Redefining F1 Progress Update

November 2019

REPORT COMPILED BY DR S.A.PHILLIPS, DR L. PARKS & DR K.WALSH

Review Members

Dr Sally Anne Phillips (Associate Dean for Placement Quality, NIMDTA)

Dr Keira Walsh (ST6 Psychiatry, ADEPT Clinical Leadership Fellow Placement Quality 2019/20, NIMDTA)

Mrs Gillian Carlisle (Quality & Revalidation Manager, NIMDTA)

Dr Lorraine Parks (Director of N.I. Foundation School, NIMDTA)

Professor K Gardiner (Postgraduate Medical Dean and Chief Executive, NIMDTA)

Contents

Executive Summary

Becoming a Foundation1 doctor is one of the most important steps of any doctor's career. As they transition from being a medical student, these new doctors move from being enrolled as students to being provisionally registered with the General Medical Council, from studying and revising for final examinations to being employed in a health service and from observing and encountering patients to providing front-line care to patients in our HSC Trusts.

It is essential that the HSC meets the needs of these very junior doctors during this crucial phase of their education and training by valuing them as colleagues and providing appropriate clinical supervision for them as provisionally registered medical practitioners. In addition the HSC needs to enable them to have time to learn and consolidate their clinical skills as required by their curriculum, facilitate them to progress in their training, protect them from an excessive or inappropriate workload and provide them with compassionate leadership and support.

The experience and training of Foundation 1 doctors has been a primary focus for NIMDTA's Placement Quality work-stream since this team led by Dr Sally Anne Phillips was set up in August 2018. The first phase of this work culminated in a Redefining F1 Summit on 1 April 2019 and the publication of a Foundation Placement Quality Report. This Report contained 12 Recommendations for HSC Trusts to implement to improve the experience and training of F1 doctors. Updates on the progress of this initiative have been presented at the DoH Medical Leaders' Forum in April and June 2019.

A Follow-up Foundation Placement Quality Workshop was held on Wednesday 9 October 2019, when again there was excellent engagement with colleagues from all the 5 HSC Trusts. It was very encouraging to see the progress that has been made by all HSC Trusts in assessing, planning and implementing these 12 recommendations. The contributions from HSC Trust colleagues have been invaluable in enabling issues and obstacles to be explored and possible solutions to be developed. However, there is still much to be done to implement these recommendations in full.

I am pleased to share this Redefining F1 Progress Update report, which details the obstacles and issues that HSC Trust colleagues have identified, highlights the good practice that has been implemented or proposed and makes suggestions for HSC Trust colleagues about achievable solutions based on the plans, actions and innovations that have been made across the HSC.

I would like to thank in particular Dr Sally Anne Phillips, Dr Lorraine Parks, Dr Keira Walsh and Mrs Gillian Carlisle for their leadership of this initiative.

We look forward to continuing to work constructively with our educational, clinical and managerial colleagues across the HSC as we move towards full implementation of all the recommendations by August 2020.

Professor Keith Gardiner 1 November 2019

Postgraduate Medical Dean and Chief Executive

Section1: Background

On 1st April 2019, Queens University Belfast and NIMDTA jointly hosted the "Redefining F1" Foundation Summit, with 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 were presented.

Following the Summit, the Placement Quality Review team, led by Dr Sally Anne Phillips (Associate Dean for Placement Quality), produced a Foundation Placement Quality Report based on the background information presented and on the proposals generated during the Summit. The Report outlined 12 Key Recommendations for HSC Trusts to improve the F1 experience. These are as follows:

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*

During summer 2019, the Placement Quality Review team met with representatives of each Trust to share the Placement Quality Review findings for each site within their Trust and the UKFPO ranking analysis for the GMC NTS 2018. The team learnt of the local actions being taken to implement "quick fixes" in advance of the August 2019 changeover, and the longer term strategies each Trust was developing.

On 9th October 2019, Queens University Belfast and NIMDTA jointly hosted a "Redefining F1 Follow-up" event. Each Trust was asked to give a short presentation outlining the actions taken to address each of the Key Recommendations and to describe the further actions planned. All key stakeholders were invited to attend and contribute, to learn and share good practice from each Trust, and to discuss the remaining common challenges which might require advice/input from the DoH.

A ‘Finding Solutions Together’ Workshop at the “Redefining F1Follow-up” event identified the good practice presented that could be easily transferred across Trusts, reviewed the obstacles encountered by all Trusts and collectively identified possible local solutions. The remaining common challenges which might require advice/input from the DoH were then considered.

This update summarises areas of good practice, identified solutions and local obstacles to implementing key recommendations and highlights areas for further development.

Section 2: Actions to address the Key Recommendations

Local Obstacles/ Issues, Good /Transferrable Practice and Suggested Achievable Solutions.

Across the region in those areas where improvement has been achieved a number of key strategies appear to have been the most effective in implementing progress. These include:

- Establishment of Strategic working groups to ensure continuing momentum of improvement
- Engagement with medical directors and senior management to facilitate progress
- Communication directly with F1 doctors to obtain further information and continuous feedback
- Seeking detailed site/ward specific feedback from F1 doctors using evidenced-based metrics.[5]
- Engagement with senior representatives from other professions or disciplines e.g. pharmacy, GP

Recommendation 1: Provide all new F1 doctors with ward-based F1 **shadowing** all day for 2 full days.

Recommendation 2: Deliver a formal **induction** for all F1 doctors to their clinical team at the start of each placement.

Local Obstacles/Issues

1) Need to deliver 2 full days of shadowing, Trust Induction and Resuscitation courses e.g. ILS, ACCA within a limited number of induction days
2) Omission of previously delivered practical training e.g. ACCA (Acute Care Course for Adults) and other useful aspects of induction to enable provision of the recommended 2 days shadowing

Good/Transferrable Practice

Implemented

The evidence is that all Trusts have been able to find local solutions to enable them to deliver two full days of shadowing and have addressed the issue of departmental/ward induction by a variety of measures including:

1) Introduction of additional paid work days (B,C,D,E)
2) Streamlining of existing Trust induction processes.
3) Introduction of ward induction handbooks/checklists – 'twenty things you need to know about the ward you are working on' written by outgoing F1s (D1)
4) Development of a Foundation online handbook (D1)
5) Introduction of a photo gallery of F1s to each ward (C2)
6) Use of a 'Speed dating' format to introduce existing hospital staff to F1s (E1)
7) Introduction of an F1 guided tour of the hospital including practical guidance e.g. location of equipment, how to organise procedures, who's who etc (E1)

Proposed

1) Introduction of a named consultant on each ward to be responsible for the induction process (D)

Suggested Achievable Solutions

It is encouraging that all Trusts reported that the recommendations for shadowing and induction had been achieved by August 2019. It is clear however, that the shadowing recommendation can only be delivered effectively, without incurring the loss of other valuable training opportunities, by delivering over a minimum five day period. The addition of an extra paid day as part of the induction process has already been adopted across a number of sites and this would be our recommended solution for all Trusts.

Recommendation 3: Fully involve F1 doctors in planned **patient reviews on a daily basis**.

Recommendation 4: Necessitate the participation of F1 doctors in the **clerking-in of patients** on average at least twice a week.

Recommendation 5: Require the active participation of F1 doctors on **ward rounds** on average at least twice a week.

Recommendation 6: Limit the time spent by F1 doctors on routine **tasks of limited educational value** to no more than 50% of their time.

Local obstacles/Issues

1) Cultural attitudes that result in many tasks (e.g. discharge summaries) being considered as solely the responsibility of F1 doctors
2) Limited number of other health care practitioners who could undertake these tasks e.g. Ward Pharmacists, Physician Associates (PAs), health care support workers, phlebotomists
3) Medical workforce challenges e.g. insufficient staff and the associated need to cross-cover during colleague absence
4) Core clinical opportunities are not being viewed as essential to F1 training e.g. attendance at ward rounds.
5) High service pressures

Good/Transferrable Practice

Implemented

The following areas of good practice were identified which directly or indirectly facilitated increased involvement of F1 doctors in patient reviews, patient clerk-ins and ward round participation and reduced tasks of limited educational value.

1) Introduction of "Ward Angels" – clerical officers who work from 4-7pm assisting with tasks e.g. completing blood forms to free up the F1 doctors for clinical work (C2)
2) Extension of "hospital at night" support to include daytime at weekends and during Bank Holidays (D1)
3) Employment of Physicians' Associates (PAs) (C2)
4) Rostering of F1 doctors by Foundation Programme Directors (FPDs) specifically to patient reviews, clerk-in duties and participation in ward rounds (A2)
5) Allocation of F1 doctors to an 'Admissions Week' – 5 days and 1 weekend per 14 week rotation to provide opportunities to clerk in emergency and elective admissions (E1)
6) Provision of training to facilitate the upgrading of healthcare assistants from band 2 to band 3 so that they can contribute to specific clinical ward tasks (D)
7) Setting up of a QI group with pharmacy:
    a. Simplification of discharge medication lists: allowing "medications unchanged" to be documented on discharge letters where appropriate (D)
    b. Better use of prescribing ward pharmacists to facilitate medicines reconciliation (D)
8) Establishing a QI group with GPs to agree the essential information required for discharge letters (D)
9) Communicating directly with Clinical and Educational Supervisors regarding the need to ensure regular clinical learning opportunities for F1 doctors.

Proposed

1) Providing, with support of QUB, the opportunity for medical students (Years 3-5) to be employed at weekends and holiday periods, to undertake specific clinical tasks e.g. phlebotomy
2) Enhancing final year medical student Assistantships to better prepare students for their F1 year by increasing their exposure to practical tasks within their capabilities and at the same time assisting the F1 s by reducing the tasks which contribute to their workload

Suggested Achievable Solutions

The key to achieving Recommendations 3, 4 and 5 will be a significant reduction in the time spent by F1 doctors on routine tasks of limited educational value (Recommendation 6). This requires an acceptance of the need for a change in cultural attitudes, recognising that duties currently perceived as "F1 tasks" may be undertaken by other members of the team and the educational need to facilitate F1 doctors to be involved in clinical tasks which are of value to them in their postgraduate training.

Evidence across Trusts suggests that part of the solution is to review and optimise the use of existing staff resources. This has been achieved in Trusts by the reassignment of duties and the up-skilling of other healthcare staff to assist with routine ward based tasks in addition to working with other healthcare groups e.g. pharmacists and GPs, to simplify and optimise services to reduce the burden of these responsibilities.

Where these measures alone do not sufficiently reduce routine "F1 tasks" investment in additional healthcare workers may be necessary. Some Trusts have already secured additional funding to extend existing services e.g. Hospital at Night, and to employ new staff to address this need. It would be our recommendation that all Trusts should take a similar approach.

Recommendation 7: Ensure F1 doctors are **aware of who the senior doctor is** (and how to contact them) for advice **for each shift.**

Recommendation 8: Provide **feedback** to all F1 doctors through their trained clinical supervisors on average on a **weekly** basis.

Recommendation 10: **Assign** F1 doctors **to a clinical team** as opposed to a clinical area.

Local Obstacles/Issues

1) Need for F1 doctors to cross cover in other clinical areas
2) Lack of awareness by F1 doctors of what constitutes informal feedback on a day to day basis
3) Shift and leave patterns
4) Geography of patient locations

Good/Transferrable Practice

Implemented

1) Dissemination of senior doctor rotas to ensure F1 doctors are aware of senior supervision and contact details (A)
2) Introduction of a "rota watch" system, which identifies doctors on call and daytime location, with explanation of the system included in induction (C)
3) Utilisation of regular senior doctor forums to enable clinical supervisors to provide more effective feedback to F1 doctors (C2)
4) Communicating directly with Clinical and Educational Supervisors regarding the need to provide regular formal and informal feedback and discussing the nature of feedback with F1 doctors (A)
5) Alignment of F1 doctors to clinical teams using a zoning system (C2)

Proposed

1) Introducing weekly meetings for F1s with clinical supervisors for formal feedback
2) Widespread utilisation of an accessible online rota system for F1 doctors to increase awareness of senior doctor cover and contact details

Suggested Achievable Solutions

An online rota information system is recommended for all Trusts to ensure F1 doctors are aware of senior supervision and contact details. A regular weekly time should be identified by each Clinical Supervisor to facilitate formal feedback to their F1.

Recommendation 9: Enable all F1 doctors to attend **3 hours of** on-site, **bleep-free, formal teaching per week.**

Implementation of this recommendation has proved challenging for the majority of sites to address.

Local Obstacles/Issues

1) Need for F1 doctors to respond to bleeps urgently
2) Lack of identification of an appropriate person to manage calls to F1 doctors during teaching sessions
3) Lack of awareness of staff with regard to the need to minimise calls to F1s during teaching time
4) Medical workforce shortages
5) High service pressures

Good/Transferrable Practice

Implemented

1) Introduction of two "bleep free" lunch time teaching sessions per week (D)
2) Identification of the barriers to attendance of F1s at organised teaching (D)
3) Relocation of teaching to a more geographically accessible site to facilitate maximum attendance (D1)
4) Placement of "bleeps in a box" (except immediate response bleeps e.g. cardiac arrest) with bleeps being answered and filtered by an appropriate staff member to minimise unnecessary interruptions (E1)

Proposed

1) Organising a rota of designated trainees/staff grades to hold the bleeps during teaching sessions
2) Increasing awareness and frequent reminders to staff of the need to minimise calls to F1 doctors during teaching sessions

Suggested Achievable Solutions

All Trusts should identify a location for teaching which is easily accessible during working hours, allocate an appropriate person to safely manage bleep calls during teaching sessions and regularly remind ward staff of F1 protected teaching time and the need to filter non-essential calls through senior nursing staff.

Recommendation 11: Ensure that F1 doctors working **out of hours'** shifts have **access to hot food** and an area to take rest breaks.

Recommendation 12: Provide **rooms** where F1 doctors can **rest after a night shift before travelling home.**

While this has been addressed in some areas, the challenges presented by limitations of local infrastructure have hindered Implementation of this recommendation for many sites.

Local Obstacles/ Issues

1) Lack of available space for rest areas
2) Difficulty securing funding for new equipment.
3) Difficulty providing meals which meet differing dietary requirements without significant food wastage
4) Lack of a dedicated person to manage rest areas and housekeeping arrangements
5) Inconsistent facilities across sites

Good/Transferrable Practice

Implemented

1) Updating of doctors' "mess" with new equipment e.g. fridge/freezer, microwave, sofas (C1)(D1)(E1)
2) Allocation of dedicated rooms for rest after night shift (B1)(C1)(E1)

Proposed

1) Setting up of a working group to review facilities (A)
2) Provision of a range of frozen meals (D1)

Suggested Achievable Solutions

We suggest that the basic amenities required to meet Recommendation 11 are an allocated room with appropriate seating and access to a microwave, fridge/freezer and frozen meals in addition to identification of a staff member to manage the area and arrange housekeeping.

Section 3: Follow-up and Re-Survey

Follow Up

While all Trusts have been able to identify and implement a significant number of local solutions to address the key recommendations, some have identified a number of continuing challenges. These include:

- Inability to access sufficient numbers of pharmacists, phlebotomists, PAs
- Lack of funding to extend Hospital at Night coverage and upscale HCAs
- Logistics of employing medical students to assist with clinical tasks

All these challenges are linked by the need to either increase or develop the existing workforce to take on a number of the clinical tasks currently required of F1 doctors. Although some Trusts have been able to identify funding to enable them to address one or more of these areas, in other Trusts this has proved more difficult to achieve.

We encourage Trusts in the first instance to identify what additional workforce initiatives would be required to enable the outstanding recommendations to be delivered and to review what is possible locally within existing resources. If after consideration, the need for additional resources remains, then individually Trusts should discuss the situation with the HSCB and DoH.

F1 Re-Survey

The Placement Quality Team at NIMDTA will be conducting a resurvey of all F1 doctors at the start of December 2019 to review their first training placement (Aug – Nov 2019) and to assess the success of the measures that have been introduced to date to improve the F1 training experience.

The survey will open on the 9th December 2019 and will be open until 3rd January 2020 at 5pm.

The results of the resurvey will be circulated to all Medical Directors, DMEs and Foundation Programme Directors and in conjunction with the next GMC National Training Survey will help to better inform Trusts of how well they have addressed the recommendations and to indicate areas where further improvement is required.

It is expected that Trusts should meet **ALL** the key recommendations for F1 training by **August 2020**

.

Section 4: Appendices

APPENDIX 1 Redefining F1 Follow-Up Meeting, Wednesday 9th October 2019

Programme

09.00 – 9.30	Registration & Coffee, Tea and Networking
09:30 – 09:35	Welcome and Introduction
Chair: Dr Lorraine Parks, Deputy Director of Foundation School, NIMDTA	
09:35 – 10:50	Presentations from Trusts *"What actions have been taken to address key recommendations, what further actions and improvements are the Trust planning, what obstacles have the Trust encountered that would require external support / regional approach to resolve, and what learning is valuable for others?"* 09:45 – 10:00 Belfast HSC Trust 10:00 – 10:15 Northern HSC Trust 10:15 – 10:30 South Eastern HSC Trust 10:30 – 10:45 Southern HSC Trust 10:45 – 11:00 Western HSC Trust
10:50 – 11.10	Coffee, Tea and Networking
Chair: Dr Sally Anne Phillips, Associate Dean – Placement Quality, NIMDTA	
11:10 – 12:20	Finding Solutions Together
12:20 – 12:30	Closing Remarks

APPENDIX 2

Recommendation 3: Fully involve F1 doctors in planned **patient reviews on a daily basis**. **Recommendation 4:** Necessitate the participation of F1 doctors in the **clerking-in of patients** on average **at least twice a week**. **Recommendation 5:** Require the active participation of F1 doctors on ward rounds on average *at least twice a week*.	
Identified **good practice** that could be easily transferred across Trust sites	• NHSCT ensured F1s part of ward rounds • Ward angels created in Southern trust from 4pm-7pm on wards to specifically help with tasks to free up F1s for clinical work. • Survey of individual wards/ areas in Western Trust of hotspot green and red zones to encourage competition. • Ward pharmacists. • Gallery of staff photos on ward. • Funding for extra hospital at night to free up F1s for attending ward rounds. • Aim for daily ward rounds. • Belfast trust identify individual on rota with time for clerking-in. • Peer support for F1s. • Northern ensured F1s on ward rounds with consultant's knowledge. • South Eastern use of medical students. • Extra funding for weekends and bank holidays. • Divorce the clinical note from the pharmacy to facilitate surcharge letters.
Obstacles encountered by all Trusts	• Twice a week not enough for F1s attending ward rounds. • Discharge letters. • Workforce. • Staff numbers. • Skill mix. • Absenteeism. • Differences between different wards. • Expanding wards and changes in layout. • Number of wards. • Cross-over. • Resistance in agreement to change from pharmacists. • Self-direction of F1s as they need to take ownership and begin to implement their solutions. • Give F1s a job description, regional discharge proforma. • Employing medical students- what does the final year assistantship look like? • Incentive to move Health care Assistants to band 3.
Possible local solutions	• Ward angel from 4pm-7pm (as done in DHH) • Employ medical students years 3-5. • Use assistantship more effectively. • PA's. • Enhancing band 2's & 3's.
Remaining common challenges which might require a regional solution.	• DoH to engage with pharmacy to agree process to meet all needs and accommodate all groups. • Diversification of the workforce by developing ACP's. • Funding for expansion of hospital at night, hospital at day and PA's.

APPENDIX 3

Recommendation 6: Limit the time spent by F1 doctors on routine tasks of limited educational value to no more than 50% of their time (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). **Recommendation 9:** Enable all F1 doctors to attend 3 hours of on-site, bleep free, formal teaching per week. (50% formal teaching should be based on the Foundation Curriculum).	
Identified **good practice** that could be easily transferred across Trust sites	• Ward angels performing focused clerical tasks from 4pm-7pm. • Protected time for clerk-ins. • ALT hosp. admissions week. • Use of PA's. • Band 2s & 3s health care assistants trained up on shift cycle with more on shift at peak times. • Work allocated on electronic system and filtered. • Band 3 phlebotomists. • Protected time for experience (1hr for clerk-ins DHH). • Bleep free training where possible. • Joint work with pharmacy to reduce medication requests for F1s. • Bringing hospital at night earlier in day shift. • Involve/employ medical students.
Obstacles encountered by all Trusts	• Bleeps need to be answered. • Funding. • Physical space. • Recruitment and retention of staff. • Expectations of F1s. • Compensation of medical students. • Staff to manage workloads. • Service pressure. • Discharge summaries. • Proforma for discharge letter with clinicians were they can write the discharge letter. • If bleep free teaching for F1s will F'2s + higher require this too?
Possible **local solutions**	• Engage with and request additional pharmacy support. • Electronic and better use of technology. • Consultant reviews with sticker system on chart to accelerate efficiency. • Employ medical students and embed expectation in curriculum. • Culture of healthcare staff needs to change. • Rotation of designated trainee to hold bleeps during teaching re-inforce to ward staff that teaching should be emergency bleep only. • PA to answer bleeps. • Review hospital at night/ clinical co-ordinators to extend service. • Engage regularly with junior doctors to obtain feedback. • Engage with GP's to see what information needs to be included in letters. • Discharge letters prepopulated and ready. • Healthcare assistants re-branded and trained to assist with task. • Balance of ensuring there is value in some tasks they must learn.
Remaining **common challenges** which might require a regional solution.	• Push for electronic discharge solution. • Issues are combined with teaching or grand rounds where more than F1s have bleeps. • Trainees in England have moved from bleeps to smart phones. • Managing expectations of F1s service pressures. • Multi-professional workforce planning- pharmacy, nursing, training numbers. • I.T, Encompass, Rota-watch.

APPENDIX 4

Recommendation 7: Ensure F1 doctors are aware of who the **senior doctor** is (and how to contact them) for advice on **each shift.** **Recommendation 8:** Provide **feedback to all F1 doctors** through their trained Clinical Supervisors *on average on a weekly basis.* **Recommendation 10:** Assign F1 doctors to a **clinical team as opposed to a clinical area.**	
Identified **good practice** that could be easily transferred across Trust sites	• Hospital at night handover discussing who the senior mentor is. • Emphasising the use of rota watch and discussing at induction its use. • Ensuring F1s are present at handover. • Regular weekly forum of senior doctors within hospital to review F1s and relay to CS. • Redefine what feedback is and can be given formally and informally. • Creating zone's and responsibility for zone's within the hospital. • Zones can work if a consultant is zoned also.
Obstacles encountered by all Trusts	• Providing weekly feedback is a challenge. • F1s' rotas. • Annual leave. • Clinical time. • Feedback may not be direct contact. • F1s not aware of who Registrar and Consultants are. • F1s present at handovers. • Feedback needs to be well signposted.
Possible **local solutions**	• Clinical Supervisor meeting weekly. • Assign F1s to clinical teams. • Zoning within the hospital for all staff. • Define and outline the teams. • Use of Rota-watch; programme for all doctors at all levels with trainees to check weekly where they are in terms or teams/wards • BHSCT using health rota. • Educate the trainees on what information is available and how to access it.
Remaining **common challenges** which might require a regional solution.	• Increase beds to stop outliers.

APPENDIX 5

Recommendation 11: Ensure that F1 doctors working out of hours' shifts have access to **hot food and an area to take rest breaks**. **Recommendation 12:** Provide rooms where F1 doctors can **rest after a night shift** before travelling home.	
Identified **good practice** that could be easily transferred across Trust sites	• Protected area's with the necessary equipment for hot food and rest breaks. • Ensuring F1s in hospital and on shift know where these areas are. • Rest breaks built in to rota, rota out with 6 weeks' notice. • Induction with 2 days shadowing and induction checklist. • Extending hospital at night models. • Nursing induction pack. • Link with QUB. • Structure in place with senior management involved. • Teaching fellows.
Obstacles encountered by all Trusts	• Funding, available space. • Someone to take lead on these projects. • Dietary requirements to be taken into consideration for hot food. • Available resources. • Housekeeping for cleaning of areas.
Possible **local solutions**	• Strong link with estates. • F1 focus groups. • Doctor groups. • Drinking fountains more accessible. • Appointment of someone to take lead. • Regional guidance of what a doctors mess is to consist of and what are requirements to use mess for rest etc.
Remaining **common challenges** which might require a regional solution.	• Change in culture/need to educate staff that F1s are entitled to take a break.

APPENDIX 6

SITE IDENTIFICATION KEY AND CONTACT DETAILS

KEY	SITE	CONTACT DETAILS	
	Belfast HSC Trust	Dr Simon Johnston, ST	simon.johnston@belfasttrust.hscni.net
A1	Royal Victoria Hospital	Dr Gary Heyburn, FPD	gary.heyburn@belfasttrust.hscni.net
A2	Belfast City Hospital	Dr Marshall Riley, FPD	marshall.riley@belfasttrust.hscni.net
A3	Mater Infirmorium Hospital	Andrew McAllister, FPD	andrew.mcallister@belfasttrust.hscni.net
	Northern HSC Trust	Dr Kate Scott, DME	kate.scott@northerntrust.hscni.net
B1	Antrim Area Hospital	Dr Jayne McAuley, FPD	jayne.mcauley@northerntrust.hscni.net
B2	Causeway Hospital	Dr Briege O'Neill , FPD	briege.oneill@northerntrust.hscni.net
	Southern HSC Trust	Dr Gail Browne, DME	gail.browne@southerntrust.hscni.net
C1	Craigavon Area Hospital	Dr Beverley Adams, FPD	DrBeverley.Adams@southerntrust.hscni.net
C2	Daisy Hill Hospital	Dr John Harty, FPD	john.harty@southerntrust.hscni.net
	South Eastern HSC Trust	Dr Craig Renfrew, DME	Craig.Renfrew@setrust.hscni.net
D1	Ulster Hospital	Dr Ailsa Fulton, FPD	ailsa.fulton@setrust.hscni.net
D2	Lagan Valley Hospital	Dr Rosemary Kelly, FPD	rosemary.kelly@setrust.hscni.net
	Western HSC Trust	Dr Neil Corrigan, DME	Neil.Corrigan@westerntrust.hscni.net
E1	Altnagelvin Hospital	Dr Athinyaa Thiraviaraj, FPD	Athinyaa.Thiraviaraj@westerntrust.hscni.net
E2	South West Acute Hospital	Dr Breffni Keegan, FPD	breffni.keegan@westerntrust.hscni.net

Foundation Programme Director (FPD)

Director of Medical Education (DME)

Specialty Tutor (ST)