2023/24

Redefining F1 PQ Update NHSCT Survey Results: 2023/24

RESURVEY RESULTS 2023/24

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Executive Summary

NIMDTA's Placement Quality (PQ) team commenced a review into the quality of Foundation Year 1 (F1) training posts in Northern Ireland in 2018. A Foundation Summit "Redefining F1" hosted jointly by QUB and NIMDTA then took place on 1 April 2019. The Summit looked specifically at the experiences of F1 doctors in NI and aimed to identify how the F1 experience could be redefined through a collaborative approach involving all of the key stakeholders. Essential F1 training outcomes were considered and priorities identified for action to improve the F1 training experience.

A Foundation PQ Report, which summarised the findings of the PQ Review and the actions agreed at the F1 Summit, was published in May 2019. This set out 12 Key Recommendations to be implemented across organisations to improve the F1 training experience. These included: ward-based shadowing; induction; clinical duties; protected teaching and work/rest facilities. Further engagement with Trusts, through PQ visits, led to the creation of locally agreed Trust actions to address the recommendations.

A Progress Update Report published in November 2019 summarised the areas of good practice across Trusts, identified solutions and local obstacles to implementing recommendations and highlighted key areas requiring further development.

Following local introduction of improvement strategies, a re-survey of F1 doctors was conducted in January 2020 to ascertain what progress had been made in achieving the 12 key recommendations. This demonstrated that regionally improvements had been made in a number of areas including ward-based shadowing, induction, protected teaching, clinical supervision and the provision of rest facilities. There had however been minimal change in the amount of time that F1 trainees were spending on tasks of limited educational value and in participating in educationally beneficial clinical duties. A further survey was conducted in December in 2021/January 2022, but a very low regional response rate (28%) made interpretation of changes difficult.

In 2023 the F1 recommendations were reviewed and updated, to a core of 8 key recommendations for F1 training delivery (Appendix 1) and a re-survey of the training experience of F1 doctors was then carried out in December 2023/January 2024.

Section 1 of this report summarises the results of the 2023/24 F1 re-survey for the Belfast Health and Social Care Trust (NHSCT) – response rate 63% (Regional 52%). This provides evidence of the progress made against the updated 8 key recommendations. The NHSCT 2018/2020 and 2021 F1 PQ survey results and the regional averages from the F1 2023/24 PQ re-survey are included for comparison.

Section 2 outlines the survey feedback on other key training areas.

The results of the resurvey will be circulated to the Department of Health as well as all Medical Directors, DMEs and Foundation Programme Directors and will help to better inform Trusts of what additional progress has been made in addressing the key F1 recommendations and where a need for further development has been identified.

Section 1: F1 Key Recommendations – Progress Update NHSCT

Recommendation	NHSCT (%)	AAH	CAU	REGIONAL
PREPARE				
1. Provide all F1 doctors with 2 days of ward-based shadowing				
2018 Survey data	75	90	60	61
2020 Survey data	77	78	75	79
Resurvey 2021	100	100	100	95
Resurvey 2023/24	92	86	100	93
Improving?	↓	↓	↔	↓
2. Deliver ward/unit induction for all F1s at the start of placement				
2018 Survey data				
2020 Survey data				
Resurvey 2021	89	87.5	100	93
Resurvey 2023/24	100	100	100	92
Improving?	↑	↑	↔	↓
Induction at least **Satisfactory**				
2018 Survey data	71	70	80	70
2020 Survey data	61	55	75	88
Resurvey 2021	56	50	100	84
Resurvey 2023/24	80	64	100	80
Improving?	↑	↑	↔	↓
Induction **Very good/Good**				
2018 Survey data	43	40	60	50
2020 Survey data	46	44	50	65
Resurvey 2021	44	38	100	62
Resurvey 2023/24	60	43	82	51
Improving?	↑	↑	↓	↓
ENGAGE				
3a. Involve F1 doctors in planned patient reviews on a DAILY basis				
2020 Survey data > 5/week	9	11	0	20
Resurvey 2021 > 5/week	0	0	0	19
Resurvey 2023/24 > 5/week	17	7	30	21
Improving?	↑	↑	↑	↔
3b. Active participation on DAILY Ward rounds				
2018 Survey data * *(at least 2/week)	43	60	0	69
2020 Survey data*	81	89	50	73
Resurvey 2021*	78	75	100	82
Resurvey 2023/24 (>2/week)	66	71	60	61
Improving?	↓	↓	↓	↓
4. Assign F1 doctors to a clinical team as opposed to a clinical area				
2018 Survey data				
2020 Survey data	0	0	0	30
Resurvey 2021	50	57	0	50
Resurvey 2023/24	33	43	20	40
Improving?	↓	↓	↑	↓

Recommendation	NHSCT (%) 2021/22	AAH	CAU	REGIONAL
SUPPORT				
5. Trained Supervisors to provide feedback to all F1s on a regular basis				
2018 Survey data (weekly)	10	20	0	30
2020 Survey data (weekly)	18	22	0	18
Resurvey 2021(weekly)	11	12.5	0	24
Resurvey 2023/24	24	36	9	22
Improving?	↑	↑	↑	↓
6. Ensure F1s are aware of who the senior doctor is (and how to contact them) for each shift				
2018 Survey data*				
2020 Survey data	73	78	50	92
Resurvey 2021	89	87.5	100	83
Resurvey 2023/24	92	93	91	87
Improving?	↑	↑	↓	↑
EDUCATE				
7. Provide all F1s a minimum of 2 hours/week of PROTECTED (bleep free) teaching				
2018 Survey data* (1-3hrs)	7	10	0	20
2020 Survey data	60	75	0	66
Resurvey 2021	33	37.5	0	40
Resurvey 2023/24 (1-2hrs)	9	15	0	41
Improving?	↓	↓	↔	↔
8. Limit time spent on tasks of limited educational value (TOLEV) to no more than 50%				
Resurvey 2021 **<50% of time on TOLEV**	33	37.5	0	35
Resurvey 2023/24	52	43	64	36
Improving?	↑	↑	↑	↔

*Recommendations 2/4/6- No question in 2018 survey for comparison

F1 Wellbeing Recommendations

Other Recommendations	NHSCT (%)	AAH	CAU	REGIONAL
WELLBEING **Ensure that F1 doctors working OOH shifts have access to hot food and an area to take rest breaks**				
Access to a fridge/freezer/microwave and hot food OOH				
2020 Survey data	100	100	100	91
Resurvey 2021	67	62.5	100	72
Resurvey 2023/24	26	54	90	60
Improving?	↓	↓	↓	↓
Access to a private on call room to rest during OOH shifts				
2020 Survey data	56	12.5	100	55
Resurvey 2021	33	25	100	32
Resurvey 2023/24	43	0	100	27
Improving?	↑	↓	↔	↓
Provide rooms where F1 doctors can rest after a night shift before travelling home				
2020 Survey data	56	62.5	50	57
Resurvey 2021	11	0	100	22
Resurvey 2023/24	43	8	90	33
Improving?	↑	↑	↓	↑

NI Regional & Trust Data			
Target achieved	Target achieved by ≥75%	Below Target	Below Target by ≥50%

Section 2: NHSCT Resurvey 2023/24 - Feedback on other Education Areas

Education Areas: NHSCT	**AAH**	**CAU**	N.I 2023 Regional
TRUST notification of on-call rota > 4 weeks (Q.4)	54	73	43
INDUCTION			
UNIT Induction at least satisfactory: (Q.6) (Very Good/Good) AAH 36% (Poor/Very Poor)	64 (43)	100 (82)	80 (50)
UNIT induction face to face/ hybrid (Q.7)	93/7	91/9	71/19
UNIT induction included introduction to team: (Q.8)	79	82	70
UNIT induction included a walk around unit/ department: (Q.8)	79	100	65
UNIT induction included familiarisation with equipment and practical aspects of the job: (Q.8)	36	64	50
UNIT induction included orientation to other clinical areas cross covered OOH: (Q.8)	7	91	30
Shadowing prior to starting F1 post: at least 2 full days (Q.9)	86	100	93
Induction adequate preparation for work as an F1: (Q.11)	43	55	55
WORKLOAD			
Workload (Day-time): (Q.12) - Very Intense/Excessive	78	64	57
Workload (Evening)- Very Intense/Excessive	93	82	80
Workload (Nightshift) – Very Intense/Excessive	86	82	71
Workload (Weekends) – Very Intense/Excessive	100	100	96
>50% of time spent on task of limited educational value: (Q.14)	57	36	64
Placement provided adequate clinical experience to be on track to complete F1 year satisfactorily: (Q.15)	57	91	84
EDUCATIONAL & CLINICAL SUPERVISION			
Informed who ES was in a timely manner: (Q.16)	100	100	97
Initial meeting with ES – within the first month: (Q.17)	93	100	94
Educational Supervision - Satisfactory (Q.19) of which (Very Good/Good)	86	82	99 (85)
Clinical Supervision (Day time) – Satisfactory (Q.20) of which (Very Good/Good)	79 (43)	100 (82)	90 (68)
Clinical Supervision (Evening) – Satisfactory (Q.20) of which (Very Good/Good)	36 (28)	64 (18)	67(34)
Clinical Supervision (Night time) – Satisfactory (Q.20) of which (Very Good/Good)	43 (36)	36 (18)	68 (40)
Clinical Supervision (Weekends) – Satisfactory (Q.20) of which (Very Good/Good)	50 (21)	36 (18)	59 (27)
Aware of senior doctor and how to contact them for each shift: (Q.21)	93	91	87

Education Areas: NHSCT	**AAH**	**CAU**	N.I 2023 Regional
FEEDBACK & HANDOVER			
Feedback on performance:(Q.22): At least a few times a month	50	73	62
Feedback: Once a month or less / Never	36/14	27/0	30/ 8
Quality of feedback (Constructive and supportive): (Q.23)	57	100	80
Routinely participated in handover at start of DAY shift/NIGHT Shift: (Q.27/28)	50/71	100/100	57/84
LOCAL TEACHING			
Amount of Local teaching provided (Q.32): At least 1-2 hours per week	69	60	79
Amount of Local teaching provided (Q.32): < 1 hour/week/ None	31/0	20/ 0	18/ 3
Protected local teaching (Q.33): At least 1- 2 hrs/week)	15	0	41
Protected local teaching: Less than 1 hr/week	85	100	59
Had to leave teaching session to answer bleep (Always/regularly): (Q.35)	69	60	42
Able to attend >50% of local teaching session: (Q.34)	85	50	76
F1 teaching adequately addressed curriculum needs: (Q.37)	46	60	61
Opportunity to assess patients in the Community setting: (Q.26)	36	0	32
WELLBEING			
Dedicated doctors' mess area to take rest breaks: (Q.39)	8	50	36
Access to a fridge/freezer/microwave and hot food OOH: (Q.40)	54	90	60
Private on-call room to rest during OOH shifts: (Q.41)	0	100	27
Access to room to rest after night shift before travelling; (Q.42)	8	90	33
GLOBAL SCORE FOR PLACEMENT AS A TRAININGOPPORTU ITY			
Global Score for placement as a training opportunity: (Q.43) Acceptable/Excellent or Very Good	15/31	67/33	34/47
CLINICAL TEAMS			
Assigned to a clinical team with a named consultant(s) leading the team: (Q.30)	43	20	40
Felt part of the clinical team: (Q.31)	79	70	82
Feel valued in this post: (Q.44)	39	89	72
F1 YEAR AS PREPARATION FOR F2			
How well do you feel your F1 Year will prepare you for F2: (Q.45) – Excellent/Good preparation	54	67	62
How well do you feel your F1 Year will prepare you for F2: (Q.45) – Satisfactory	31	22	24
How well do you feel your F1 Year will prepare you for F2: (Q.45) – Poorly prepared	15	11	14

CLINICAL ACTIVITIES

ACCESS to TRAINING OPPORTUNITIES:

ACCESS to Training Opportunities Clinical Activities per week	NHSCT: **AAH**			
	None	1-2	3-5	>5
Ward Rounds	14	14	57	14
Presented patients on Ward rounds	50	0	21	29
Clerked in patients (Emergency or elective)	43	14	29	14
Reviewed a patient (planned, daily routine review)	29	21	43	7
Reviewed a patient (as an emergency)	0	0	21	79

ACCESS to Training Opportunities Clinical Activities per week	NHSCT: **CAU**			
	None	1-2	3-5	>5
Ward Rounds	10	30	60	0
Presented patients on Ward rounds	60	40	0	0
Clerked in patients (Emergency or elective)	70	30	0	0
Reviewed a patient (planned, daily routine review)	10	20	40	30
Reviewed a patient (as an emergency)	10	10	40	40

ACCESS to Training Opportunities Clinical Activities per week	NI Regional figures 2023			
	None	1-2	3-5	>5
Ward Rounds	18	21	31	30
Presented patients on Ward rounds	56	19	12	13
Clerked in patients (Emergency or elective)	48	30	14	8
Reviewed a patient (planned, daily routine review)	33	25	21	21
Reviewed a patient (as an emergency)	3	19	35	42

ACCESS to TRAINING OPPORTUNITIES: to gain experience in following areas (Q.25)

ACCESS to training to gain experience in patients' needs	AAH	CAU	NI Regional
Physical Health	100	100	97
Mental health/psychological needs	57	100	68
Social wellbeing	64	90	72

ACCESS to TRAINING OPPORTUNITIES: to assess patients in following clinical settings (Q.26)

OPPORTUNITY to assess patients in following clinical settings	AAH	CAU	NI Regional
Acute	100	90	92
Non-Acute	100	100	90
Community	36	0	32

ACCESS to TEACHING ACTIVITIES

ACCESS to Teaching activities per month	NHSCT: **AAH**			
	None	1-2	3-5	>5
Formal teaching sessions presented by trainees on a curriculum-based topic; Senior doctor present	46	31	23	0
Formal teaching sessions presented by trainees on a curriculum-based topic; Senior doctor NOT present	62	23	15	0
Formal teaching sessions presented by senior doctors	8	62	23	8
Clinical governance/QI/M&M/Audit meetings	46	54	0	0
Simulation based training	69	31	0	0
Senior doctor led bedside teaching	100	0	0	0
Senior doctor led ward rounds	8	23	8	61

ACCESS to Teaching activities per month	NHSCT: **CAU**			
	None	1-2	3-5	>5
Formal teaching sessions presented by trainees on a curriculum-based topic; Senior doctor present	30	50	10	10
Formal teaching sessions presented by trainees on a curriculum-based topic; Senior doctor NOT present	70	30	0	0
Formal teaching sessions presented by senior doctors	10	40	40	10
Clinical governance/QI/M&M/Audit meetings	70	30	0	0
Simulation based training	90	10	0	0
Senior doctor led bedside teaching	80	20	0	0
Senior doctor led ward rounds	10	20	30	40

ACCESS to Teaching activities per month	NI Regional figures 2023			
	None	1-2	3-5	>5
Formal teaching sessions presented by trainees on a curriculum-based topic; Senior doctor present	24	39	33	4
Formal teaching sessions presented by trainees on a curriculum-based topic; Senior doctor NOT present	58	26	13	3
Formal teaching sessions presented by senior doctors	16	41	36	7
Clinical governance/QI/M&M/Audit meetings	62	37	1	0
Simulation based training	69	27	4	1
Senior doctor led bedside teaching	85	12	2	1
Senior doctor led ward rounds	18	12	24	45

Section 3: Trainee Comments

ROTA

AAH

"It would have been preferred if the rota had been shared 6 weeks before, as is mandated by the BMA"

INDUCTION

AAH

"Most areas of induction to the department were good. Poor induction area was the shadowing days - only two f1 staff were scheduled for the last two days of their rotation, which was our shadowing days. This meant that we could not all shadow these two members of staff and many of us were doing jobs with no supervision due to the wards being very busy."

"Departmental induction was on Friday, started the post 2 days before this"

"Departmental induction was poorly timed, focused on irrelevant topics and didn't explain how the department was structured."

"Presentations from current F1s giving advice about working OOH was probably the most helpful part of the induction days."

CAU

"Causeway gave us a full medical and surgical induction to all F1s so we were able to work across both specialties. The induction was really helpful just for general knowledge of how the hospital works, how the bleep system works and how to access the shared folder on the trust computers."

"Induction was timely (within first week) and when we sought further clarification we had a further induction for opportunity to ask questions. As a surgical F1 as we also cross covered medicine and we therefore received an induction for both areas"

SHADOWING

AAH

"I would not count two days of shadowing as shadowing experience as there were not enough f1s scheduled to work, therefore I could not shadow them and I was doing ward jobs unsupervised"

"I received 2 full days of shadowing on paper, however in practice there were only 2 outgoing FY1s available for 11 of us to shadow, and one of them went to theatre. Therefore, we were thrown in at the deep end and working as FY1s to fill the gaps on the rota, rather than shadowing."

"Only 2 F1's working that day, 11 new F1s trying to shadow them"

"Did have two shadowing days but worth noting that the department allowed the outgoing f1s to take annual leave for these days so we had no one to shadow and had to work in place of the outgoing f1s."

CAU

"It prepared me as much as possible"

WORKLOAD

AAH

"Many might answer emergencies/sick patients but that is just when the excessive work becomes panicking, the reality is that there are dangerous staffing levels out of hours and a workload that prevents any personal progression or collaboration"

"Evening and weekends: excessive workload - trying to balance practical tasks, chasing results, responding to sick patients over a vast number of medical wards and completing discharge letters at the weekend."

“There are a lot of time-consuming duties like kardex re-writes, discharge letters, having to input investigation orders and then attempt to call imaging or Everlight to get it actually done but the majority of these things are themselves consequent to other staff not having time. I never got the impression any staff group or member was lazy or inefficient. In fact, overtime is a commonly accepted fact performed just so the workload of those taking over isn't brutalizing.”

“No support from seniors, ask for help and never came. Poor team work and treatment disrespected FY1”

CAU

“Overwhelming workload, extreme pressures to discharge patients who often were not fit for discharge and being the only doctor on the ward for most of the day. Out of hours only doctor covering wards as F2 and IMT were on take/with sick outliers in ED. Other doctors only came to the wards if you called them when you were out of your depth.”

“Surgery did not have pharmacists - I feel this is a safety issue. At points with insufficient medical staffing there were only 4 F1s covering the medical side of the hospital - this was also a safety issue and was due to too many off on annual leave/sick/scheduled off as working part time.
Hospital at night were very helpful and made nightshift more manageable however it was still busy.”

“Phlebotomist team was extremely helpful in hours but after 4pm (until H@N) we had to do all the cannulas, blood cultures, VBGs etc and on top of the reviews of sick patients in the evenings this made the workload extremely heavy.”

“Pharmacy staff were extremely helpful and worked very hard to help us with discharge letter etc. However, their staffing levels were low which had a knock-on effect on increasing pressure for medical staff to do discharge letters”

CLINICAL SUPERVISION

AAH

“SHOs are on the take after 5pm and are extremely busy. I could count on one hand the number of times I have seen a registrar or consultant after 5pm.”

“Day time had very little senior grade involvement. F2s were approachable and present but busy themselves. Accordingly, there was no proactive input from other staff members than F1s. Senior grades were explicitly approached regarding this and it led to no attempted change in behaviour.”

“Out of hours cover is so busy that having more than one person attending to any single scenario is irresponsible. F2s were typically welcoming of escalation but you would have to quickly relay the issue to them and move on to the other mounting jobs.”

“Staff at all levels worked excessively. Very hard to escalate concerns to some seniors, do not want to help. Others are excellent”

“The level of supervision depended on the senior staff who were on shift. One consultant and reg did a daily evening second ward round which was great to ensure all the necessary tasks were complete during normal working hours and that a senior Dr had reviewed the patients’ bloods/scans etc which really helped us as F1s feel supported in managing these complex patients. Sadly, this was the exception to the rule and the majority of the time supervision and senior support was lacking.”

CAU

“Out of hours felt very unsupported. F1s had the responsibility of managing sickest patients on the ward by themselves”

“Staffing levels in Causeway Hospital is just poor and unsafe. On one of my weekend shift, I was the only person managing a sick patient in a ward (NEWS of 13 for example), no SHOs were able to come and help as there was a stroke call. There is no registrar out of hours in this hospital”

"For surgery clinical supervision was poor during the day and at weekends as they were in theatre, and the F1 was generally left to do the tasks by themselves. Medicine was better at providing clinical supervision. Night shifts were busy and while most of the time I could contact seniors if I needed there was poor supervision as they too were busy."

"My clinical supervisor was very approachable and helpful. He was available and keen to support. One of the issues was that I was not actually in the same department as my clinical supervisor due to rota pressures which obviously made clinical supervision more complex. Some of the medical consultants did provide a mentorship/supervisor role as they were aware of this issue with surgical/medicine cross cover and supervision."

FEEDBACK

CAU

"Feedback was mostly informal and from other foundation doctors or multidisciplinary team."

HANDOVER

AAH

"Ward handover is F1 to F1. Take patients are presented at formal handover and although F1s are present for this, they are not invited to be involved and not included/do not contribute to this."

"No morning handover on wards"

"Handover is F1 to F1 at the start of Nightshift and rarely will I see a registrar for handover at this time."

"In an unsuitable room. It starts between 8.15 and 9.30am depending on the consultant. It is very excluding. Consultants can be extremely rude to SHOs about patients admitted on the take."

"Evening and night handover - medical registrar goes through the different wards in orderly fashion and patients are discussed per ward. Tasks requiring completion allocated to different grades as appropriate."

CAU

"F1-F1 during the day and post day, formal handover at night with hospital at night team leading."

"Morning handover is just between the F1s. Night handover is with the rest of the night team and sick patients are discussed. "

"Day shift handover is between F1s. This was excellent and I think was great for patient safety as we were made aware of any issues overnight and any jobs for day shift to do. The culture of morning handover was really positive for patient safety and continuity of care.
Night time handover is coordinated by H@N and was also useful. 5pm handover is undergoing change to try to make it more formal however as there is no hospital at day this is difficult to achieve, therefore the responsibility lies with the various clinical teams and will depend on individual culture/buy in."

TEACHING

AAH

"No departmental based teaching sessions, only teaching sessions we had were the ones organised by foundation director for all F1s in the hospital"

"Our departmental teaching was organised for the same time as F1 trust teaching. The department would not rearrange this to allow F1s to attend teaching."

"F1s have to stay on the ward to do all the tasks and deal with all the sick patients so there was no time for teaching or training opportunities"

CAU

"Ward pressures prevented teaching regularly"

“There were potentially only 1-2 core teaching sessions that were delivered in person at causeway, all the rest were streamed from Antrim. I would have liked more face to face”

“All F1 core teaching was zoomed from Antrim. When I was able to attend one of these sessions I arrived on time, zoom was not connected, no room was originally booked for it. When admin staff did try and get zoom set up it turns out the teaching had begun at 1pm sharp in Antrim and the teacher decided not to connect to zoom.”

“Never had face to face core teaching.”

“All of my teaching sessions were part of my lunchtime, and were not protected. Multiple times I was covering more than one ward by myself and so I found it difficult to get to teaching”

TRAINING OPPORTUNITIES

AAH

“Workload so intense it not only precludes achieving portfolio goals but also hampers clinical improvement. There is little time for case consideration, observation or discussion with seniors or follow through with patients or cases. This leads to a situation in which not only is there little in the way of training opportunity and team member involvement but often it puts juniors in unsafe positions. The extent of advice from seniors regarding this was regularly inane and empty: "make sure you take your breaks", "look after yourselves", "keep doing hobbies you enjoy". There was very little trust recognition of the issues in a way that was serious and solution orientated. An example of this was a wellbeing session where staff brought up issues of unsafe conditions, workload, burnout and resignations and the responses were moved past into a recommendation of breathing exercises.”

“Very poor training post - constantly being left to manage very sick patients on our own. Belittled by senior management, toxic department to work in. If I had an F2 post here I would consider a different career”

CAU

“I learnt an awful lot out of hours due to lack of support. This has really pushed me and prepared me as a doctor to respond to clinical need and emergencies. However, as a whole ward tasks e.g. discharges took priority over attending ward round or reviewing non-emergency patients.”

“I feel like this placement is more service provision than learning. I am gaining clinical skills (I feel more confident clinically) but educationally, I find it hard to attend sim sessions, no protected teaching time”

OTHER COMMENTS

AAH

“Taking on more clinical responsibility in this post compared to other departments has allowed me to become confident in referrals and jobs more routinely done by SHO’s. This is a positive but comes from being chucked in out of your depth with no idea how to do these things but expected by your seniors to do it without delay or questions.”

CAU

“While this was a difficult placement I could not have had a more supportive team. Any lack of support was always due to multiple unwell patients requiring the attention of the limited number of doctors.”

“The majority of the F2/CT/IMT/ST doctors were very good, approachable and trustworthy even though they were overworked. Hospital at night were extremely helpful and made night shift more manageable. Phlebotomists were good and helped the majority of the time.”

SUGGESTIONS FOR IMPROVEMENT

AAH

"Protected teaching / break times"

"Prioritise teaching / Bleep free time and teaching"

"Organised weekly teaching"

"Ensuring attending core teaching is encouraged over routine administration tasks"

"Better senior support"

"Less admin level work"

"No overlap between night shift and day shift – extend night shift by half an hour to allow fir handover."

A doctor's room that is fit for purpose (more computers, more space, away from where patients can hear)

CAU

"Allowing trainees to be in a base ward for at least a month/ The opportunity to stay on one ward/team / Based on one ward for the rotation"

"Increase staffing levels"

"Less administrative jobs"

"Pharmacist in surgery (and dedicated med F1/SHO for med patients in surgical 1)"

"Protected teaching time"

APPENDIX 1

FOUNDATION YEAR 1

PLACEMENT QUALITY
F1 KEY STANDARDS

F1 Key Standards

Key standards for F1 training for HSC Trusts are to:

PREPARE

1. Provide all new F1 doctors with a minimum of 2 full days of ward-based shadowing
2. Deliver a unit induction to all F1s at the start of each 4-month placement, which includes: a walk around the unit, an introduction to key members of the team, familiarisation with equipment and the practical aspects of the job (e.g. ordering investigations communication systems/ ward duties) and an induction to other units covered out of hours

ENGAGE

3. Ensure that all F1s take part in daily reviews and ward rounds
4. Assure that F1 doctors work as part of a clinical team as opposed to being assigned to a clinical area

SUPPORT

5. Ensure that trained supervisors provide feedback (formal or informal) to all F1s on a regular basis
6. Ensure F1 doctors know who the senior doctor is and how to contact them for each shift

EDUCATE

7. Ensure that measures are in place to provide all F1s a minimum of 2 hours per week of protected teaching on curriculum mandated topics
8. Utilise other health care professionals to minimise the time F1s spend on tasks of limited educational value

APPENDIX 2: Targets and Colour coding for PQ Survey Education Areas/Tables

Education Areas	Target (% of trainees)
TRUST notification of on-call rota > 4 weeks (Q.4)	100%
Induction appropriate (Q.6)	100%
UNIT induction included introduction to team: (Q.8)	100%
UNIT induction included a walk around unit/ department: (Q.8)	100%
UNIT induction included orientation to other clinical areas cross covered OOH: (Q.8)	100%
Shadowing prior to starting F1 post: at least 2 full days (Q.9)	100%
Workload (Daytime) Very intense/Excessive (Q.12)	≤50%
Workload (Long Day) Very Intense/Excessive	≤50%
Workload (Night) – Very Intense/Excessive	≤50%
Workload (Weekends) – Very Intense/excessive	≤50%
Initial meeting with ES – within the first month: (Q.17)	≥90%
Educational Supervision - Satisfactory (Q.17)	≥90%
Clinical Supervision (Day time/Evening/Night time/WEs) – at least Satisfactory (Q.20).	≥90%
Feedback (formal or informal): At least a few times a month (Q.22)	100%
Feedback: Less than once a month (Q.22)	0%
Training Opportunities: Involved in planned patient reviews on a DAILY basis (Q.24)	100%
Training Opportunities: Participation in DAILY ward rounds (Q.24)	100%
>50% of time spent on task of limited educational value: (Q.14)	0%
Assigned to a clinical team with a named consultant(s) leading the team: (Q.30)	100%
Aware of who senior doctor is and how to contact them for each shift: (Q.21)	100%
Local Teaching: At least 1-2 hours/week (Q.32)	100%
Protected Local Teaching: At least 1-2 hours/week (Q.33)	100%
Protected local teaching: <1 hr/week (Q.33)	0%
F1 teaching adequately addressed curriculum needs: (Q.37)	100%
WELLBEING: Felt part of the clinical team: (Q.31)	100%
WELLBEING: Feel valued in this post: (Q.44)	100%
WELLBEING: Access to a fridge/freezer/microwave and hot food OOH: (Q.40)	100%
WELLBEING: Private on-call room to rest during OOH shifts: (Q.41)	100%
WELLBEING: Access to room to rest after night shift before travelling: (Q.42)	100%
Global Score for placement as a training opportunity: At least Acceptable (Q.43)	100%
Feel F1 Year will be satisfactory or good preparation for F2: (Q.45)	100%
Feel F1 Year will leave you poorly prepared for F2: (Q.45)	0%

NI Regional & Trust Data			
Target achieved	Target achieved by ≥75%	Below Target	Below Target by >50%