Health Education England

School of Medicine Newsletter

Yorkshire and the Humber – Spring 2019/20

Welcome

Welcome to the Spring 2019/20 School of Medicine Newsletter. We have lots of useful information for you in this edition including the appointment of new TPDs who we welcome to the team, National Training Survey Results, a rotation mapping summary, and a helpful piece on Trainees Experiencing Difficulty (TEDs, formerly known as Doctors in Difficulty).

National Training Survey Results

The data from the annual National Training Surveys is available publicly and can be a very useful source of information for both trainees and trainers to help either demonstrate certain areas are performing well or less well or to help target improvements. It's available from https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/national-training-surveys-reports by clicking on "access online reporting tool" (note: some old computers find it hard to process this page).

The most useful reports are often those under the "popular reports" tab which break down the reports either by hospital site or more broadly by trust. Filtering the reports is easy (but may take some time for computers to process) using the dropdown menus (Health Education Yorkshire and the Humber is generally the first option to pick). If you're interested in individual questions, these can be accessed by clicking on the raw scores and selecting "question items" (this loads in a popup window so may need authorisation to do this).

As well as looking at trainee results the results of the trainer survey are also available on the same site ("trainer results") at the top of the first page on the online reporting tool. These are well worth looking at for trainees in particular - they give a real insight into some of the difficulties faced by trainers and how they often don't have time provided to train!

I'd recommend you spend a short period of time playing about with the website as you may well find it answers some very common questions such as: do trainees find night shifts more intense at one trust than another; how often do trainees work beyond their rostered hours; what's the quality of training like at a certain site etc. The GMC release the information as a driver of local change and although HEE use it there's nothing stopping it being used at local level as well to push arguments for various service improvements - if anyone has any success stories, we'd love to hear about them!

Dr Matthew Roycroft – Former Leadership Fellow

Rotation Mapping

Accurate and appropriate mapping of training rotations is essential to the delivery of the highest quality training by mitigating vacancies to training rotations. Each training rotation is unique in terms of numbers of trainees with requirements both geographical and subspecialty specific. However, there are generic principles that affect all rotations that are worth considering.

At the Y&H HEE Educational Supervisor training day on 16/11/2018 I was asked to offer a rotation planning workshop. Having spent approximately 5 years as a Respiratory Medicine TPD in South Yorkshire, and being *au fait* with ST rotations, I constructed a 'ST trainee rotation building challenge' for delegates. This focussed around a 10-placement rotation over 4 hospitals – 4 posts at a teaching hospital and 2 posts at each of three DGHs. I incorporated the impending arrival of IM3 training that would reduce training by one DGH training site. A selection of personas was created reflecting trainees on said rotation with a variety of personal factors designed to highlight key areas of good (and often my own previous, unwitting, bad) practice.

My recommended solution to this, and by extrapolation, all rotation mapping exercises is the construction of a spreadsheet annotated with date on the y axis and with each of the posts across the x axis (see below).

Date	TH1	TH2	TH3	TH4	DGH A1
Aug-18					
Feb-19					
Aug-19					
Feb-20					

Etc…

As trainees join the rotation following national recruitment or inter/intra-deanery transfer they can be speculatively allocated to appropriate training slots. Change in circumstances, e.g. Out of Programme, Maternity can be incorporated, sometimes creating sufficient rota gaps that may be 'added up' to create a full training slot, allowing this amalgamated post to be opened up for further recruitment. Successful and regular modifications to this live document has the advantage of making TPDs aware of recruitment opportunities, tracking OOP and maternity periods and alerting Trusts to upcoming vacancies to allow locum appointments to service, or similar, to be made. The initial speculative additions are modified by the changing needs of all trainees following change or circumstance or ARCP/PYA outcomes. The document can then be transcribed to the Y&H HEE rotation grid released to Trusts.

Some specific themes emerged.

1. **Maternity Leave**. A trainee, despite being OOP, must remain in an allocated slot on the rotation. The post cannot be released to recruitment. It is important to remember that although a trainee can declare a preference in terms of length of maternity (usually up to 1 year) they are entitled to change their minds and return sooner. It is therefore necessary to leave their 'salaried' position open to avoid 2 trainees in a single salaried slot. On the Y&H HEE training grid submitted to Trusts they will therefore appear BOTH in a clinical slot AND in the OOP(M) area of the document.

2. **Length of attachments**. It is considered best practice for most specialties for trainees to spend blocks of 12 months at individual training sites. This gives trainees a consistent period in a single Trust, limits disruption at work and sometimes in-home lives e.g. childcare arrangements, limits HEE staff workload in terms of rotation management and offers Trusts a longer term view of junior doctor staffing. In addition, if possible, attempting to maintain at least 2 trainees in each training location allows for a level of peer support to trainees. Clearly, in the presence of multiple rotation vacancies this may not be possible.

3. **Less than Full time working**. Several options are available to trainees including 50%, 60% and 80% of full-time work patterns. Of note 2 trainees at 80% can job share in a single NTN post. Alternatives, especially if there are odd numbers of LTFT trainees within the rotation, include acting in a supernumerary post or acting as a LTFT trainee in a full time slot. In the latter it is especially important that the trainee ensures that their training needs are met appropriately. All LTFT trainees are advised to negotiate their programme well in advance with their TPD, Clinical Director of their receiving Trust and their job share partner (if available).

4. **Out of Programme trainees**. Many Trusts are uncomfortable with trainees taking time out of programme, especially if this impacts on the staffing of GIM and on call rotas. Y&H HEE are both encouraging to trainees considering OOP (research, experience, career break) while also being concerned should 'in programme' trainee numbers fall to a level that negatively impacts the training quality of those trainees. In a world where LAT appointments are no longer allowable and LAS appointments are becoming more difficult to appoint to, TPDs can use an accurate rotational grid to determine the most

appropriate time and least impactful period for a trainee to take OOP.

5. **Grace period**. Post CCT trainees are eligible for a 6-month attachment to allow them time to gain a consultant post. This 'period of grace' is not a training period, the trainee is a pure service provider and can be sent anywhere within the rotation that service provision is required. For many the preference is to not take this period and exit the training rotation on their CCT date. To do so requires the trainee to formally inform their TPD of their desire not to take their 'period of grace' AND to formally resign from the rotation by writing to both the TPD and the HR department at their hospital. Failure to do so could result in the trainee being expected to work a pre-resignation term (usually 3 months) following their CCT date.

6. **Academic clinical fellows and academic clinical lecturers**. Many rotations support a variety of models (e.g. ACF – 9 months clinical, 3 months academia per year for 3 years; ACL 50:50 clinical/academic) for academic trainees. Most of these posts are now considered supernumerary. It is important for TPDs to be aware of the duration of these posts and track future trainee plans. For example, an ACF unsuccessful after 3 years in obtaining and ACL or fellowship post (with funding) will return to the non-academic training rotation for a further 2 years (of a 5-year programme) to CCT. Close discussion with academic TPDs and trainees and careful consideration of academic trajectory at joint clinical and academic ARCPs is required.

It is likely that more challenges than these emerge during rotation planning with regular modifications and renegotiations required especially in response to ARCP outcomes and outstanding training requirements. The comments above offer possible answers to some of the more regularly encountered issues that arise with tentative advice with regard detailed rotation mapping. I offer my own view and a reflection on how I planned the South Yorkshire respiratory medicine rotation, and fully accept that this may not be a one size fits all model. Each TPD will undoubtedly find their own way of delivering the best rotation plans for their trainees. My thanks to those who attended the workshop, for the discussion points raised and for the, what I'm sure will be, excellent feedback!

Dr Stephen Bianchi – Deputy Head of School of Medicine

Trainees Experiencing Difficulty (TEDs)

Doctors often face difficulties at some point in their careers. Trainees have difficulties, which may affect their performance in the workplace, because:

- they are failing to make satisfactory progress
- they may have a specific difficulty in one area of training e.g. exams
- circumstances are making it difficult for them to fulfil their training requirements e.g. health issues. alternatively, the trainee may be experiencing inter-personal difficulties with others or exhibiting unacceptable behaviours.

The 3 basic tenants when dealing with a trainee in difficulty:

- Patient safety is paramount and over rides everything else.
- The trainee must be treated fairly, and processes must be open and transparent.
- Supervisors and TPDs must maintain appropriate boundaries within the supervision relationship i.e. you are not their doctor or counsellor.
- Trainees must be copied into all correspondence pertaining to them.

THE HEE TEDs list

Type	Example
Conduct	Taken unpaid leave – unannounced Likely to be denied employment due to issues raised in DBS check
ARCP2	Exam failure
ARCP3	Lack of eportfolio entries failure to achieve curriculum in required timescale(s) and an extension is required
ARCP4	Exit program
GMC conditions imposed	Allegations by a patient of inappropriate behaviour. Trust will make GMC referral. Eg Patient complaint of sexual assault during clinical examination
SI: serious incident	Involved or associated with or just named
Complaint / Revalidation Exception Report	Family of a patient complaint

Key Domains of a trainee in difficulty:
The educational management of a trainee in difficulty is formulated from considering the following:

Clinical Performance

- Knowledge
- Skills
- Non-technical skills

Personality Behaviour

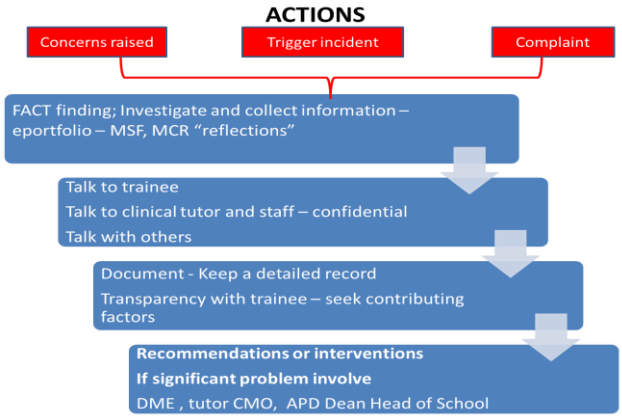
- Professionalism/conduct
- Non-technical skills
- Motivation
- Cultural
- Religious

Health

- Personal stress
- Family stress
- Career frustrations
- Financial
- Acute and chronic illness

Environment

- Organisational
- Workload
- Bullying
- Harassment



Summary

- Don't ignore problems, they will not go away, they only tend to get worse if not diagnosed and managed appropriately.
- Don't avoid difficult conversations; these are the conversations that can prevent difficulties escalating.
- Involve your colleagues for help. Involve relevant people such as the DME in the trust and TPD/HOS at HEE for advice and help and use the administrative support available in the Programme Support Team at HEE.
- Involve the trainee and make the process as transparent and supportive as possible.

Professor Sunil Bhandari – Deputy Head of School of Medicine

Internal Medicine Update

The rotations for IM year 1 and 2 placements have now been finalised. There are 159 rotations, although only 131 have been put into recruitment for August 2020 as we over-recruited to CMT rotations commencing in August 2018, as happened in most regions last year. This means that for August 2020 we would aim to recruit to 159 rotations, leaving us with a shortfall of 28 IM2 trainees. At the same time 45 posts currently used for CMT will be converted to ICM (Intensive Care Medicine) posts, meaning a potential shortfall for that one year, 2020-21, of 73 posts. We will provide Trusts with details of where these shortfalls will occur as soon as possible. Steady state will be reached in August 2021 with all rotations filled, subject to satisfactory recruitment.

We now move to planning IM3 placements to commence from August 2021. JRCPTB have suggested a total number of IM3 posts of approximately 75-80% of the total number of IM1-2 rotations to allow for trainees exiting to group 2 specialties or leaving the programme for other reasons. Therefore, we need approximately 120 IM3 posts across Yorkshire and the Humber. At least 59 posts will be created from a 20% top-slicing of existing funded NTNs in the group 1 specialties and the higher specialty STCs (Specialty Training Committees) are currently identifying these posts. 5 funded CMT NTNs surplus to requirements for IM 1-2 rotations will transfer into IM3. Trusts are being asked if they wish to fund the creation of IM3 posts from some or all of their share of the 45 CMT posts converted to ICM placements. At the same time Trusts are being asked if they want to move existing funded non-training grade posts into IM3 or fund new IM3 posts. Priority will be given to the posts created from those not needed for CMT as they have been converted to ICM posts but it is likely that there will be plenty of opportunities for Trusts to offer further posts, as even if all the surplus CMT posts are used there will still be a shortfall of around 12 posts for IM3.

IM3 rotations will comprise two 6-month placements and where possible trainees will be placed in one of the two Trusts they were based in for IM1 and IM2 and at least one of the 6-month placements will be in a specialty they have not previously experienced in IM training. We will be designing a local process for allocating IM3 placements in April 2021 based on these principles.

There is a new assessment framework for IM training based on capabilities in practice. On 15th April a team from the Royal College of Physicians will be coming to develop local faculty, including College Tutors, to cascade training in the new assessment framework out to Educational Supervisors in all our training locations by August. Trainees will need a tailored induction to the new IM training programme and this will be delivered as a one-day induction on three weekend days over the first two weekends in August. This day will be counted as a work day for each trainee.

To develop and quality assure the new training programme we will be revising the current STCs for CMT and GIM, starting with the creation of an Internal Medicine STC in place of the CMT STC from August 2019.

TPD Appointments

We would like to welcome the following new Training Programme Directors who have recently been appointed within the School of Medicine:

CMT West Deputy TPD – Mansoor Ali

CMT East Deputy TPD – Colin Jones

Occupational Medicine TPD – Prosenjit Giri

Rachel Noble – Programme Support Manager