**19 Feb 2020 20:00**

**Obstetrics and gynaecology**

A locum SHO was on-call over the night. Although they obtained the locum access card and ECare smartcard they struggled to actually gain access to computers, particularly computers in AE department where the tap and go computers and also computers in doctors' room was not allowing them to log in. This created a safety issue as they were not able to read referrals or check blood investigations while they are in A&E. In addition, they could not document their reviews, findings, or plans. In fact, they had to write them on random pieces of papers, then when they had time later to log in and document everything. This has led to significant delays in documentation, delays reviewing patients, extra fatigue and stress on them and they were not able to perform their jobs smoothly. The doctor decided to cancel their last shift with us on short notice because of the IT obstacles faced and management had to urgently find locum cover on very short notice.

**21 Oct 2019**

**Respiratory Medicine**

There are 2 teams in each ward (female and male ward), each led by 1 respiratory consultant. 3-4 junior doctors are assigned to each ward. Since the start of this rotation, me and my colleagues have been leaving work around 6-7pm, occasionally 8:30pm (normal working hours ends at 5pm). This is despite the new turnover junior doctors familiarising themselves with using electronic patient records. This was partly due to the large influx of critical patients, but these are expected and anticipated scenarios. The major contributing factor was the lack of junior staffing and to some extent senior support. Occasionally, there is only 1-2 FY1/SHO in the wards. We have escalated to the rota coordinating team but countless occasions we did not receive any response. We have registrars who are all approachable and reachable when immediate advice is needed. Inevitably, many of the non-urgent ward jobs were pushed to the end of the shift or needing to be carried over to the next day, some of which have delayed patient's discharge or have caused patient care dissatisfaction and subsequently patient / family complaint. On reflection, our seniors could have pro-actively share our workload e.g. Speaking or referring to internal/external specialties, have difficult discussion with patient and family, reviewing scans and images remotely and catching up with juniors with a plan update. This would relief the workload on juniors tremendously during overwhelming times. However, this rarely occurs as understandably, registrars have their own afternoon agenda such as endoscopies, meetings, clinics and covering inpatient referrals. Often our registrars catch up with us towards the end of our shift, during which most of the urgent priorities would have been dealt by ourselves already at the expense of piled up non-urgent ward jobs to chase. This has been ongoing for the last few months which cumulatively have impacted our physical and mental health as well as our morality. Frequently we were working inefficiently with exhaustion and countless break downs to a point where we did not look forward to coming in to work. Furthermore, we have missed out on numerous core and non-core teaching sessions and educational opportunities as leaving the wards with considerable amount of ward jobs and unwell patients would mean that our shift would end beyond our social working hours in addition to putting patient safety at risk.

**23 Sep 2019**

**Otolaryngology**

No cover arranged despite HR being made aware of the staffing issues.

**23 Sep 2019**

**Otolaryngology**

Colleagues on ALS course, no cover arranged during the day, ended up staying late to finish jobs.

**17 Sep 2019**

**Otolaryngology**

On call person off sick. Covered on call for the day. Immense workload and not been able to finish jobs on time. Pending jobs from day shift.

**16 Sep 2019**

**Otolaryngology**

Extra hour worked due to increased workload

**22 Jul 2019**

**Urology**

• I was the only member of the junior doctor team looking after Urology patients • Generally manageable list of patients but complex urological needs • Poor senior support in managing complex patients that required senior input • On-call consultants and registrars unaware of patient's complex issues and therefore poor plans and decision making – a lot of the holistic management was left to the FY1 to manage including a patient that was ?stroke that the registrar would not come to see RE resus status (senior sister on ward had to raise concerns to a consultant in order to resolve this) • More of a service provision rather than a teaching environment • On-call registrar adding to workload of the junior doctor by asking junior doctor to see patients in A&E/ ESC despite the junior doctor having a ward full of patients to manage (the on-call patients should be managed by the registrar as is in his role description) – this has been bought up to senior colleagues on multiple occasions (FY1 have their own on-call rotas). • Chaotic ward rounds with no structure with minimal consultant input. • As a consequence of all the above, I was having to stay back many hours beyond my shift to resolve a lot of the tasks and ensure that all patients were accounted for and the registrars clerked patients were holistically managed (RE regular meds, acute treatments, scans booked, etc).

**15 Jul 2019**

**General surgery**

• I have been HO2 this week • My shift is 8am-6pm, I have finished at 8:45pm each day (Monday and Tuesday) = 2 hour and 45 mins extra each day• Across all surgical departments there were only 4 juniors (1 covering urology, 1 covering colorectal, 1 covering acute admission and myself covering everything else) • On 16/7, I have managed over 30 patients alone (with some help from colorectal FY1 when he wasn't busy/ clerking TCI), with 9 discharges, 2 patients that became unwell including 1 patient that went into T1RF and became acutely delirious that had to be admitted to DOCC for NIV, 5 family discussions and 95 bleeps throughout the day (see bleep sheet attained from switchboard) • Suboptimal care is being provided to patients, as a consequence • Consensus from all junior doctors on surgery is that of burnout and neglect towards the rota coordination – many wanted to be present at the SDU meeting because of the ongoing issues.

**19 Jul 2019**

**Accident and emergency**

Violent patient delayed assessment of other patients meaning I stayed late

**17 Jul 2019**

**Accident and emergency**

Violent patient meant assessment of other patients was delayed

**24 Jun 2019**

**Accident and emergency**

I got no rest break at all in the 1600 - 0100 shift. It was dangerously busy with long waits for lots of patients.

**22 Jun 2019**

**Accident and emergency**

Due to finish 1600 - 0100 shift. Department became very busy just after midnight with 3 patients brought to resus. I was asked to see unwell patient with dka. Department was busy and no consultant to escalate concerns to (although I was supported by experienced and capable middle grades and itu) after

dealing with this patient I had to refer patients I had seen earlier. Safety concerns are that ED didn't have enough staff, and my documentation/referral to surgical team may be questioned as I was completing these referrals when I was tired.

**02 Jun 2019**

**General surgery**

Overtime on call in Urology

**01 Jun 2019**

**General surgery**

Significant overtime

**25 May 2019**

**General medicine**

Medical on call was extremely unsafe. Night before was short-staffed leading to handing over 15 patients to day team. Numbers kept increasing throughout the day and waiting times were easily exceeding 16 hours, resulting in serious safety implications. Support from seniors was lacking, patients were extremely unwell with no escalation plans. Some patients who were seen in ED were not managed and received no proper initial treatment. It was extremely stressful for the junior doctors and there is so much more to it as well.

**05 Apr 2019**

**General surgery**

Locum surgery registrar for the night did not turn up. The team was not informed, and this had to be chased. The locum's DBS check had run out prior to the shift. We felt that the cover was not as safe during this shift due to not having on site senior escalation for acute surgical issues

**22 Mar 2019**

**Gastroenterology**

Stayed to finish tasks