessive workloads particularly during the night and at weekends;
- spend substantial periods of their working days carrying out tasks of limited educational value;
- are too busy to avail of available formal education sessions; and
- are reporting 'burnout'.

Training Survey

The first stage of the Foundation Year 1 (F1) PQ Review involved background research into the Foundation Programme curriculum and educational framework to identify the required Foundation training outcomes. The 2018 GMC NTS data and the UK Foundation Programme Office (UKFPO) Ranked Scores, which are derived from the analysis of national GMC data for all HSC Trusts delivering foundation training in Northern Ireland (N.I), were evaluated.

A detailed training survey, for completion by trainees who were employed in F1 training posts between August 2017 and August 2018, and based on key aspects of the Foundation Programme educational framework was designed by the PQ review group and approved by the Director of the N.I Foundation School. The survey was circulated to the targeted doctors in October 2018 (via a Survey Monkey® link) and remained open for completion for a period of 3 weeks. The survey was promoted using emails by the NIMDTA Foundation Programme team. The survey generated a 42% response rate (103/244). There were responses from Foundation doctors who had trained in every hospital training F1s in N.I. with at least 4 responses from each hospital.

Focus Group and Forums

A focus group was conducted by the PQ review team as a follow up to the Foundation PQ Survey in November 2018; seven foundation trainees, who had worked in five of the ten hospitals training F1s, participated.

In addition a series of foundation forums were conducted in <u>all</u> hospital sites training Foundation doctors across N.I. as part of the VALUED work-stream.

Foundation Programme Educational Framework

A two- year, general postgraduate medical training programme which forms the bridge between medical school and specialist/general practice training.

The **syllabus** comprises four sections.
Section 1: Professional behaviour and trust
Section 2: Communication, team working and leadership
Section 3: Clinical care
Section 4: Safety and quality

There are 20 foundation programme training 'outcomes' to be achieved within the curriculum; these are termed '**foundation professional capabilities**'. (FPC)

Professional Behaviours and Trust
- Acts professionally (FPC 1)
- Delivers patient centred care and maintains trust (FPC 2)
- Behaves in accordance with ethical and legal requirements (FPC 3)
- Keeps practice up to date through learning and teaching (FPC 4)
- Demonstrates engagement in career planning (FPC 5)

Communication, Team-Working and Leadership
- Communicates clearly in a variety of settings (FPC 6)
- Works effectively as a team member (FPC 7)
- Demonstrates leadership skills (FPC 8)

Clinical Care
- Recognises, assesses and initiates management of the acutely ill patient (FPC 9)
- Recognises, assesses and manages patients with long term conditions (FPC 10)
- Obtains history, performs clinical examination, formulates differential diagnosis and management plan (FPC 11)
- Requests relevant investigations and acts upon results (FPC 12)
- Prescribes safely (FPC 13)
- Performs procedures safely (FPC 14).
- Is trained and initiates management of cardiac and respiratory arrest (FPC 15)
- Demonstrates understanding of the principles of health promotion and illness prevention (FPC 16)
- Manages palliative and end of life care under supervision (FPC 17)

Safety and Quality
- Recognises and works within limits of personal competence (FPC18).
- Makes patient safety a priority in clinical practice (FPC 19)
- Contributes to quality improvement (FPC 20)

Both the survey and focus group questions were split up into 6 categories:

1. Shadowing and Induction
2. Clinical Duties and Workload
3. Clinical Supervision and Feedback
4. Educational Opportunities and Formal Teaching
5. Supportive Environment, Teams and Facilities
6. Overall Opinions

Section 2: Analysis and Recommendations

1. Shadowing and Induction

The UK Foundation Programme Reference Guide[2] states that Local Education Providers (LEPS) '*should provide a timetabled block of ward-based shadowing lasting at least two days (i.e. at least 50% of the minimum four days). The ward-based component should include the opportunity to shadow a clinical handover. In addition, appointees should have the opportunity to shadow F1 doctors undertaking an out of hours shift, if this is part of the role they will be taking up.*'

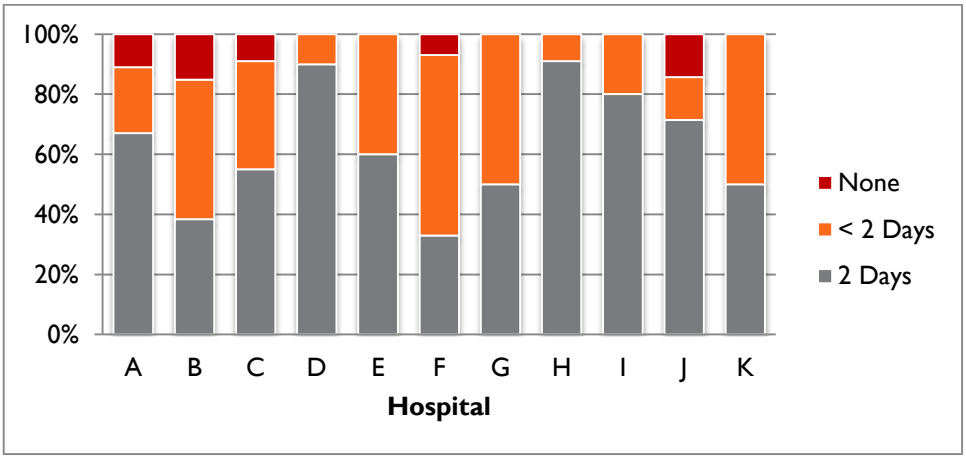
The U.K Foundation Programme Office (UKFPO) provides information based on the GMC NTS results which gives each of the 197 U.K Trusts which deliver foundation training a ranking for their performance across the fifteen GMC domains of practice. In N.I. the UKFPO national rankings for induction and shadowing for the five HSC Trusts were 80, 157, 148, 180 and 155 out of 197 (Table 1).

Table 1: UKFPO Rankings for Shadowing based on GMC data – HSC Trusts hosting F1 doctors (2018)

TRUST	UKFPO Ranking (n/197)
TRUST 1	80
TRUST 2	159
TRUST 3	148
TRUST 4	180
TRUST 5	155

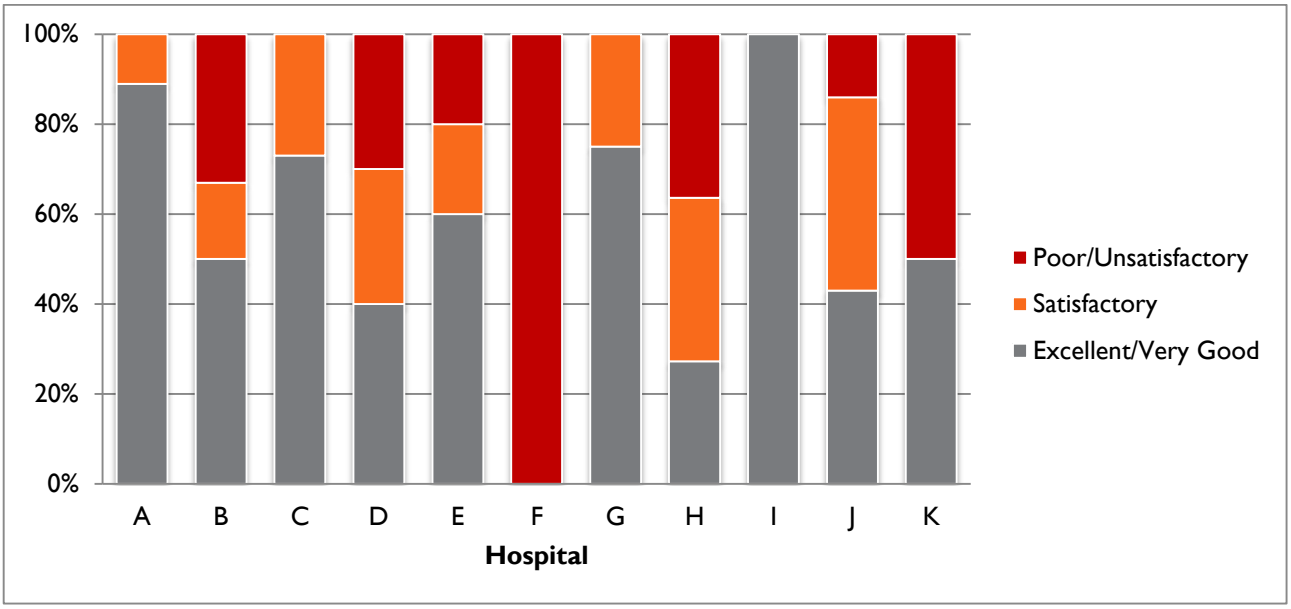
Two days of shadowing the outgoing F1 was reported by only 61% of new F1s with 39% indicating that they had received less than the recommended 2 days and 7% reporting that they had no opportunity for shadowing prior to taking up their post. Compliance with this requirement was lowest in hospitals B and F with only 38% and 33% of new F1s receiving 2 full days of ward-based shadowing (Figure 3). The commonest reason given for not achieving this requirement for shadowing was time being taken up by other components of induction within LEPs such as issuing of ID badges, car parking passes, computer passwords etc.

Figure 3: Ward based Shadowing by Hospital



Although there were positive comments in regard to Trust induction with 94% of respondents stating that it was excellent/satisfactory, the standard of departmental/unit induction was less acceptable. Appropriate unit induction with a clear understanding of individual roles and responsibilities within the post was reported by only 70% of trainees with 30% of respondents indicating that they were unclear of their roles and responsibilities, rating unit induction as poor/unsatisfactory. Performance in this domain is shown in Figure 4.

Figure 4: Departmental/Unit Induction by Hospital



Key Recommendations: Shadowing and Induction

Shadowing

Provide all new F1 doctors with ward-based F1 shadowing all day for 2 full days

The UK Foundation Programme Reference Guide states that *'The induction component of the shadowing period for new F1 doctors should be comprehensive but time efficient to allow maximum time for ward-based shadowing.'*
It is recommended that Trusts put in place alternative arrangements to deliver elements of Trust induction such as the issuing of ID badges, car parking passes, computer passwords, mandatory training etc. so that these necessary components of induction do not take time out of the required minimum of 2 full days ward-based shadowing.

Induction

Deliver a formal induction for all* F1 doctors to their clinical team at the start of each placement

**Including F1 doctors who are commencing on out of hours shift or who have a late start date.*

All trainees should receive an appropriate induction to their unit as highlighted by the GMCs Promoting Excellence: standards for medical education and training.[3] The NIMDTA induction checklist is available online (http://www.nimdta.gov.uk/quality-management/meeting-gmc-standards/good-practice/) and is a useful tool in achieving this. This can then be signed by the F1 doctor and clinical supervisor and retained for future reference.

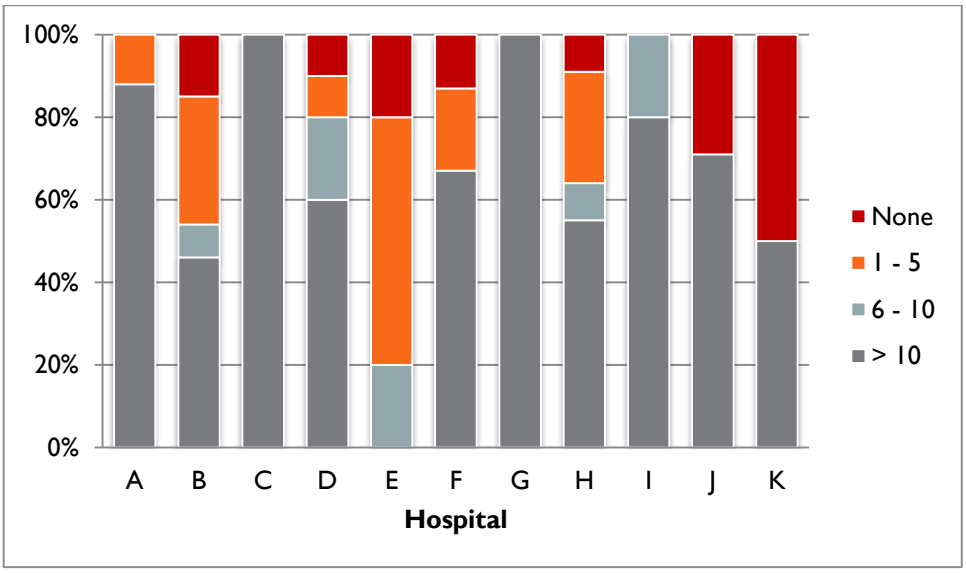
2. Clinical Duties and Workload

Clinical Duties

Trainees were asked about various clinical activities during their F1 post. This ranged from attendance at ward rounds, presentation of patients at ward rounds, clerking in elective and emergency patients, carrying out planned daily patient reviews and reviewing patients as an emergency.

There was evidence of limited attendance at ward rounds; 22% of F1 doctors reported attendance at less than 2 ward rounds a month and a further 33% of respondents indicated that they had never presented a patient on a ward round. There was variation between hospital sites as shown in Figure 5.

Figure 5: Ward round attendance per month by hospital site



The survey also indicated that F1 doctors have limited exposure to key training opportunities, such as clerking-in patients and conducting daily patient reviews. Only 38% of F1 doctors reported clerking-in elective patients more than 10 times a month

Clinical Duties

22% Attend less than 2 ward rounds a month

33% Never present on a ward round

74% Clerk in less than 5 emergency cases a month

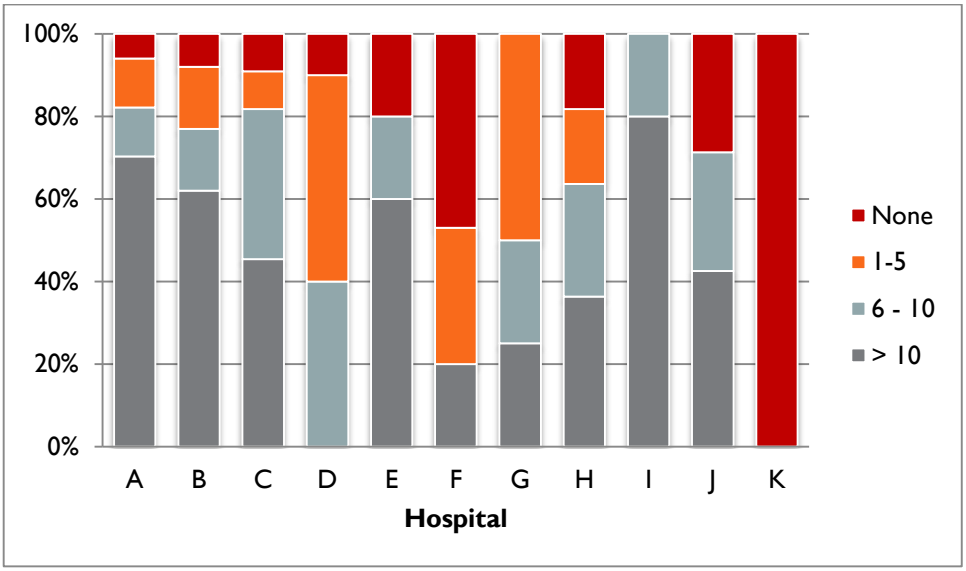
45% Clerk in less than 5 elective cases a month

39% Conduct less than 5 routine daily patient reviews a month

75% See more than 10 emergency patient reviews a month

with 45% clerking in less than 5 elective patients a month. A further 39% of respondents indicated that they conducted less than 5 routine daily patient reviews a month (Figure 6).

Figure 6: Routine daily patient reviews per month by hospital site



In contrast, despite limited attendance on ward rounds and little exposure to routine admissions or daily patient reviews, 75% of F1 doctors reported making more than 10 emergency patient reviews a month.

Clinical Workload

The UKFPO rankings for Workload put four out of the five N.I. Trusts within the bottom ten percent nationally and the fifth Trust in the bottom twenty five percent. The national rankings for the five N.I. HSC Trusts were 161, 188, 197, 192 and 185 out of 197 (Table 2)

Table 2: UKFPO Rankings for Workload based on GMC data – HSC Trusts hosting F1 doctors (2018)

TRUST	UKFP Ranking (n/197)
TRUST 1	161
TRUST 2	188
TRUST 3	197
TRUST 4	192
TRUST 5	185

Workload intensity during the day was reported by 51% of respondents as very intense or excessive, with 40% reporting the same at night and 81% at weekends. This varied significantly across NI hospitals as shown in Figures 7a & 7b. Respondents highlighted a high administrative workload, particularly in relation to the amount of time required to complete daily discharge summaries and significant numbers of routine tasks e.g. venepuncture, ECGs and blood forms, as major contributing factors. Respondents indicated that involvement in tasks of limited educational value took up on average 63% of their time.

Suggestions for improvement from both survey free text comments and focus groups included increased phlebotomist/nurse involvement in blood taking, expansion of phlebotomist service to include weekends, ward pharmacists and more support staff at weekends.

Figure 7a: Day time Workload by Hospital

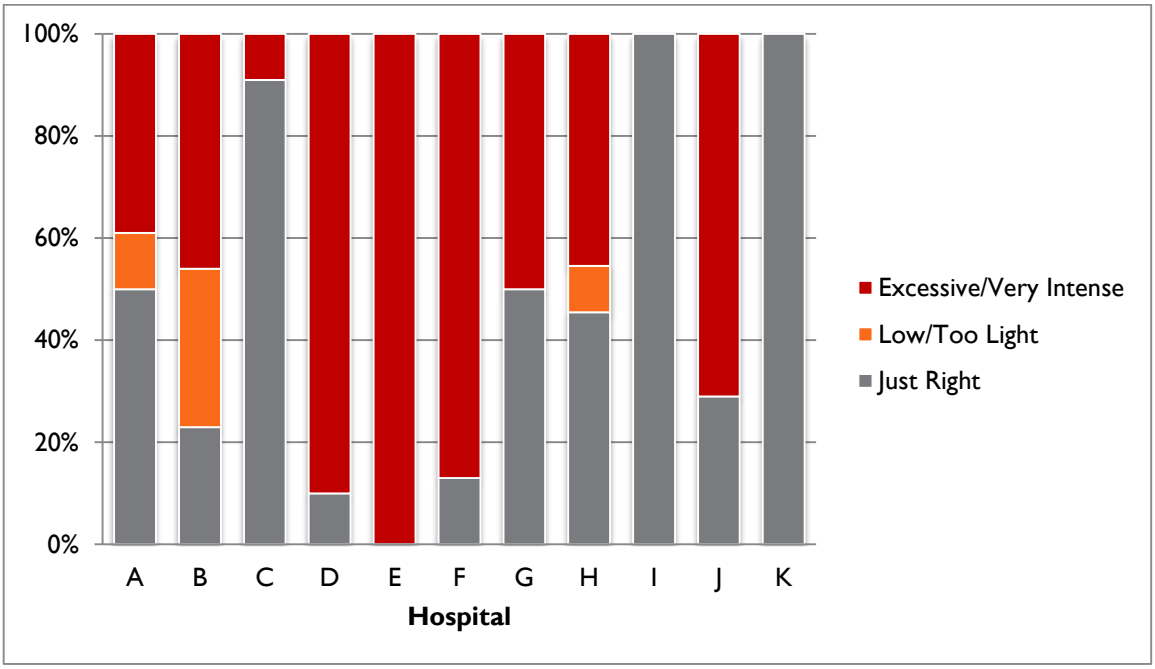
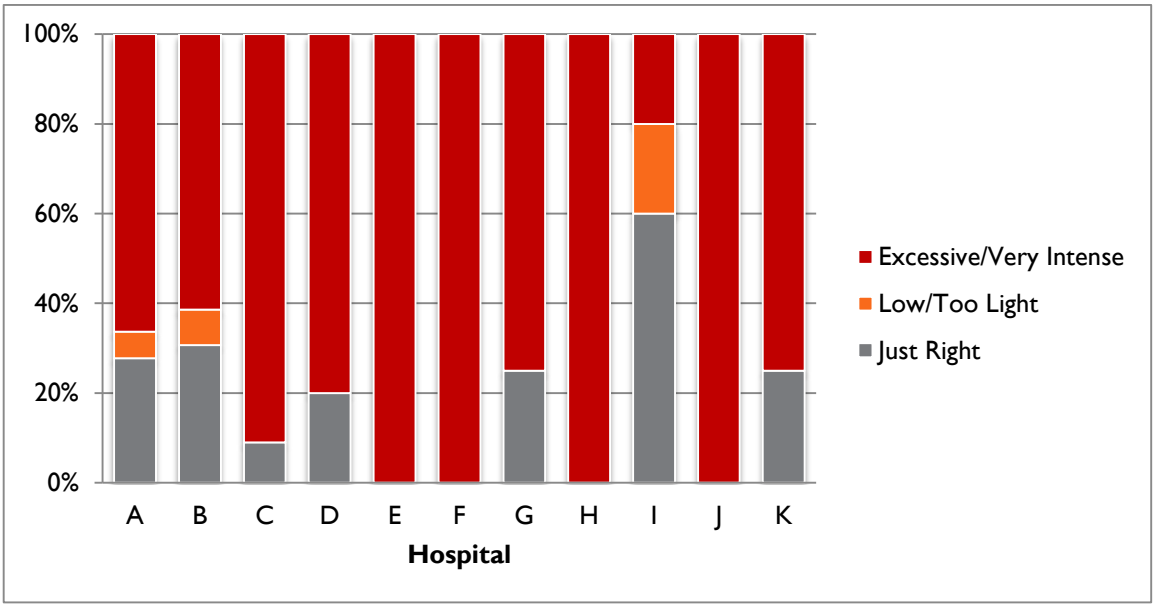


Figure 7b: Weekend Workload by Hospital



Key Recommendations: Appropriate Clinical Duties and Workload

Clinical Duties

Require the active participation of F1 doctors on ward rounds on average at least twice a week;

Fully involve F1 doctors in planned patient reviews on a daily basis.

Necessitate the participation of F1 doctors in the clerking-in of patients on average at least twice a week;

As set out in the Foundation Programme Training Outcomes, all F1 doctors have a requirement to develop professional capabilities in communication, team-working and leadership skills, clinical assessment, diagnosis and management (Foundation professional competencies 6-12)[2]. All F1 doctors should therefore have the opportunity to actively participate in daily ward rounds, as part of a ward team; to observe and participate in clinical decision making processes, to present cases to more senior colleagues and to receive constructive feedback to facilitate their development and training needs.

All F1 doctors should be involved in daily routine patient reviews and have the opportunity to discuss findings and management plans with more senior colleagues.

F1 doctors should not be pulled away from ward rounds to undertake non-urgent routine tasks of limited educational value.

Clinical Workload

Limit the time spent by F1 doctors on routine tasks of limited educational value to no more than 50% of their time*.

Trusts should give consideration to ways in which routine tasks could be re-allocated to non-medical support staff and to developing the role of nurse practitioners / physician associates within the ward setting to reduce the administrative burden on F1 doctors. Extension of existing phlebotomy services to include weekends and employment of a ward pharmacist to assist with drug reconciliation for discharges should be considered.

Completion of discharge summaries should not be the sole responsibility of the F1 doctor. There should be a review of the current discharge processes at Trust level including IT involvement to determine a more efficient method of collating the required information to populate discharge summaries and free up F1 doctors for direct patient care.

* Examples include venepuncture, IV cannulation, peripheral blood cultures, preparing and administering IV medication/injections, performing ECGs. F1 doctors should complete no more than 5 discharge letters per day

3. Clinical Supervision and Feedback

Clinical Supervision

The UKFPO rankings for Clinical Supervision put two of the five N.I. Trusts within the bottom half of the national rankings. The national rankings for clinical supervision during the day in the five Trusts were 54, 122, 80, 125 and 99 out of 197 (Table 3). Four of the five Trusts ranked higher for out of hours supervision in comparison to day time supervision with Trusts 1 and 2 in the top 25% nationally (Table 4).
Trust 4 was ranked unfavourably in comparison with other UK Trusts in both day time and OOH supervision with positions of 122 and 101 out of 197 respectively.

Table 3: UKFPO Rankings for Clinical Supervision based on GMC data – HSC Trusts hosting F1 doctors (2018)

TRUST	UKFPO Ranking (n/197)
TRUST 1	54
TRUST 2	122
TRUST 3	80
TRUST 4	125
TRUST 5	99

Table 4: UKFPO Rankings for Clinical Supervision OOH based on GMC data – HSC Trusts hosting F1 doctors (2018)

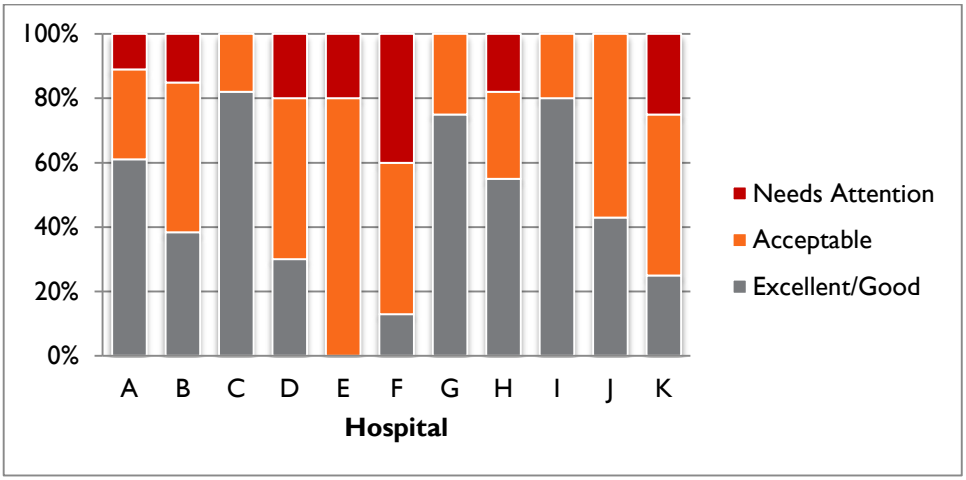
TRUST	UKFPO Ranking (n/197)
TRUST 1	41
TRUST 2	29
TRUST 3	53
TRUST 4	101
TRUST 5	78

In the trainee survey, clinical supervision was rated as good/excellent by 45% and acceptable by 39% of respondents. Significant concerns with clinical supervision were reported by 16% of respondents with trainees indicating that they felt it necessitated specific attention. Performance in this domain is shown in Figure 8.

In some units F1 doctors reported a lack of senior supervision after the morning ward round and at evenings and weekends. Overall senior support out of hours was however rated by 69% of F1 doctors as sufficient, in keeping with the better performance indicated in the national rankings. Free text comments indicated that in some units trainees had difficulties in accessing senior support out of hours.

Good practice was identified in one unit where the F1 was 'buddied' with the CT1 trainee, working the same shift pattern out of hours, which provided continuity of supervision and greater opportunity for teaching and development of technical and non-technical skills.

Figure 8: Clinical Supervision by hospital site



Feedback

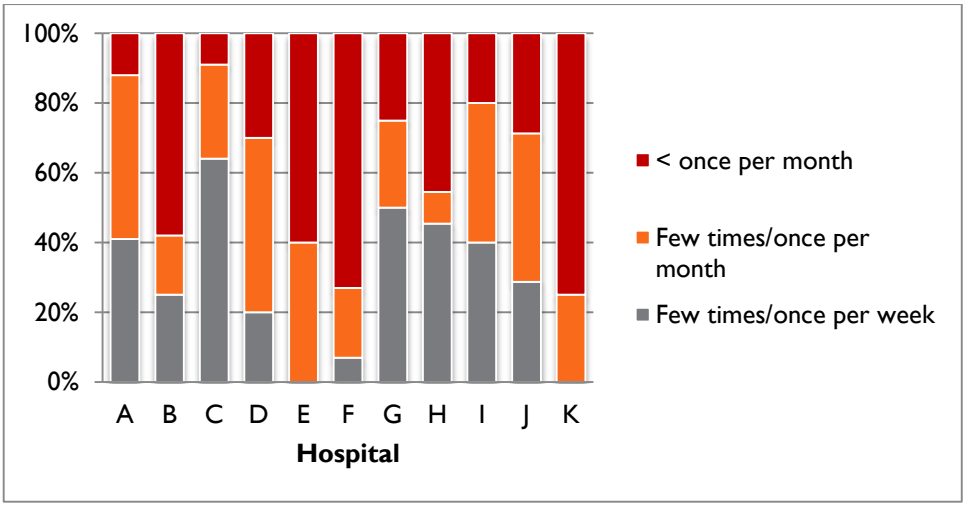
An overall deficiency of feedback on performance was highlighted in the survey, with 40% of trainees reporting receiving feedback less than once a month and only 19% of trainees reporting receiving feedback every week. These findings are supported by the UKFPO national rankings (Table 5). Two of the five Trusts ranked in the bottom 25% for feedback with one Trust being ranked 194 out of 197 (Table 5).

Table 5: UKFPO Rankings Feedback – N.I. Foundation Trusts (2018)

TRUST	UKFPO Ranking (n/197)
TRUST 1	85
TRUST 2	194
TRUST 3	156
TRUST 4	110
TRUST 5	128

Individual hospital performance in this domain is shown in Figure 9.

Figure 9: Feedback by hospital site



Key Recommendations: Clinical Supervision and Feedback

Ensure F1 doctors are aware of who the senior doctor is (and how to contact them) for advice for each shift.

The GMCs Promoting Excellence: standards for medical education and training [3] in its requirements related to the learning environment and culture states in section R1.8 that

"Organisations must make sure that learners have an appropriate level of clinical supervision at all times by an experienced and competent supervisor, who can advise or attend as needed. The level of supervision must fit the individual learner's competence, confidence and experience. The support and clinical supervision must be clearly outlined to the learner and the supervisor."

Provide feedback to all F1 doctors through their appropriately trained Clinical Supervisors on average on a weekly basis.

The GMCs Promoting Excellence: standards for medical education and training [3] in its requirements related to supporting learners states in section R3.13 that

"Learners must receive regular, constructive and meaningful feedback on their performance, development and progress at appropriate points in their medical course or training programme, and be encouraged to act on it."

Attendance at daily ward rounds and regular opportunities to present patients to senior colleagues is recommended to provide opportunities for constructive feedback in the ward setting.

The UK Foundation Programme Reference Guide[2] states in section R3.44 that

'All those engaged in assessing learning encounters in the workplace must be trained in the assessment methodology, providing feedback and in equality and diversity awareness. They should also be competent in the procedure or activity under assessment.'

The GMCs Promoting Excellence: standards for medical education and training [3] in its requirements related to supporting educators also highlights in sections R4.1 and R4.2 that

'Educators must be selected against suitable criteria and receive an appropriate induction to their role, access to appropriately funded professional development and training for their role, and an appraisal against their educational responsibilities.' and

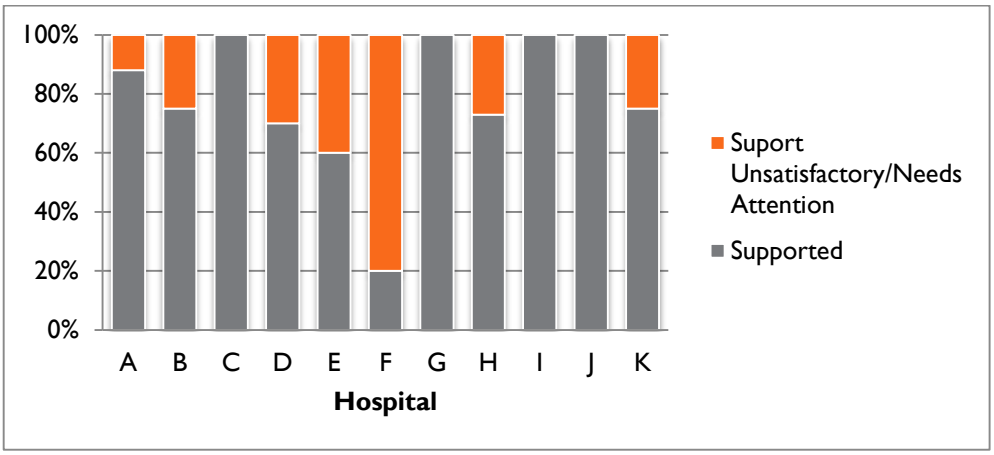
'Trainers must have enough time in job plans to meet their educational responsibilities so that they can carry out their role in a way that promotes safe and effective care and a positive learning experience.'

All clinical supervisors should be GMC recognised trainers, and be able to demonstrate up to date training in giving feedback in the workplace.

4. Educational Opportunities and Formal Teaching

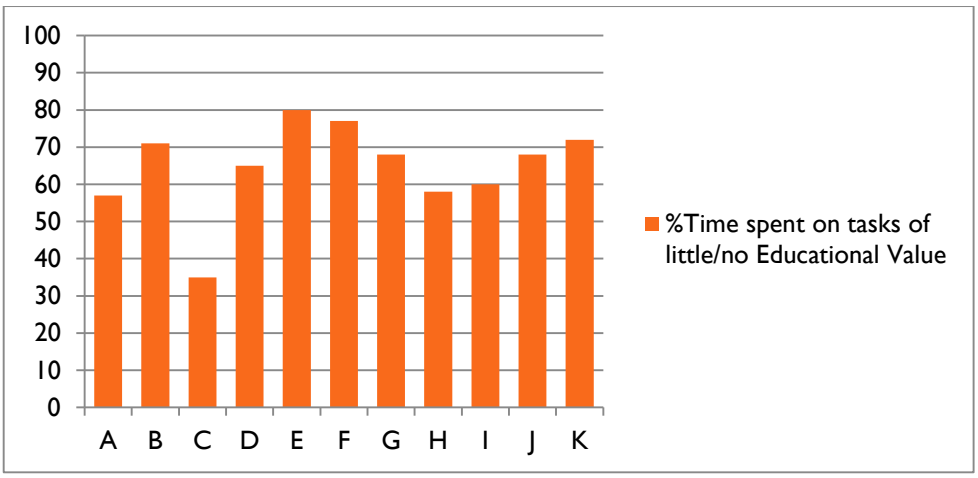
When asked about the educational environment, 74% of F1 doctors indicated that they felt supported/encouraged in their post to maximise their educational opportunities. Significant concerns about educational support were however reported in one site (Hospital F), with 80% of trainees indicating that they felt support was less than satisfactory/unsatisfactory and requiring attention. Performance by hospital site in this domain is shown in Figure 10.

Figure10: Support to Maximize Educational Opportunities by hospital site



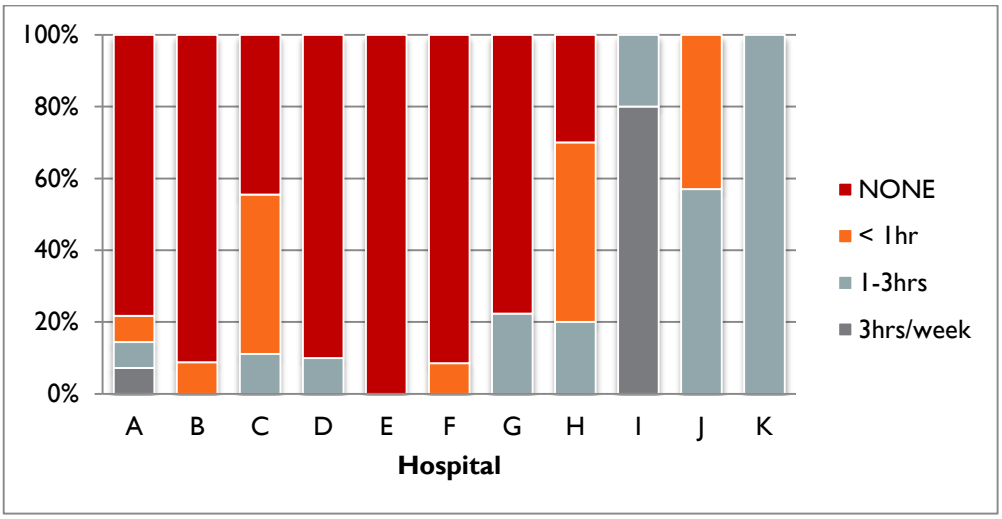
Despite the generally high level of support noted above, F1 doctors reported spending on average 63% of their time doing routine tasks of little/no educational value. This ranged from 35% in the best performing hospital to over 70% on four hospital sites (Figure 11).

Figure 11: Percentage time spent on tasks of limited educational value by hospital site



In the trainee survey 95% of F1 doctors reported not receiving 3 hours of protected (bleep-free) formal teaching per week (Figure 12) with 57% of trainees stating that they received no protected teaching and 45% of F1s indicating regularly having to leave teaching sessions to answer a bleep.

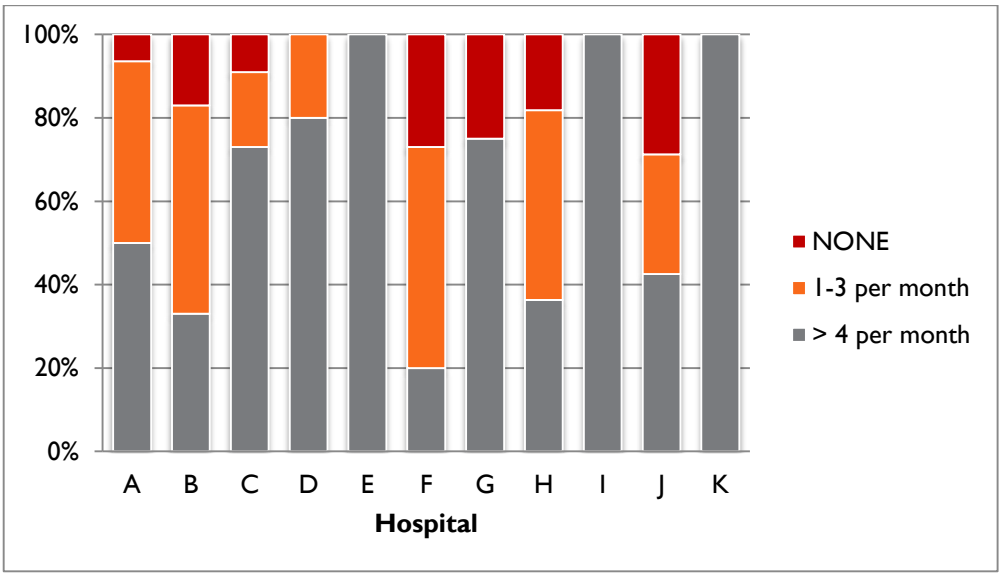
Figure12: Protected (bleep-free) teaching per week by hospital site



When questioned further about attendance at different types of teaching activities per month, 82% of F1 doctors indicated that they had received no formal consultant led bedside teaching and no attendance at monthly audit or MDT meetings was reported by 68% and 53% of trainees respectively.

Formal teaching sessions, presented by trainees on a curriculum-based topic with a consultant present were reported to occur at least 4 times a month by 65% of F1s but a further 13% of respondents indicated that this never occurred despite curriculum requirements[2] (Figure 13).

Figure 13: Formal teaching sessions on a curriculum-based topic with a consultant present by hospital site.



Key Recommendations: Educational Opportunities and Teaching

Enable all F1 doctors to attend 3 hours of on-site, bleep-free, formal* teaching per week

The UK Foundation Programme Reference Guide[2] (section 3.49), section states that all F1 doctors should have access to three hours of protected in- house formal education each week and should be released to attend this.

'F1 doctors are entitled to three hours of in-house, formal education as part of their working week, which should be relevant, protected ('bleep-free') and appropriate to their F1 training. Foundation doctors must be released to attend and should give their pagers to someone else so that they can take part'.

There is also a requirement for delivery of curriculum based teaching (section 3.47)

'There should be a generic teaching programme in both F1 and F2. The generic teaching programme should be mapped to the curriculum. A register of attendance should be maintained and a minimum of 70% attendance or equivalent should be achieved in each year.'

* 50% of formal teaching should be based on the Foundation Curriculum.

5. Supportive Environment, Teams and Facilities

The UK Foundation Programme Reference Guide[2] states that the Foundation programme aims to *'provide the opportunity to develop leadership, team working and supervisory skills in order to deliver care in the setting of a contemporary multidisciplinary team and to begin to make independent clinical decisions with appropriate support'*

In N.I. the UKFPO rankings for a supportive environment across the five Trusts were 85, 140, 83, 185 and 184 out of 197 (Table 6)

Table 6: UKFPO Rankings Supportive Environment – HSC Trusts hosting F1 doctors (2018)

TRUST	UKFPO Ranking (n/197)
TRUST 1	85
TRUST 2	140
TRUST 3	83
TRUST 4	185
TRUST 5	184

When surveyed about supportive environment in their workplace as part of a series of focus groups, 21% of new F1s stated that they did not feel part of their team, and 40% did not feel part of the identity of their hospital. There were positive remarks from some doctors with regards to team working both with seniors and with other members of the multidisciplinary team however there were also a large number of comments indicating that F1 doctors felt that people barely noticed their presence, and that they felt isolated from all other team members.

A related issue that was raised by F1s was the absence of areas to network with other doctors. Only 41% of F1 doctors stated that they had a mess in their hospital. Focusing further on in house facilities only 31% of F1s had access to a F1 on call room, only 22% were aware of an area to rest post night shift if needed, and only 8% had access to hot food out of hours.

Key Recommendations: Supportive Environment, Teams and Facilities

Assign F1 doctors to a clinical team as opposed to a clinical area.

Provide rooms where F1 doctors can rest after a night shift before travelling home.

Paragraph 9 of schedule 12 of the U.K National terms and conditions of service for NHS doctors in training [4] states that

'Where a doctor advises the employer that the doctor feels unable to travel home following a night shift or a long, late shift due to tiredness, the employer shall where possible provide an appropriate rest facility where the doctor can sleep. The hours when the doctor is resting in the hospital under these circumstances will not count as work or working time. Where the provision of an appropriate rest facility is not possible, the employer must make sure that alternative arrangements are in place for the doctor's safe travel home.'

Ensure that F1 doctors working out of hours' shifts have access to hot food and an area to take rest breaks.

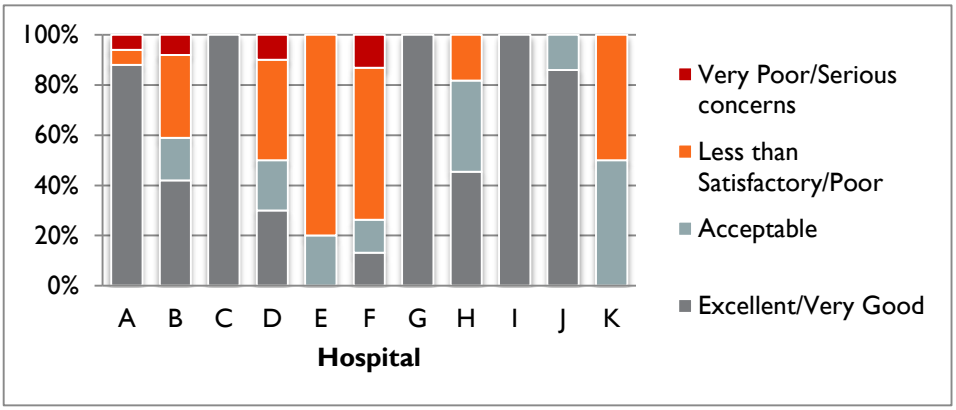
Paragraphs 4 and 7 of schedule 12 of the National terms and conditions[4] state that

'Where doctors are required to work during the overnight period, they must be able to access both hot and cold food and drink.'
'Doctors who are rostered to work a night shift must have access to a space in which to take a meal and other rest breaks. This should ideally be provided in an area away from patients, where possible.'

6. Overall Opinions

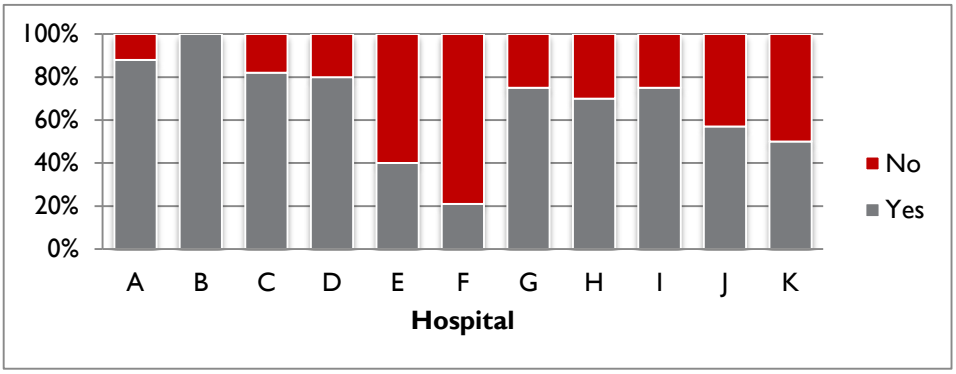
When asked to provide a global score for their training placement just over half of F1 doctors (55%) rated their placement as excellent or very good, with a further 14% rating it as acceptable. Training placements however were reported as being less than satisfactory or poor by 26% of respondents with a further 5% indicating that their placement had been very poor, reporting serious concerns (Figure 14).

Figure 14: F1 placements as a training opportunity.



Five hospitals (A, C, G, I and J) performed well with F1 placements being rated by over 85% of trainees as excellent or very good as a training opportunity. In contrast on three hospital sites (E, F and K) over 50% of F1 doctors rated the training placement as less than satisfactory or poor. In keeping with this result, on these three sites (E, F and K) 60, 79 and 50 % of trainees respectively reported that the teaching received throughout the year had not adequately addressed their curriculum needs (Figure15)

Figure 15: F1 Teaching adequately addressed curriculum needs



Overall 70 % of all F1 doctors in the survey indicated that their F1 year was excellent or good overall preparation for F2 with only 6% feeling they were poorly prepared. In three

Overall F1 Opinions of their training placement

F1 Training placements

55% Excellent/Good

31% Unsatisfactory/ Poor

F1 Teaching adequately delivers curriculum needs

69% Yes

31% No

F1 Year prepared trainee for F2

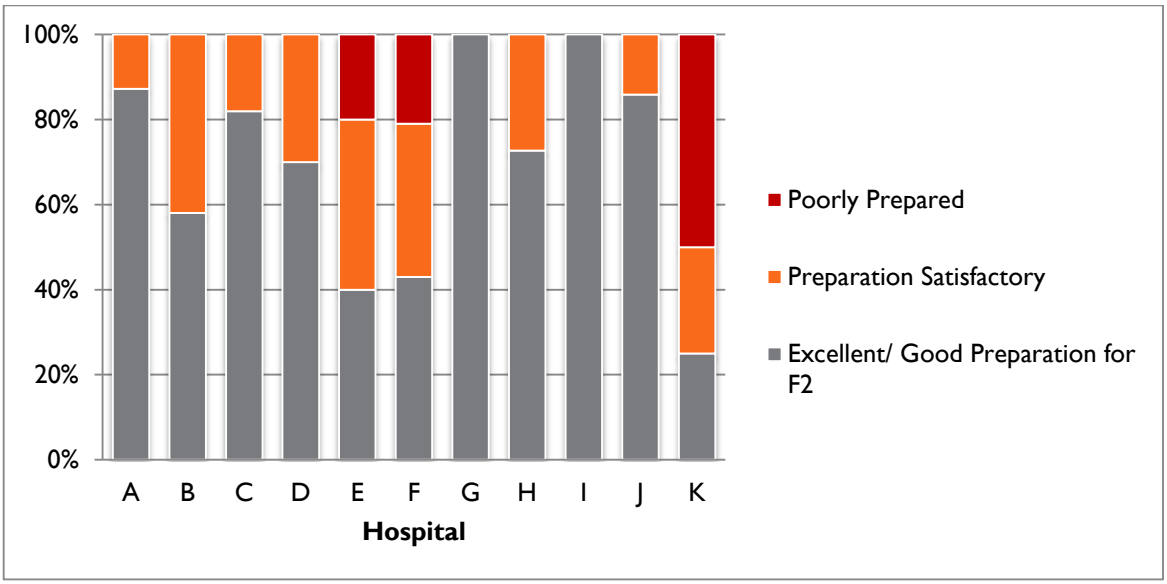
70% Excellent /Good preparation

24% Satisfactory

6% Poorly prepared

hospital sites (E, F and K) however this figure rose to 20, 21 and 50% respectively (Figure16).

Figure 16: F1 year prepared trainee for F2 year



Trainee Suggestions for Improvement

When asked to give three suggestions for what would improve training in their current post the most frequently occurring responses were:

- F1s must go on ward rounds
- More support staff/phlebotomists/ nurse involvement in routine tasks e.g. blood taking, ECGs, cannulas
- Involvement of other staff in discharge summaries
- Encourage trainees to present cases on ward rounds
- More feedback from seniors
- More opportunity to clerk in patients
- Less service provision, more educational opportunities
- Formal ward rounds
- More consultant –led teaching
- More protected teaching time

Section 3: Trust and Regional Responses

Redefining F1 Summit

A Foundation Summit "Redefining F1" was held on 1st April 2019, hosted jointly by Queens University Belfast and NIMDTA; the aim being to consider specifically the experiences of F1 doctors in NI and to identify how the F1 experience could be redefined through a collaborative approach involving all of the key stakeholders.

Representatives of all interested parties in the NI Foundation Programme (DoH, HSCB, PHA, HSC Trusts, NIMDTA, QUB, GMC, BMA, and Trainee representatives) attended and participated actively in the Summit. The outcomes that F1s are expected to achieve during their first year of practice and the feedback from the PQ Review was presented. Four workshops were held looking at expected F1 training outcomes, priorities for action to address immediate concerns, what steps each organisation could take to address less than satisfactory aspects of the F1 role (Induction, Shadowing, Formal Education, Workload, Team Working and Clinical Duties) and what actions could be taken at Regional level.

The programme for the Foundation Summit and the output from the workshops has been collated and summarized (Appendices 1-5)

Proposed Actions

In response to the evidence presented from Foundation GMC NTS data; UKFPO Foundation rankings; NIMDTA Placement Quality Review of Foundation year 1 training and the collated output from the Summit workshops, a number of actions are proposed to ensure that progress is made in addressing the concerns raised about current F1 training:

1. NIMDTA will produce a Foundation Placement Quality Report based on the background information presented at the Foundation Summit and on the proposals generated during the Summit.

2. NIMDTA Placement Quality Team will meet with each HSC Trust to
    a. Share data for each site within the Trust
    b. Implement quick fixes
    c. Agree local action plans

3. HSC Trusts will identify what is within their power/control to change to improve F1 experiences and what system-wide changes may need to be introduced.

4. NIMDTA and HSC Trusts will discuss with HSCB/PHA and DoH regarding system-wide solutions that need to be introduced.

5. ***Local actions*** and ***System-wide solutions*** will need follow up through meetings, surveys and focus groups to monitor implementation of actions, to identify improvements and to enable reporting of progress

Quick fixes identified at the time of the Summit and which should be acted on as a matter of urgency were:

- Provide all new F1 doctors with ward-based F1 shadowing all day for 2 full days;
- Deliver a formal induction for all F1 doctors to their clinical team at the start of each placement;
- Fully involve F1 doctors in planned patient reviews on a daily basis;
- Necessitate the participation of F1 doctors in the clerking-in of patients on average at least twice a week;
- Require the active participation of F1 doctors on ward rounds on average at least twice a week;
- Ensure F1 doctors are aware of who the senior doctor is (and how to contact them) for advice for each shift
- Provide feedback to all F1 doctors through their trained Clinical Supervisors on average on a weekly basis
- Enable all F1 doctors to attend 3 hours of on-site, bleep-free, formal teaching per week;

Section 4: List of Recommendations

The key recommendations for HSC Trusts are to:

1. Provide all new F1 doctors with ward-based F1 shadowing all day for 2 full days;
2. Deliver a formal induction for all* F1 doctors to their clinical team at the start of each placement;
3. Fully involve F1 doctors in planned patient reviews on a daily basis;
4. Necessitate the participation of F1 doctors in the clerking-in of patients on average at least twice a week;
5. Require the active participation of F1 doctors on ward rounds on average at least twice a week;
6. Limit the time spent by F1 doctors on routine tasks of limited educational value to no more than 50% of their time**;
7. Ensure F1 doctors are aware of who the senior doctor is (and how to contact them) for advice for each shift;
8. Provide feedback to all F1 doctors through their trained Clinical Supervisors on average on a weekly basis;
9. Enable all F1 doctors to attend 3 hours of on-site, bleep-free, formal teaching*** per week;
10. Assign F1 doctors to a clinical team as opposed to a clinical area;
11. Ensure that F1 doctors working out of hours' shifts have access to hot food and an area to take rest breaks;
12. Provide rooms where F1 doctors can rest after a night shift before travelling home;

**including F1 doctors who are commencing on out of hours or who have a late start date*

*** Examples include venepuncture, IV cannulation, peripheral blood cultures, preparing and administering IV medication/injections, performing ECGs. F1 doctors should complete no more than 5 discharge letters per day*

**** 50% formal teaching should be based on the Foundation Curriculum*

References

1. General Medical Council (2018). *National Training Survey. Deanery: NIMTDA.* Available at: https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/national-training-surveys-reports

2. UK Foundation Programme Reference Guide 2016 http://www.foundationprogramme.nhs.uk/sites/default/files/2018-07/Reference%20Guide.pdf

3. General Medical Council. *Promoting Excellence: standards for medical education and training*. Manchester: GMC July 2015.https://www.gmc-uk.org/education/standards-guidance-and-curricula/standards-and-outcomes/promoting-excellence [accessed 26 November 2018]

4. Terms and Conditions of Service for NHS Doctors in Training. https://www.nhsemployers.org/-/media/Employers/Documents/Need-to-know/Terms-and-Conditions-of-Service-for-NHS-Doctors-and-Dentists-in-Training-England-2016-Version-2--30-March-2017.pdf

Appendices

Collated Trust and Regional responses from the four workshops held at the 'Redefining F1 Summit' 1st April 2019.

Appendix 1: Redefining F1 Foundation Summit Programme

Appendix 2: Workshop 1 Foundation Year 1 Curriculum: Professional Capabilities (FPCs)

Appendix 3: Workshop 2 3 Quick Wins

- Culture
- Rota Allocation and notice
- Work shadowing and induction
- Clinical duties/ward rounds
- Improving discharge letters and efficiency
- Doctors' Mess/Facilities
- Formal education

Appendix 4: Workshop 3 Induction and Work Shadowing

Formal Education

Appendix 5: Workshop 4 Workload and Clinical Duties

Team Working

Appendix 1 Redefining F1 Summit

Monday 1 April 2019

Programme

10.00-11.15	Session 1	Chair: Professor Pascal McKeown
10.00-10.20	NI Foundation Programme	Professor Keith Gardiner
10.20-11.15	F1 Outcomes Workshop	Dr. Lorraine Parks
11.15-11.30	Coffee break	
11.30-13.00	Session 2	Chair: Dr. Paddy Woods
11.30-12.15	F1 Experiences in NI	Dr. Sally Anne Phillips Dr. Michael Doris Dr. Gillian Blayney
12.15-13.00	Priorities during F1 Workshop	Facilitator: Dr. Ian Steele
13.00-13.40	Lunch	
13.40- 15.00	Session 3	Chair: Dr. Lyn Wilson
13.40-14.10	What does good look like: ○ Induction ○ Shadowing ○ Formal Education ○ Team working ○ Workload ○ Clinical duties	Foundation Programme Directors
14.10-15.00	Workshop – Induction, Shadowing and Formal Education	Facilitator: Oliver Boylan
15.00-15.15	Coffee break	
15.15-16.15	Session 4	
15.15-16.00	Workshop – Team working, workload, clinical duties	Facilitator: Oliver Boylan
16.00-16.15	Closing Remarks and Next Steps	Professor Keith Gardiner

APPENDIX 2

"How can the necessary training and experience can be provided within the workplace to enable Foundation Year 1 doctors to achieve the Professional Capabilities listed below?"

Section 1: Professional Behaviour and Trust	
1. Acts professionally	• Observation / Role Modelling – Seniors lead by example • TAB/360 feedback on interactions in a formal and informal way • Difficult to formally deliver • Having defined standards/expectations – perhaps at induction • Teaching trainees how to feedback to others • Ensure F1's are member of the team – ward rounds – "Buddy Up"
2. Delivers patient centred care and maintains trust	• Permission to contribute, getting on ward rounds • Role Modelling, embedding in team • Follow up on tasks / agreed courses of action • Fragmentation of rotas makes continuity of care challenging • Removal of tasks of non-educational value (discharge) • Ensure support staff are available to allow F1's to attend handover etc.
3. Behaves in accordance with ethical and legal requirements	• Understanding and knowing what the ethical and legal requirements are • Advice from more senior doctors • Highlighting of relevant information in Trust Policy & Procedures, effective induction • Ensure part of team
4. Keeps practice up to date through learning and teaching	• Bleep-free uninterrupted teaching • Encouraging the multi-professional team to contribute to teaching • Planned teaching time in rota
5. Demonstrates engagement in career planning	• Educational supervisor contact • Exposure to a variety of areas with enough time to experience • Designated career exploration days/taster sessions • Dedicated study leave for e.g.: post graduate exams in F1 • Taster modules as F1's, promote taster-modules as F2's better
Section 2: Communications, Team-working and Leadership	
6. Communicates clearly in a variety of settings	• Participates in - Ward rounds/Handover – not optional • Handover/present cases • SBAR/Discharge Letters / active listening – taught at medical school • No formal teaching – needs to be done in the workplace
7. Works effectively as a team member	• Sense of belonging – Feel part of a team – Introduction at Induction • F0/F1 – work shadowing • Review Rotas • Protect each other – value strategy • F2 course on team member – F1 do not get study leave
8. Demonstrates leadership skills	• Participates / leads ward round • QI/Patient safety initiative - present • Forum with senior medical input

Section 3A: Clinical Care	
9. Recognises, assesses and initiates management of the acutely ill patient	• Time/space to undertake this (experience/training/supervision/feedback) • Accessibility to others • Multidisciplinary team • Simulation of scenarios (safe environment as student) • Learning opportunities to do themselves "Post take ward rounds/ Clerking in patients", and then receive feedback on accuracy. • Education on National Early Warning Scoring (NEWS)
10. Recognises, assesses and manages patients with long term conditions	• Time/space for supervisors • Protected period of time vs acute issues • Team working • Experiential learning – see one, do one = feedback e.g.: in outpatients • Avoid distracting duties • Simulation training – Human Factors training – simulation with a team
11. Obtains history, performs clinical examination, formulates differential diagnosis and management plan	• Attach to team • Pair F1 with senior Doctor (registrar) • Confidence to ask for help • Seek help: help is willingly given (psychological safely to say "I don't know what to do") • Protected teaching –Bleep free • Don't have Invisible consultants
12. Request relevant investigations and acts upon results	• Member of team • Feedback from team • Over emphasis on task orientated work • Prioritise lists • Bring back the tem – 'Morning huddle'
Section 3B: Clinical Care	
13. Prescribes safely	• PSA – prescribing safety assessment completed before end of F1 • SCRIPT Modules • Electronic prescribing • Supervision – F0 placement • Pharmacist mentoring/ ward pharmacist • Purple pen initiative • Transferring knowledge to the real world
14. Performs procedures safely	• Supervised as F0's, QUB, adequately supported • Clarifying Non-QUB whether signed off • Protected time • Simulation needs time & added to the curriculum • Facilitating support from other disciplines
15. Is trained and manages cardiac and respiratory arrest	• ILS completed in first month • Formal ALS training • RTO onsite • Simulation updates

16. **Demonstrates understanding of the principles of health promotion and illness prevention**	• Relatively low positivity as F1 at present: challenge • Exposure to the specialty teams • Primary care/public health focused time out • Undergraduate theory – exposure to specialist teams
17. **Manages palliative and end of life care**	• Good support from palliative care teams • Teaching • Time out to join palliative care team • Community exposure
Section 4: Safety and Quality	
18. **Recognises and works within limits of personal competence**	• Encouraged to attend ward rounds/board rounds/handover – actively participate and contribute • SBE – call for supervisor help in scenarios • Positive affirmations and constructive feedback/reflection • Accessibility of senior colleagues (Do not use – "I am sorry to call you"). Culture feeling able to ask for help • Ownership of tasks across the team • Being part of a team – role/skills/responsibilities – F1's can be disconnected. Feeling part of a team • Consultant presence - physician of the week • Be given appropriate tasks and given feedback: need to see some new patients and not just admin work e.g.: 2 wk. supernumerary post & block time spent in MAU • No Generic Skills in F1
19. **Makes patient safety a priority in clinical practice**	• SBE – recognition of patient safety issues in scenario • Ward culture of patient safety being priority/role modelling • Encouraged to attend and participate in morbidity & mortality meetings/clinical governance meetings • Communication – culture of ensuring good MD communication • Having time to do the tasks • SAI like investigations: including trainees in this
20. **Contributes to quality improvement; shows evidence of involvement in quality improvement initiatives**	• Formal QI training programme within trusts • HSC/Trusts QI projects (involvement at F1 level) • Building on basics laid down in QUB • Understanding the context and culture of QI & place in patient safety • Participate in mentoring/ appropriate mentors

APPENDIX 3

	Workshop 2: Quick Wins	
Quick Wins	**How would you implement them?**	**When by?**
Culture	• Useful to find out what top performing Trusts are doing that is so different to NI experience • Is there something about them being supernumerary every week/month and looking to see if there are tasks that could be taken up by other disciplines (workforce implication for other disciplines) • Term to be discussed "Doesn't have to be a doctor" • Team coffee break after a ward round, to welcome the F1 and encourage them to feel part of the team • Photos for wall alongside nurses at each changeover • Bleep box – manned by someone - ward manager • Empowerment – helping F1s to feel comfortable and able to say no when it is clearly not an educational component • Clearly defined F1 role – job description/place in the team • Culture of Ward based learning • Matching with senior colleague • Buddying	
Rota allocation and notice (6 wks notice)	• By August we should all commit to doing it 6 weeks in advance. • Making sure that structures within the Trust work and are invested in properly to make sure the rota works • Timely information flow between HR and units/rota coordinator • Create the rota and then address gaps. Allow trainees to pick their line and that's their line in the rota (by August 2019) • Who should be doing the rota? • More consideration of work/life balance on rota design	August 2019
Work shadowing & Induction	• Ensure 2 days shadowing is delivered and protected • Ensure sufficient local induction for trainees "Out of sync" or at each changeover • Online induction at Trust level appears to be addressed, but is there scope to roll this out at unit level? • Proposal of Enhanced Induction, similar to Core Surgical Training • Learn from other trusts for workplace based learning • Meeting the expectation of F1s • F0-F1 year in same hospital. Selection – feeling around the table, even doing 6 weeks in the hospital that you are going to be F1 is better than doing it in the hospital that you are not! • Some area doing it well, but we need to learn from those Trusts, as to how they do that. • Bootcamps – run scenarios for them • Video blog - so trainees can see where things are: toilets, mess, etc.	August 2019 Spring 2020

Clinical Duties / Ward Rounds	• Team working model works best • Rota of F1 attendance at ward rounds – "named" • Potential to take Ward Round bleep • More of medicine model • Establish a culture that the F1 is there to clerk in, do ward rounds, do job of a doctor • Culture of Ward based learning • Investment in Phlebotomy and other AHPs who are capable of taking workload from juniors. • Ward manager could take responsibility for protecting the F1 and allocate duties to others. • Tasks to be completed by senior staff too and not all left to the F1/F2	
Improving discharge letters and efficiency	• Use "Big Hand" on ward round / consultants dictate during ward round • Bleep free/protected time to complete discharge letters • Honed down format, i.e. sticky note for key points • Structured discharge letter template (15 mins each x 20 per day) • Discharge template: ➢ Diagnosis ➢ Secondary Diagnosis ➢ Discharge medications ➢ Follow up investigations • NHSCT – 'doctor light' – pharmacists produce half the discharge (discharge letter template) • Input from others – pharmacist, physician associates • Electronic systems support, i.e. Encompass	
Doctors Mess/Facilities	• Need to prioritise space in each Trust • Hospitals are tight for space • Needs to be a safe place for juniors • In England – some trainees provide financial contribution • Increase camaraderie • Mess specification: ➢ Hot food/microwave ➢ Secure (Pass controlled) ➢ Fridge/Food/Recharge station ➢ Computer access ➢ On call rooms / Rest Beds ➢ Areas/Lockers/Facilities ➢ Provision of food rather than purchasing own (out of hours) • Some advantages to all grades of trainees together sharing experiences • Rest areas provided for those coming off nights – somewhere to rest after nights before travelling home	August 2019
Formal Education	• Providing consultant lead teaching • Bleep free teaching • Bleep box – manned by another professional who can they take messages and explain F1 in teaching. • All staff informed of process. • Bleep reasons were audited in one Trust • Scheduled/fixed formal teaching	

APPENDIX 4

Workshop 3: Induction and Work shadowing	
Trust Responses	**Regional Responses**
What actions can we take as an organisation to improve the quality of the F1 experience in relation to induction and shadowing?	**What actions should be taken at Regional level to ensure a system wide approach to improving the quality of the F1 experience in relation to induction and shadowing?**
Strictly adhere to and protect two days on ward prior to start (Monday and Tuesday)	Focus groups: To hear trainees voice & what they think would be useful and valuable at induction
Welcome evenings at ALL changeovers – to facilitate meeting the senior team, other teams, accessing passwords and badges, car parking etc.	Information overload: What way do trainees want to receive/obtain information?
Ensure consistency in Departmental / Unit Induction by introducing a checklist: • Bleep arrangements • How to book X-ray • Drug cupboard and location • Food out of hours	Use the outgoing F1: they can provide support, tour of ward, introduce them to permanent staff Meet the Doctor that had your job in form of "buddy scheme"
Incorporate attendance at Hospital at Night into work shadowing	Review good practice from data available UK wide
Introduce a buddy system, i.e. F1 with CT.	Facilitate networking with other F1s in NI
	Mandatory training: What are the requirements and are they the same across all the trusts? Better coordination across Trusts
	Regional Induction: All F1 group together. Change in format for 2019. Involvement of FPDS/Reps from each unit.
	In April connect the F0 to F1 that had their job 2-3months beforehand
	Lead employer Role presents opportunity to find out and streamline what happens locally
	Trust specific videos/vlogs – to include visual tour, F1 top tips
	Long term objective – remove the need for new passwords etc. between Trusts
	Introducing the Purple Pen scheme in more trusts.

Workshop 3: Formal Education	
Trust Responses	**Regional Responses**
What actions can we take as an organisation to improve the quality of the F1 experience in relation to formal education?	**What actions should be taken at Regional level to ensure a system wide approach to improving the quality of the F1 experience in relation to formal education?**
Bleep Free: - • Bleep passed up to senior colleague (clinical or clinical co-ordinator) • need to understand bleep filtering • admin monitoring of bleeps • back-fill for trainee during teaching	Educational contract between Trainee, Trust and Deanery as to what to expect in F1 year. A tri-partied agreement – to include Job Plan / Description
Engagement of good quality educators / Trainer upskilling	Consider Study Leave for F1
Multi-disciplinary education emphasis	Why Lunchtime? Other times? Pre-shift, Post-shift Days in Lieu if attending on own time Leave at least one lunchtime free
Mandatory nature emphasised	Study Leave integrated on a Curriculum for F1 doctors
Trainee involvement in design of programme: What & how it is being delivered	Development of IT facilities Delivery of education using Zoom etc.
Walk in Clinic for nurse led simulation clinical skills	Formal education facilitated by Senior Foundation Doctor inclusion in delivery of training across sites in one Trust.
Teaching Fellows specifically for F1 (similar to "DUCT" Designated Under Graduate Clinical Tutor training)	Protected Time
Revisit study leave arrangements for F1	Structured Programme
First-Step West (@50%enrolled) : - Out of hours	What Foundation Doctors want to learn: involvement of foundation doctors in design of programme

APPENDIX 5

Workshop 4: Workload & Clinical Duties	
Trust Responses	**Regional Responses**
What actions can we take as an organisation to improve the quality of the F1 experience in relation to workload and clinical duties?	**What actions should be taken at Regional level to ensure a system wide approach to improving the quality of the F1 experience in relation to workload & clinical duties?**
Expansion of Hospital at Night to include weekends / bank holidays / weekday evenings	Hold relevant organisations to account for delivery of expected & required practical experience to F1s
Investment in other roles: • Phlebotomy / Pharmacy • Band 2/3 HCAs • Physicians Associates • Ward Co-ordinator • Employ Medical students as HCA evenings & weekends will require funding (DoH need to address)	Issue directive to Trusts "if you have an F1, this is what the other members of the team should be doing"
Discharge Summary solutions: • Prescribing Pharmacists / Ward based Pharmacists to complete medications on discharge letter • Discharge to be seen as a Team activity not necessarily a F1 duty • Standardisation of discharge letters • Daily Review template • Prep discharge summary on Ward round – Pilot in Urology BHSCT	Invest in alternative Staff/roles to carry out tasks of limited educational value.
Investment in IT Solutions: • Computer on Wheels – update during ward rounds for discharge letter (90% done on during ward round) • speech recognition accelerated access • Printers that work and access to computers for bloods • Single login for multiple systems • Additional access to computers	Identify specific number of procedures/tasks which the F1 must complete during the year. Limit the number of the tasks which are of limited educational value, e.g. max number of discharge letters QUB suggested max number of discharge letters per Foundation Year 1 trainee
Team Culture: • Team duties • Timetabling and Allocation of Duties, Ward rounds & Grand Rounds • Teaching of Clerk-ins • Consult Foundation Year 1 Junior Doctors forum	Greater use of technology to speed up writing of discharge letters.

Workshop 4: Team Working	
Trust Responses	**Regional Responses**
What actions can we take as an organisation to improve the quality of the F1 experience in relation to team working?	**What actions should be taken at Regional level to ensure a system wide approach to improving the quality of the F1 experience in relation to team working?**
Team Culture: • Introduce Huddles • Photos place on wall at each placement – to include names • Timetabling and Allocation of Duties, Ward rounds & Grand Rounds	Change in format of the Regional induction: • Initial overall induction • Run sequential to each trust possibly by video link • To include F1 to give tips and info
Protected time for F1 to work with consultant time-table (1hr day)	All NIMDTA Recognised trainers should be acting as role models in being team players.
Opportunities for F1 to present/demonstrate leadership: • Grand Ward Rounds – F1 can present • Handover – F1 to present case	Encourage mentorship and provide training and recognition for mentors
Communication: • Regular Team/Departmental meetings • Regular meetings with FPD • Link with Ward sisters/AHP's • Regular Forum to resolve issues	Share examples of Teamwork good practice between Trusts and Units.
Share good practice between teams	Regional Education evenings
Need to redefine role as a result of no increase in number of junior doctors and increase in workload and numbers of wards	Social Media # No one left behind # My name is # Valued
	Push towards change in culture across region from Consultant downwards, in relation to: Medical staffing Responsibility Reality Direct push for change towards "People who aren't at the event today"
	Schwartz Rounds
	Joy in work paper on Health Care improvement
	Collective Consultant meeting & commitment to improving
	Doctors mess
	Form organisation to take part in sports and social events.