

Visit to The Mid Yorkshire Hospitals NHS Trust

This visit is part of a regional review and uses a risk-based approach. For more information on this approach see [the General Medical Council website](#).

Review at a glance

About the visit

Visit dates	30 October 2014
Site visited	Pinderfields Hospital
Programmes reviewed	Undergraduate - Leeds School of Medicine, foundation, obstetrics & gynaecology and paediatrics and emergency medicine.
Areas of exploration identified prior to the visit	Patient safety, rota gaps, handover, induction, quality management processes, equality and diversity, placements and curriculum delivery, assessment and feedback, support for students and trainee doctors, student assistantships and preparedness, training and support for trainers, transfer of information, bullying and undermining.
Were any patient safety concerns identified during the visit?	Four potential patient safety concerns were identified during the visit and following the Trust's response to each concern, one of the four concerns was referred to the GMC's enhanced monitoring process. Please see requirement 6. The other concerns will continue to be monitored by the Trust and Health Education Yorkshire and the Humber going forward.
Were any significant educational concerns identified?	One significant educational concern was identified during the visit. Please see requirement 7.

Has further regulatory action been requested via enhanced monitoring?

One patient safety concern has been referred to the GMC enhanced monitoring process. We will be working with the LETB to monitor improvements.

Summary

- 1 We visited The Mid Yorkshire Hospitals NHS Trust as part of our regional review of undergraduate and postgraduate medical education and training in Yorkshire and the Humber. During the visit we met with foundation doctors from a range of specialties including surgery, paediatrics, obstetrics & gynaecology and emergency medicine, and higher specialty trainees in paediatrics, obstetrics & gynaecology, and emergency medicine. We also met students in years 4 and 5 of the MBChB programme at Leeds School of Medicine.
- 2 The Mid Yorkshire Hospitals NHS Trust was established in 2003, and is an associated teaching hospital. The Trust has over 8000 staff, and is run over three sites – Pinderfields Hospital, Pontefract Hospital and Dewsbury and District Hospital. The Trust is currently undergoing a reconfiguration of services across the three sites, which will see many changes to the ways services are delivered. These changes will include the development of Pinderfields hospital to accommodate more patients, and an increase in planned surgery and outpatient care at Dewsbury. There are also plans for Pontefract Hospital to provide an elective centre with a 9am-5pm A&E service, but with no inpatients. Implementation is underway, with plans for reconfiguration to be completed by 2017.
- 3 Overall, student placements and the overall undergraduate experience is working well at the Trust. Students are well supported and placements are well organised. We found that the experience for doctors in training has not been as positive, and that this is largely due to rota gaps and reductions in training numbers, which we heard have led to issues with workload, supervision and difficulties accessing teaching. We found that the formal quality control processes in place were not clear. Whilst the team saw evidence of how issues were identified, it was not clear how these issues were addressed, and how action plans were put in place to ensure they were resolved. The Trust's relationship with the Local Education and Training Board was also unclear.

Areas of exploration: summary of findings.

This section identifies our findings in areas we agreed to explore prior to the visit.

Patient safety

The doctors in training and students we met with over the course of the visit were aware of their duty to report patient safety issues, and all are confident that they would know who to speak to if they had a concern. Most doctors in training suggested that they would report any incidents to their educational supervisor in the first instance. In the meeting with the senior and education management teams we

heard of some initiatives for students and doctors in training to report issues of patient safety, for example, a “MY patient safety” email address which will go straight to the Director of Medical Education, and a patient safety bulletin. Whilst most doctors in training were aware of the patient safety bulletin, some suggested that it did not always contain the most useful information and was therefore not routinely read by them. Additionally, those we met with did not recognise the “MY patient safety” as a means of reporting incidents. Please see recommendation 1.

During the visit, discussion with doctors in training at both foundation and higher specialty training level raised some patient safety concerns. These were linked to issues with an intensive workload for some trainees, and a lack of access to senior support in some instances. Please see requirement 3.

Rota gaps

Throughout the visit, we heard that rota gaps and reductions in training numbers are affecting training and service. This was reflected in meetings with educational and clinical supervisors, doctors in training, and the senior and education management teams. Rota gaps were found to be more prevalent in some departments than others, for example within obstetrics and gynaecology. We heard from doctors in training that the department is stretched to capacity, particularly at night with an example of a single trainee being on call for both obstetrics and gynaecology. Please see requirement 6.

In discussion with the senior management team, we heard that there is an environment of learning despite rota gaps. This correlated with what we heard from foundation doctors, that they value the educational opportunities that are available to them, in spite of rota gaps. Paediatric higher specialty trainees also discussed upcoming rota gaps, and indicated that as of December 2014 there were likely to be five gaps in the rota. The impact of this on their training was a concern for them, and the senior and education management team confirmed that within paediatrics, the number of middle grade

	<p>higher specialty trainees can be 10 -15 percent down in numbers.</p> <p>The use of locums to fill rota gaps within emergency medicine was also identified as an issue by the management team. The doctors in training indicated that whilst there are rota gaps, there is good locum cover and they are able to access educational opportunities.</p> <p>Educational and clinical supervisors indicated that they are currently spending less formal time with doctors in training than they used to. They indicated that the training experience has changed, and there are a lot of pressures for doctors in training currently. In discussion with the senior management team we heard of plans for reconfiguration, due to be finalised in 2017, and that the intended changes should help to alleviate some of the current service pressures. However, we did not see evidence of a cogent strategy to address pressures in the interim. Whilst it is recognised that the issue of rota gaps is not isolated to this Trust, and that this is a national problem, the impact of rota gaps on supervision, workload, and education must be reviewed, and processes to attempt to minimise impact must be clarified.</p>
Handover	<p>The quality of handover across specialties was found to be variable. For example, whilst we heard from foundation doctors within paediatrics that handover is well structured and attended, foundation doctors within surgery reported that there was a lack of a formal, detailed handover at night and on weekends. Please see requirement 2.</p>
Induction	<p>The quality and consistency of departmental induction was found to be varied across specialties. Whilst some trainees reported receiving a detailed two day induction, others reported not receiving an induction at all. Please see requirement 5.</p>
Quality management processes	<p>The impact of service pressures and rota gaps on the quality of training was discussed in all meetings throughout the visit, and identified as an ongoing</p>

	<p>issue. The extent to which the Trust board were aware of this issue was unclear, as we heard that education is not a standing agenda item at Trust board level. Please see requirement 8.</p> <p>Through our discussions over the course of the visit, it emerged that there are a number of quality control processes in place within the Trust but the inter-relationship between them, and their impact is unclear. Formal processes for sharing information with the LETB were also unclear, including the transfer of information process and the formal processes for identifying and addressing concerns that emerge. It is also not clear how actions from other quality systems, such as the LETB quality visits, are followed up effectively. Please see requirement 4.</p>
<p>Equality and diversity</p>	<p>In discussion with the senior management team, we heard that whilst they previously felt they were behind other organisations in regards to an equality and diversity strategy, an equality and diversity lead is now in place at the Trust, who has formalised their strategy and is in the process of rolling out how it is incorporated into all systems. We also heard that medical staffing teams ensure that all equality and diversity training is kept up to date, and they were confident that all supervisors receive appropriate training, which is mandatory. The educational and clinical supervisors we met with confirmed that they receive equality and diversity training as part of their roles, and additional training is required if you are also involved in other roles, for example as examiners or involvement in award schemes. It was not clear if this information was shared at LEP Board level.</p>
<p>Placements and curriculum delivery</p>	<p>The students we met with were extremely positive about the placements they had received at the Trust, indicating that they were of high quality and linked to their medical school curriculum. We heard that undergraduate placements are well structured, students are always expected by departments, and that staff are positive and want to teach students.</p> <p>Students particularly valued their opportunities for</p>

simulation training, and they gave examples of the opportunities for personal development they have through use of the simulated lab in their self-directed learning time. Simulation training for students was recognised as positive by various groups we met with over the course of the visit. In a meeting with higher specialty trainees, we heard that there is teaching on simulation courses for students, delivered by enthusiastic clinical leadership fellows, and this will soon be introduced for foundation doctors. The higher specialty trainees we met with would like to see this expanded so they could get training on simulation from consultants. We heard that there were plans for trainees who teach students to receive teaching sessions on using the mannequins but this had not happened yet.

The foundation doctors we met with indicated that despite the impact of service pressures, they value the educational opportunities that are available to them. Generally, foundation doctors indicated that they were receiving enough experience across their rotations in order to meet the requirements of the curriculum. This was supported by educational and clinical supervisors, who stated that they have a clear awareness of the foundation curricula, and foundation doctors can achieve the required competencies through their placements at the Trust. Paediatric and emergency medicine higher specialty trainees were also generally happy with the overall training that they received, although within paediatrics we heard there are anxieties about impending rota gaps, and the impact this will have on training.

In discussion with higher specialty trainees within obstetrics and gynaecology, we heard that the balance between training and service within the rotas was not currently appropriate for allowing them to meet the requirements of their curriculum. Please see requirement 7.

Assessment and feedback

The students and doctors in training we met with over the course of the visit were generally happy with the level of assessment and feedback they

	<p>receive through their placements. Students indicated that their assessments were fully timetabled, and they were always provided with detailed information regarding the content of the assessments. Whilst foundation doctors spoke of high service pressures at all levels which can impact on the amount of assessment and feedback they are receiving, in general they were appropriately assessed and received feedback on their performance. Higher specialty trainees also discussed the impact of service pressures on receiving assessments, and that within some departments, for example emergency medicine and gynaecology, consultants and doctors in training having time to complete assessments is often a struggle. This was supported by the clinical supervisors we met with who recognised that trainees may feel that the support they receive from them is limited, due to a lack of time for training in job plans. Both educational and clinical supervisors however, did mention that training for completing workplace based assessments and giving feedback is offered by Leeds School of Medicine and the LETB.</p>
<p>Support for students and trainee doctors</p>	<p>Medical students reported feeling very well supported throughout their placements across the Trust. Many commented that their placements have been the best they have experienced, both in terms of the support they have received and their exposure to a variety of clinical settings. They also indicated that they would know who to contact within the Trust if they had any problems whilst on placement, and would feel comfortable in reporting any issues.</p> <p>The doctors in training we met with, at both foundation and higher specialty level, presented a varied experience of receiving support. Whilst they would know who to contact if additional support was needed, due to service pressures and rota gaps, we heard that some doctors in training had difficulty in accessing senior support. This was particularly prevalent within obstetrics and gynaecology (please see requirement 6) and within surgery out of hours (please see requirement 3).</p>
<p>Student assistantships</p>	<p>The foundation doctors we met with during the visit</p>

<p>and preparedness</p>	<p>suggested that the student assistantship they had completed as a fifth year had been very useful in preparing them for their foundation year. Shadowing foundation doctors had also been helpful in allowing them to see what the role of a foundation doctor is like.</p> <p>The students we met with were extremely happy with the quality of placements they had received at the Trust and felt that they were being well prepared for their careers. Within emergency medicine, for example, we heard that students work alongside the foundation year two doctors and shadow their hours. They said that this has given them a good understanding of what they do, and has therefore been useful in preparing them for the foundation programme.</p>
<p>Training and support for trainers</p>	<p>In regards to training available for educational and clinical supervisors, we heard from the supervisors that they are all encouraged to have training, and they were aware of training courses being run by Health Education Yorkshire and the Humber. Through discussion with both the supervisors and management team, we were told that a record of educational supervisors who have completed training in relation to their role is being effectively monitored.</p> <p>The clinical and educational supervisors we met with were particularly complimentary about the level of feedback they received for undergraduate placements. Leeds School of Medicine consolidate data and share it with the undergraduate tutor and educational leads through the Multi Professional Education and Training (MPET) meeting. This then gets cascaded to all supervisors. They find it particularly useful that this data provides an overall picture of the student experience on placement, and also individually for each specialty. This feedback, as well as the training supervisors receive, was found to support individuals in the development of their skills as supervisors. The students we met with were all very pleased with the support they receive from their supervisors, and this was clearly an area working</p>

	well.
Transfer of information	<p>The process for the transfer of information between the LETB and the Trust was not clear. Whilst the educational and clinical supervisors we met with were very positive about the level and quality of information they received from Leeds School of Medicine in regards to undergraduate training, they indicated that they had never personally received information from the LETB about individual trainees. In discussion with the education management team, we heard that there was a lack of formalised processes for information sharing between the Trust and the LETB. Please see requirement 4.</p>
Bullying and undermining	<p>We heard from the senior management team that there is a bullying and undermining policy in place at the Trust, and that trainees are made aware of it at induction. We also heard that trainees and students are encouraged to raise any bullying or undermining they experience, and staff act on any information they receive in relation to it. The higher specialty trainees we met were agreed that bullying and undermining had been covered in induction. They indicated that they would feel comfortable in accessing support if it was needed, and they would report any issues to their educational supervisor. This was supported by the educational and clinical supervisors we met with, who indicated that they would expect trainees to approach them to report any issues, and they would investigate. Whilst the foundation doctors we met with suggested that there were some instances of feeling undermined by nursing staff, it seemed that these were isolated incidents, rather than regular occurrences, or an ongoing issue. The majority of trainees we met with agreed that they would contact their educational supervisor in the first instance if they experienced or witnessed any issues of bullying and undermining.</p>

Requirements

We set requirements where we have found that our standards are not being met. Our requirements explain what an organisation has to address to make sure that it meets those standards. If these requirements are not met, we can begin to withdraw approval.

Number	Paragraph in <i>Tomorrow's Doctors / The Trainee Doctor</i>	Requirements for the LEP
1	TTD 1.2	Current terminology must be used when referring to the grades of doctors in training and designing rotas to ensure appropriate clinical supervision and expectations of doctors' competence.
2	TTD 1.6	There must be formal, well organised handover arrangements in place across all specialties.
3	TTD 1.11	Foundation doctors in surgical posts must have timely access to on site senior support, and there must be a clearly defined pathway for accessing this support at all times.
4	TTD 2.1	There must be clearly defined and formalised quality control processes in place in relation to postgraduate education, to demonstrate how issues are managed locally, and in collaboration with the LETB.
5	TTD 6.1	All doctors in training must receive a departmental induction. An up to date, accurate record of those who have, and have not received a departmental induction should be closely monitored.
6	TTD 6.10	The workload of higher specialty doctors in training within obstetrics and gynaecology must be reviewed to ensure that the intensity of work is appropriate in ensuring the delivery of high-quality, safe patient care.
7	TTD 6.32	Learning opportunities must be integrated into service provision to ensure that trainees are able to progress appropriately within their training.
8	TTD 7.2	The quality and sustainability of medical education and training must be formally considered at local education provider (LEP) board level.

Requirement 1: Current terminology must be used when referring to the grades of doctors in training and designing rotas.

- 4 Throughout the visit, the doctors in training and staff we met with frequently used the term 'senior house officer' (SHO) and referred to SHO rotas. 'SHO' can refer to doctors in training from foundation year 2, core medical training years 1 and 2 and general practice specialty trainees, and we heard from the foundation doctors that there is no distinction on SHO rotas between the different training grades. The term was also used in meetings by the higher specialty trainees and the education management team.
- 5 The term 'senior house officer' or 'SHO' provides ambiguity for doctors in training, members of the multidisciplinary team, and patients, as it does not specify the level of training of the individual doctors and may lead to doctors being asked to work outside the limits of their competence or without appropriate supervision. The grades of doctors in training must therefore be used, going forward, so that everyone has an awareness of the level of training that each individual doctor is currently at.

Requirement 2: There must be formal, well organised handover arrangements in place across all specialties.

- 6 Foundation doctors within surgery indicated that there is a lack of a formal, detailed handover at night and on weekends. We heard that this was due to rota gaps and the resulting heavy workload for foundation year one doctors during these times. We heard that rota gaps at night and on weekends means that a high number of patients (40-50) are being handed over to foundation doctors, without appropriate time within the handover process to discuss very sick patients that may require closer monitoring. The foundation doctors indicated that this could lead to patient safety concerns for these patients, and we heard that foundation year one doctors had developed their own informal handover process to try and ensure patient safety during these times, in the absence of an appropriate formal process.
- 7 In discussion with foundation and higher specialty trainees and their clinical and educational supervisors, we heard that there was also a lack of a formalised handover process within emergency medicine. The foundation doctors we met with described an informal process where one 'SHO' hands over to another. Both foundation doctors and higher specialty trainees said that there is no formal handover process in place within emergency medicine, that there is no team handover, and no named person that they must hand over to. We heard that the lack of a team handover has been raised with consultants, but as consultants start at 9am, and the handover is at 8am, a team handover would not work within this department. The educational and clinical supervisors we met with confirmed that handover within emergency medicine is difficult because of rota and shift patterns and whilst there are handover practices, these tend to be informal. The current handover arrangements were acknowledged by the supervisors as sub-optimal.

- 8 Higher specialty trainees within emergency medicine acknowledged that team handover was challenging, but that a system of “handover stickers” had been introduced to help this process. We heard that this was proving helpful for more junior staff at handover time, and this has improved overall patient safety. Higher specialty trainees within obstetrics and gynaecology indicated that there were good, formal processes for handover. It is therefore clear that the handover processes across specialties are variable, and that there are ongoing issues within both surgery and emergency medicine regarding ensuring a detailed, formal handover process at all times. This should therefore be reviewed to ensure continuity of care for patients going forward.

Requirement 3: Foundation doctors in surgical posts must have timely access to on site senior support at all times.

- 9 In discussion with the education management team, we heard that there would not be a situation where the only senior support for a foundation doctor in training would be off site. We heard from foundation doctors in surgery that whilst there was on site senior support, it was often not timely, and the pathways to access senior support were not clearly defined. We heard examples of delays in getting support due to consultants and registrars being in theatre and unable to attend immediately, with delays of up to an hour. It appears that rota gaps within surgery are an issue, and this has led to an intense workload for foundation doctors and a lack of timely support being available.
- 10 We heard that if foundation doctors in urology posts had an immediate concern, they would contact the on call urology registrar, and if unavailable, they would contact the general surgical registrar. Whilst they indicated that the general surgical registrars were approachable when they had contacted them in the past, the foundation doctors did not recognise this as a formalised process for accessing senior support when they could not reach the urology registrar. They could not recall being told by senior staff that this was the process for accessing support when the urology registrar was unavailable, and was something they had initiated themselves. The pathway for accessing senior support in any situation should therefore be formalised.

Requirement 4: There must be clearly defined and formalised quality management processes in place to demonstrate how issues are managed locally, and in collaboration with the LETB.

- 11 One area identified by the Trust for development was the formalisation of their quality management processes. We heard that there were sometimes inconsistencies in how fitness to practise and doctors in difficulty processes were followed up, and how action plans to address issues were monitored formally. We heard that a lot of processes remain informal and person specific, and this correlates with the documentation provided prior to the visit. It was clear that the Trust holds a lot of data regarding known issues and collect feedback from doctors in training, however it

was not clear how the Trust uses this information to inform changes and improve education and training.

- 12 Throughout the visit we heard examples of concerns being raised by doctors in training and consultants at board level, but it was not clear what the formal processes were for addressing these concerns. An example of an issue raised is the tracking of patients within the medical assessment unit, which is a known issue within the Trust, but the steps followed through to address the issue and bring it towards a solution were unclear. In discussion with the educational and clinical supervisors, emergency medicine was given as an example of a department that had been added to the risk register. We heard that this was raised with the senior management team, and has been discussed, but the department had not had any further information or feedback about what the follow up actions to address issues would be.
- 13 It was also unclear what the trigger points are for sharing issues with the LETB. During the visit, we heard that communication with the LETB can be on an informal basis. Formal processes need to be strengthened to ensure a level of robustness in the quality management system, both internally, and between the LETB and the Trust.

Requirement 5: All doctors in training must receive a departmental induction.

- 14 We heard from the senior management team that a departmental induction checklist is kept as a means of monitoring induction across specialties. There was an acknowledgement that they could not be sure that every trainee had received a departmental induction, and that they may be of varying quality across, and within specialties.
- 15 Whilst obstetrics and gynaecology trainees reported detailed, extensive departmental inductions, we heard from foundation doctors within surgery that they did not receive a departmental induction when they started at the Trust, and were not told who to report to on their first day. We also heard variable experiences from those within emergency medicine, and although some doctors in training had received an induction, there were others whose induction was incomplete due to staffing shortages.
- 16 All doctors in training must receive a departmental induction, and it was clear from discussion with trainees that their experiences were variable, even within specialties. Central monitoring of departmental inductions should be reviewed to ensure that all trainees are receiving them through every rotation.

Requirement 6: The workload of higher specialty doctors in training within obstetrics and gynaecology must be reviewed.

- 17 Over the course of the visit, we heard about the impact of rota gaps on workload. We heard from obstetrics and gynaecology higher specialty trainees that a registrar could

be on call for both obstetrics and gynaecology, and that when put in this position, they feel unable to provide a good level of care for gynaecology patients due to the competing pressures within obstetrics. Clinical and educational supervisors also spoke of the rota gaps within this department as an issue, and though we heard that steps were being taken to fill the gaps and develop new job plans, there was an acknowledgement that this had led to a lack of support for trainees within gynaecology.

- 18 Rota gaps, coupled with an intense workload for doctors in training who need to cover both obstetrics and gynaecology, has the potential to lead to patient safety issues. We also heard that some acute admissions to the gynaecology unit were not seen by consultants.
- 19 In response to the concerns identified, the Trust acknowledged that the gap in consultant acute gynaecology cover is a well-recognised issue, and that this competes with acute obstetrics cover. The Trust have begun to make changes to improve the current situation within obstetrics and gynaecology, indicating that acute gynaecology consultant cover will increase between 9am and 5pm on the Pinderfields site on 1 in 4 weeks and between 9am and 1pm 3 in 4 weeks. The Trust also anticipates that by April 2016 they will have separate rotas. The current workload for trainees within obstetrics and gynaecology continues to be a concern, in regards to ensuring the safety of patients and the quality of training going forward. This has therefore been referred to the GMC's enhanced monitoring process.

Requirement 7: Learning opportunities must be integrated into service provision to ensure that doctors in training are able to progress appropriately within their training.

- 20 We heard that some doctors in training are not being provided with sufficient learning opportunities, required in order for them to progress, for example a lack of gynaecological operating experience (1.5 days of experience during a 3 month attachment) and doctors in training being asked at short notice to fill gaps in clinics, being called if necessary from other hospital sites. We also heard that theatres are overbooked so there is not much access for doctors in training. This was in contrast to the information we heard in a meeting with the education management team regarding this department, where it was indicated that there is representation of trainees at every level of the rota and that regardless of service pressures, it is ensured that trainees are not taken out of training.
- 21 Doctors in training referred to feeling as though they were primarily on the ward for service provision, rather than training, and that the current rota arrangements reflect service needs rather than training needs. This is linked to the workload pressures previously identified (see requirement 6). Doctors in training in this department have an extremely intense workload, and this is recognised by trainees as the main reason that they have been unable to access the above mentioned training opportunities that are essential to their progression.

Requirement 8: The quality and sustainability of medical education and training must be formally considered at local education provider (LEP) board level.

- 22** We heard from the senior management team that education and training is not a standing item at trust board level, although relevant items may be escalated via the Quality Committee. This standard specifies that all employing organisations, as LEPs of postgraduate training, must consider postgraduate training programmes at board level. This should therefore be ensured going forward to inform the board of their performance and action plans, based on quality monitoring by the Trust, LETB and Medical School.
- 23** The Trust is under pressure from rota gaps and service pressures and this was acknowledged by all we spoke with, including doctors in training from whom we heard that this is impacting on their ability to access training opportunities, for example within obstetrics and gynaecology (see requirement 7). There was also discussion over the reconfiguration of service across the three sites within the Trust, and we heard some concerns from doctors in training about this, especially those in paediatrics.
- 24** In regards to future plans for the reconfiguration of sites, we found no evidence of a training and education strategy and heard there was little dialogue with clinical commissioning groups about training and education. A clearly documented plan would provide all stakeholders with appropriate information regarding the future of education provision within the Trust, to ensure that the sustainability of education is being suitably considered going forward.

Recommendations

We set recommendations where we have found areas for improvement related to our standards. Our recommendations explain what an organisation should address to improve in these areas, in line with best practice.

Number	Paragraph in <i>Tomorrow's Doctors/ The Trainee Doctor</i>	Recommendations for the LEP
1	TTD 6.9	The success and impact of current initiatives for disseminating information to trainees across the trust should be measured, to ensure they are effective.

Recommendation 1: The success and impact of current initiatives for disseminating information to trainees across the trust should be measured.

- 25** We heard from the education and senior management teams of some initiatives in place to share information with doctors in training and students across the Trust. Documentation reviewed prior to the visit and discussion at the visit made reference to the patient safety bulletin, which provides a summary of issues that have occurred throughout the Trust. Whilst doctors in training had an awareness of the bulletin, they did not feel that the information provided through it was always useful and therefore some did not routinely read it.
- 26** We also heard of the Junior Doctor Operational Group (JDOG), where key members of the management team, managerial and educational representatives, consultants, and trainees at various levels of their training are invited to attend a meeting to discuss issues on a 2-3 monthly basis. Whilst this sounded to be a very positive initiative, many of the doctors in training we met with had not heard of it. The Trust should therefore consider how all communication initiatives are promoted to doctors in training, and where applicable, students, to encourage their involvement and engagement with the Trust management and staff.
- 27** When discussed with the management team, it was acknowledged that the effectiveness of communication with trainees was not being currently evaluated, although they have developed many channels for communication. It is therefore suggested that the success and impact of these initiatives are evaluated and regularly monitored, to ensure that they are being utilised to their full capacity going forward.

Acknowledgement

We would like to thank The Mid Yorkshire Hospitals NHS Trust and all the people we met during the visits for their cooperation and willingness to share their learning and experiences.