Core Medical Trainee Handbook

Addenbrooke's Hospital

2018

Last revised Feb 2018

Authors

Dr Colin Mason (RCP Tutor)

The Core Medical Trainees of Addenbrooke's Hospital (2017-2018)

Welcome!

Welcome to Core Medical Training at Addenbrooke's! We are delighted to have you. We hope you enjoy your training here.

We have introduced this handbook in the hope that it will answer most of the common questions that people have about their training throughout the year. It has been largely written by your CMT colleagues from their experiences in the Trust in recent years.

These are tough times for patients, hospitals and doctors. It has been a particularly tough time for junior doctors – undervalued and overworked and all the time overshadowed by the unpopular implementation of the new contract.

The CMT group is, in my opinion, the most cohesive group of junior doctors in the hospital at the moment. They support each other, socialise with each other and clearly enjoy their training, their work and their patients.

Don't forget, Medicine is brilliant and we need to keep it that way.

Dr Colin Mason

RCP Tutor, 2018

The Top 12 Things You Need to Know About CMT Training at Addenbrooke's

1. Contacts

RCP Tutor for CMT – Dr Colin Mason – colin.mason1@addenbrookes.nhs.uk – The main contact for PACES teaching, training issues, curriculum issues, eportfolio advice, advice for ARCP preparation.

RCP Tutor for CMT/GIM – Dr Lisa Willcocks – lisa.willcocks@addenbrookes.nhs.uk – The main contact for the GIM SpRs and also contributes to the CMT programme.

Rota issues should be directed to medical staffing first – usually Claire Mendes (Claire.mendes@addenbrookes.nhs.uk - ext 3034) or Hannah Weeks (hannah.weeks@addenbrookes.nhs.uk - ext 4533). The rota is supervised and overseen by Dr Caroline Lebus (caroline.lebus@addenbrookes.nhs.uk) – one of the Acute Medical consultants.

If you have leave requests while on your acute block, contact medical staffing and Dr Lebus. If you have leave requests while on your ward attachment, contact medical staffing, the covering ward consultant at the time and your educational supervisor

Annual and Study leave forms are available on MERLIN and paper forms are on the wall just outside the medical staffing office.

For technical issues with the eportfolio, Educational Supervisor allocation and the weekly CMT teaching programme – contact the administrator, James Gough, in the Clinical School – jg893@medschl.cam.ac.uk (Ext 254846). Copy Dr Mason in please.

The CMT regional Training Programme Chairman is Ian Fellows (ian.fellows@nnuh.nhs.uk). The CMT regional Training Programme Director (TPD) is Tony Griffiths (Anthony.Griffiths@ldh.nhs.uk).

For issues with rotations – e.g. swaps, unanticipated leave, withdrawal from programme etc – contact Lynsey Searle (Lynsey.searle@addenbrookes.nhs.uk – ext 217760) in the first instance and copy Dr Mason in.

You will have 2 Associate College Tutors (ACTs) to represent your interests locally and regionally – these will be elected/decided upon early in the year. In addition, for the last 2 years we have had a CMT committee compromising of 2 to 4 trainees. Feel free to contact me if you are interested in being an ACT or being on the committee.

2. Educational Supervisors

Once allocated an Educational Supervisor, you should stick to the same one while you are at the Trust. If you would prefer to change when you switch rotation in

February (e.g. if your new rotation is in your chosen specialty) please let Emma Shone and me know.

You should contact your supervisor and set up an educational meeting as soon as you begin. It is particularly important to discuss the plan for clinic attendance, procedural opportunities and QIP ideas at this meeting.

You should aim to meet formally at the beginning, in the middle for a mid-placement review and again at the end of your first 6-month placement (generating an end of attachment report in January). You should aim to meet your ES again approximately 1 month prior to your ARCP to complete your final ES report and sign-off your curriculum (ARCPs for CT2s are in May, ARCPs for CT1s are in July, ACF ARCP dates vary according to availability of the Academic TPD).

If you are staying within the Trust (as per most CT2s), you will keep the same Educational Supervisor all year but you will be allocated a new Clinical Supervisor for your second rotation in February. The role of the new Clinical Supervisor will be to supervise your induction, clinical work and educational opportunities within that attachment. You should evidence meeting them with an "induction appraisal" in your portfolio. Ideally, you will meet them again for a mid-point review a month prior to ARCP to monitor progress. They do **not** need to complete an Educational Supervisor's report.

If you are leaving us next February (as per the majority of the CT1s), you will require a new Educational Supervisor in the new Trust who will then be responsible for the supervision of your training for the rest of the year and for your final year Educational Supervisor report prior to ARCP.

3. PACES teaching

We try to provide a programme of evening PACES tutorials to correspond with each PACES diet. This is facilitated by consultants often with some peer 2 peer teaching from post paces CMTs and SpRs. Programmes begin approximately 2 weeks prior to the commencement of each diet and last for approximately 3 weeks. I would appreciate if those of you intending to sit PACES in each diet could let me know in advance so that I can anticipate numbers attending.

We run a Mock PACES course in the last week of every January that is open to all trainees in the East of England. For details of other Mock PACES in the region, visit the deanery website - https://heeoe.hee.nhs.uk/medicine/core-medical-training/courses-and-training-days

There is a "Teaching/Exam Practice" list available on the "shared lists" section in EPIC. All trainees can easily add or remove patients from this list. It is used by both PACES candidates and medical students so be mindful of the risk of patient exhaustion. Avoid assigning frail patients, patients with a higher than normal infection risk or those with more complex personal and family dynamics. Presence on the list does not automatically imply a patient's consent so this should be acquired in the normal fashion. Some helpful comments e.g. relevant examination,

what station the patients are suitable for etc should be visible on the teaching list if they have been added correctly.

Your help in maintaining this teaching list particularly around the time of PACES exams would be much appreciated. I will try to remind you how to add and remove patients with intermittent emails during the year and am happy to do so any time if you ask me.

4. Teaching

You have 2 dedicated CMT teaching sessions a week. On Thursday lunchtime at 1pm, there is a weekly lecture aligned to the CMT curriculum coordinated by Jasmin King in the Clinical School. On Wednesday mornings at 8.15am, you have the "Hot Case" session coordinated by Jasmin and Dr Mason together (see "6" below). The intention is that both of these sessions are bleep-free.

You should reflect on the teaching sessions in the portfolio and link them to any deficient areas as evidence of engagement with the CMT curriculum.

Hospital Grand Rounds take place every Wednesday at 1pm in the William Harvey Lecture Theatre in the Clinical School. There is a pharmaceutical supported lunch (subsidised to 1GBP) beginning at 12.30 in the canteen in the Clinical School beforehand. The details of the Grand Rounds are circulated by Jasmin in the weekly teaching update email circulated every Friday afternoon.

On the evening of the first Tuesday of every month, we stream in the RCP London "Teach In" sessions to the Clinical School. Sessions are from 7-9pm and are advertised in the weeks coming up to the sessions. Sandwiches and refreshments are provided from 6.30. Most sessions are facilitated by one of our consultants. There is no need to pre-register and 2 CPD points are available for each session.

Remaining dates for 2018:

Tuesday October 2nd	Respiratory Medicine
Tuesday November 6th	Infectious Diseases and HIV
Tuesday December 4th	Rheumatology

5. Regional Teaching Days

These usually take place 3-4 times a year, typically in September, February and June. You should aim to attend at least 3 of these over the 2-year CMT programme. You should let your ES and team know of these dates as soon as possible so that they are aware that you would like to be away that day. This is particularly important for the February meeting as you will likely have only just started in a new post – this may involve you informing a different Trust (typically West Suffolk for CT1 trainees). The last regional teaching day usually has a strong QIP focus so you should be aspiring in advance to submit your QIP for judgement at this meeting.

6. Hot Case Teaching

This takes place every Wednesday at 8.15am. 2 trainees are needed for each session, 1 to present a case, 1 to sit in the “Hot Seat”. Cases may have unusual diagnoses but should present in a fashion commonly seen on the medical take. The focus should be on diagnostic reasoning and peer-2 -peer sharing of knowledge and ideas. Ideally, the presenter will do a short presentation illustrating the key learning points at the end. This is usually consultant-facilitated. Dr Mason usually aims to circulate a timetable to canvas for volunteers approximately 1 month in advance.

7. Clinics

CMT1s starting in August 2017 now need to attend 40 clinics in total at least over their entire CMT training.

The gold standard is that a CMT would have a regular clinic rostered as part of their clinical rotation. This has proven difficult to enforce for many reasons. Clinic attendance should be discussed at your initial Educational Supervisor meeting. Clinic attendance should be reviewed at your 3 month mid placement catch-up meeting and addressed if deficient.

A CMT Training Week was introduced in February 2017 to address this issue and seems to have been largely successful in doing so, so far.

If there is no facility to attend clinics within a firm, there is an existing list of clinics at which CMT have been welcome to attend (see later on in this handbook).

In the past, the deanery defined that a satisfactory clinic attendance required a CMT to see a minimum of 2 patients independently, discuss the cases with the consultant and then generate the clinic letter for these cases. This rule has been relaxed; it is now recognised that there is significant educational value from CMTs sitting in clinic with a consultant and observing provided time is allowed for discussion.

Ideally learning will be supplemented with WBPA/SLEs but this is not mandatory to evidence a clinic attendance.

Clinics should be numbered and evidenced in the “logbook” section of your Personal Library in the Excel file format from the JRPCTB (Summary of Clinical Activity & Teaching Attendance)

8. Procedures

Familiarize yourself with the procedural requirements for each year of CT training. Almost all of the ascitic drains and pleural aspirations are performed by dedicated teams at Addenbrooke’s. These services can be contacted directly to arrange experience and while they are often quite busy, they have been very willing to accommodate trainees. See later on in this handbook for the section covering “Opportunities for Procedures”

Nb – Summative DOPS forms with comments to suggest “competent unsupervised and to deal with complicatons” are needed for ARCP success at

CT2. Not having these has caused numerous headaches for trainees in the past at ARCP.

Procedural courses can be booked on the deanery website and will be advertised locally by the clinical school and deanery administrators.

http://mededlive.co.uk/cmt/#

9. Interim Reviews

All CT2s should expect to receive an interim review of their eportfolio by the College Tutor (Dr Willcocks or I) in January. All CT1s should expect an interim review of their portfolio in April (this will be in your new Trust for most CT1s who start here in August).

The interim reviews are intended as an early reminder of your progress against the decision aid of the curriculum and are performed with the intention of avoiding unnecessary and time-consuming outcome 5s/interim reviews at ARCP. Please read them carefully when you get them.

10. Simulation Training

It is strongly recommended that you attend a simulation session during CT training, ideally in CT1 year. These are usually highly valued by trainees. They are also extremely useful for addressing areas in your curriculum such as DC cardioversion, the “Emergency Presentations” required in CT1 year (e.g. anaphylaxis) and so on. Book yourself a place on the deanery website.
http://mededlive.co.uk/cmt/#

11. WBPA/SLEs

EPIC has made it easier in some ways to complete ACATs at Addenbrooke’s as it easier for your assessor to read your assessments and then discuss and feedback on them with you.

See the “ARCP Requirements” sections in the next section in the handbook for a reminder of the SLE requirements for CMT training and be mindful of the fact that only consultant-led SLEs/ACATs are counted for ARCP.

12. Quality Improvement Projects (QIPs)

All trainees need a QIP project plan, QIP report and QIP assessment tool (QIPAT) to be evidenced in their eportfolio prior to ARCP.

QIPs require multiple measurements of (usually simple) data at regular intervals so should require at least 4 months to be performed properly. Projects should be small and can involve multiple trainees and can be carried over across rotations between trainees.

The aim should be to improve quality of patient care but other options e.g. improvements in education are more than acceptable.

Ideal areas of focus are those with easily measureable outcomes – e.g. content of discharge summaries, reduction in waiting times, reduction in unnecessary investigations, reduction in unnecessary catheterisations and so on. Targets should be set and run charts of repeated data analysis (ideally every 6 to 8 weeks) should be generated.

The best QIPs will have the chance to be presented to your peers at the regional training day next June. Addenbrooke's trainees have had the winning QIP presentations in the region for the last 2 years.

See the links on the HEEoE website for previous CMT QI Projects.

https://heeoe.hee.nhs.uk/medicine/core-medical-training/quality-improvement-qi-projects

See the section "Tips for Completing Quality Improvement Projects (QIPs)" later on.

And that's it (for now).

Good luck and enjoy. I look forward to working and learning alongside all of you this year.

Dr Colin Mason
Consultant in Geriatric and General Internal Medicine
FRCP and RCP Tutor, Addenbrooke's Hospital
TPD for Geriatric Medicine, East of England
Feb 2018

ARCP Requirements – Core Medical Training Year 1

To progress satisfactorily (i.e. achieve an Outcome 1) for CMT Year 1, each trainee needs:

1. A satisfactory end of year Educational Supervisor report

2. To have passed MRCP Part 1 at least

3. To have attended at least 20 clinics over the year

4. To have satisfied the following procedural requirements:

(i) Essential procedures part A – skills lab or supervised practice (any DOPS) for all of the following

a. Advanced CPR
b. Ascitic tap
c. LP
d. NG tube insertion and checking
e. Pleural aspiration (but support for USS allowed)

(ii) Essential Procedures part B – no requirements for CT1
a. Central venous cannulation
b. Intercostal drain insertion
c. DC cardioversion

5. To complete a MSF and a MCR

   A valid MSF must have at least 3 consultant responses, a mix of medical and allied staff and be complete within 3 months of sending the tickets.

   The MCR should not include the ES and can be spread throughout the year.

6. At least 10 **consultant-led** SLEs/WBPA including at least 4 **consultant-led** ACATs per year

7. To have the 5 following areas of their curriculum ratified by their ES

   (i) Common competencies
   - Trainee to link evidence for at least 5
   - Trainee to ratify at the group level only (i.e. at the top)
   - ES to ratify at the group level only preferably with comments

   (ii) Emergency presentations (must be achieved by end of CT1) – each must be signed off individually by trainee and ES prior to ARCP
   a. Cardio-resp arrest – ALS acceptable or DOPS
   b. Shocked patient – skills lab but ideally SLE
   c. Unconscious patient – skills lab but ideally SLE
   d. Anaphylaxis/severe drug reaction – skills lab or SLE

   (iii) Top presentations
   - Trainee to link evidence for at least 11 (of the total of 22)
   - Trainee to ratify at group level
   - ES to ratify at group level

   (iv) Other important presentations
   - Trainee to link evidence for at least 15 out of 39
   - Trainee to ratify at group level
   - ES to ratify at group level

(v) Essential CMT procedures (see section 4 above) – each must be rated individually by trainee and ES
- Part A – skills lab or supervised practice for all 5
  - Trainee to ratify at group level
  - ES to ratify at group level
- Part B – no requirements for any at end of CT 1
- Part C - optional section – no targets required

This can be done with as few as 5 ticks/ratifications each by trainee and ES.

8. Quality Improvement Projects (QIPs)

A Quality Improvement Project (QIP) plan, report and QIP assessment tool (QIPAT) should be evidenced within the portfolio.

9. Others
   Valid ALS cert uploaded into portfolio
   Evidence of teaching attendance and ideally of teaching given with feedback
   All trainees must complete a Form R prior to attending ARCP
   Any complaints or serious incidents must be addressed on the Form R with a dated reflection in the portfolio

ARCP Requirements – Core Medical Training Year 2

To progress satisfactorily (i.e. to achieve an outcome 6), each trainee needs:

1. A satisfactory end of year Educational Supervisor report

2. To have passed PACES

3. To have attended at least 40 clinics over the 2 year period (clearly label in the logbook either as a numbered reflection in the reflective part of the portfolio or as an uploaded summary of clinic activity that is easy to locate in the portfolio)

4. To have satisfied the following procedural requirements:

(Nb All Summative DOPS must have “cs” for “competent unsupervised and to deal with all complications” excepting for pleural aspiration where b or c is

allowed in the domain for “technical ability” if the sole reason for this score is rated as the need for assistance with ultrasound)

(i) Essential procedures part A

a. Advanced CPR – any “competent” participation in a real-life cardiac arrest – 1 summative DOPS

b. Ascitic tap – 1 summative DOPS
c. LP – 1 summative DOPS
d. NG tube insertion and checking – 1 summative DOPS

e. Pleural aspiration (but support for USS allowed) – 2 summative DOPS with 2 different assessors but see note above

(ii) Essential Procedures part B

Skills lab certificate or satisfactory supervised practice (formative DOPS) is acceptable. Trainees should aim to aspire to summative DOPS but not essential.

a. Central venous cannulation (support with ultrasound allowed)
b. DC cardioversion
c. Intercostal drain insertion (support for ultrasound allowed)

5. To complete a MSF and a MCR

A valid MSF must have at least 3 consultant responses, a mix of medical and allied staff and be complete within 3 months of sending the tickets.
The MCR should not include the ES and can be spread throughout the year.

6. At least 10 **consultant-led** SLEs/WBPA including at least 4 **consultant-led** ACATs per year

7. To have the 4 remaining areas of their curriculum ratified by their ES

(i) Common competencies

- Trainee to link evidence for at least 10
- Trainee to ratify at the group level only (i.e. at the top)
- ES to ratify at the group level only preferably with comments

(ii) Top presentations

- Trainee to link evidence for all 22
- Trainee to ratify at group level
- ES to ratify at group level

(iii) Other important presentations

- Trainee to link evidence for at least 30 out of 39
- Trainee to ratify at group level
- ES to ratify at group level

(iv) Essential CMT procedures (3 ticks – see section 4 above)

- Part A
  - Trainee to evidence 1st 4 with 1 summative DOPS
  - Trainee to evidence pleural tap with 2 summative DOPS
  - Trainee to ratify at group level
  - ES to ratify at group level

- Part B
  - Skills lab or supervised practice (any DOPS) at a minimum
  - Trainee to ratify at group level
  - ES to ratify at group level

- Part C
  - Optional section – no targets required

Only 6 ticks each (by the trainee and ES) are needed here!

(v) Quality Improvement Projects (QIPs)

A Quality Improvement Project (QIP) plan, report and QIP assessment tool (QIPAT) should be evidenced within the portfolio.

(vi) Others

Valid ALS cert uploaded into portfolio
Evidence of teaching attendance and ideally of teaching given with feedback
All trainees must complete a Form R prior to attending ARCP
Any complaints or serious incidents must be addressed on the Form R with a dated reflection in the portfolio

Opportunities for Procedures

Essential Procedures Part A

CPR

We are currently running a voluntary CMT crash week rota to increase CMT exposure to the cardiac arrest team. We hope to embed this in your timetable by August 2017. When you are on the crash team, you are expected to attend D4IDA every day at 8am and make yourself known to the Rapid Response Registrar and team i.e. let them know you are a CMT and are hoping to get some exposure to crash situations that week. You need a Summative DOPS here (all “c”s to be ticked) but you don’t necessarily need to be leading the arrest, just to have a competent participation in a cardiac arrest situation

Ascitic Tap (and abdominal paracentesis in the "Desirable Procedures" section)
Fiona Smith, fiona.smith@addenbrookes.nhs.uk or Aileen Inte (aileen.inte@addenbrookes.nhs.uk) Clinical Nurse Specialists, Bleep 152-982/Ext 56529; Hours of work Mon/Tues/Thurs/Fri 0730-1600

Taps and ascitic drains are done on an almost daily basis on D5 ward so get in touch with them too if you would like to achieve this.

Predominantly ascitic drains however can talk through and be assessed for taps.

Lumbar Puncture
Mary Hulett, Libby Hutchinson (elizabeth.hutchinson@addenbrookes.nhs.uk), Harri Parsons (harriet.parsons@addenbrookes.nhs.uk), Premlata Telgote - CNPs in Neurology 152 716
Availability: Monday-Thursday 9.30-11.30AM – R3 Neurosciences PIU/Day Unit

There is a regular supply of LPs on R3 ward. It is best to contact first on extension 2021/2256 or bleep 152 716 after 9.45 am to check to avoid "double-bookings" and patients whom they can predict in advance whether they are likely to be amenable.

The Neurology SpR and CMT are good people to ask for ad hoc cases and to point you in the right direction. Another reasonably reliable source is the FY2 on A3 Neurosurgery ward who regularly do LPs.

The Haematology Day Ward on C10 also has a regular supply of LPs daily. Contact the Haematology SpRs or CMTs in advance or contact extension 217312 in the mornings to discuss with the team.

Nasogastric Tube Insertion
We have found that the most reliable place for regular NG tube insertion is R2 (Acute Stroke) ward. Many of the patients here require NG tube insertion and they have often not been inserted in ED but are inserted early in the mornings after their post take review by the stroke team. So checking in with the stroke nurses or the stroke team in the mornings is a good idea if you need to do this.

Pleural Aspiration (or insertion of intercostal drain in "Essential Procedures Part B")
pleuralservice@addenbrookes.nhs.uk or office directly on Ext 349189 (01223 349189)
Pleural specialist nurses: Hannah Collins 156 2197; Interventional Pulmonology Senior Clinical Fellow – Keshav Sharma. Lead Consultant – Dr Jurgen Herre.

They have been extremely helpful in accommodating CMTs. Be mindful that they are currently the busiest pleural service in the country and be aware that any more than 2 trainees at a time is unlikely to be feasible.

The pleural team would prefer you spend a whole day with them as part of your training week if possible rather than just attend for the procedure and leave.

There is currently a Pleural Procedures WhatsApp group at CUH. Please join if you still need to address this competency.

Essential Procedures Part B

Central Venous Cannulation

The procedures courses have already been discussed in the "Top 12 Tips" section. The renal team regularly insert lines but also need to train up their own SpRs – however, it is still worth asking if you are on a rotation in that service or in advance of your training week if there are any opportunities.

The ICU consultants have previously recommended contacting the "Vascular Access Unit" (for PICCS and IJVs) where the nurses are always happy to be approached by junior doctors who want to get experience. The best thing is to call 6020 or 152 080 and speak to the coordinating nurse. They commented that trainees shouldn't dismiss the usefulness of PICCs – it's an out of plane Seldinger technique much like IJ lines (except more difficult!).

They also commented that most major cases in theatre will need a CVC and most anaesthetists will be willing to help if approached in advance – the cases can be found on EPIC and the planned anaesthetist on the anaesthetic rota can be found on Connect." Dr Andrew Johnston, ICU Consultant, may be a good person to contact here for advice by email.

DC Cardioversion

Contact Dr Sharon Wilson (sharon.wilson@addenbrookes.nhs.uk) in advance. There is an elective DC cardioversion list on the 4th Monday of the month in the ATC (only 1 trainee per session, book well in advance – if you wish to attend, you can contact the cardiology team directly) and ad-hoc cardioversions happen regularly, particularly on Monday and/or Tuesday afternoons.

There is currently a DC Cardioversion WhatsApp Group administered by Dr Wilson

Intercostal drain insertion (see "Pleural Aspiration" above)

List of Clinics Willing to Accommodate CMTs

Please contact consultants in advance if you wish to attend (clinic codes in brackets where known). If any of the below is incorrect, please email Dr Mason with the updated details

Ambulatory Care (EAU 3 every day)

Acute Medicine - Dr Graggaber, Lebus, Coggle (AMAO PDF)
RADAR (acute geriatric care) – Dr Hampton/Diver (ADD RADAR JLH, ADD RADAR JMD)

Almost daily TIA clinics in R3 ward Mon – Thurs (ADD TIABPT PJM3)

Monday

AM

Liver transplant – 9 AM - Clinic 12 – Dr Gimson/Allison
Renal transplant – Clinic 12

PM

Gastro – Acute IBD clinic – Dr Tim Raine (ADD ACUTEIBD MP1) Clinic 12
ID - Dr Carmichael/Elinor Moore – General - 2PM, Clinic 1A (ADD AJC1 AJC1)
Neurology Rapid Access Clinic – Dr Tim Rittman
Neuro - Dr Paul Worth – general, 2pm, R3 (ADD R3 PFWO)
Prof Alasdair Coles/Dr Amanda Cox - Neuroimmunology clinic - 2pm, clinic 12
Parkinson's disease clinics – Dr Alistair Mackett and Duncan Forsyth (ADD AJMP AJMA or ADD AJM AJMA; ADD DRF DRF)

Tuesday

AM

Neuro - Dr Peter Martin – general, 8.30am
Haematology - Dr David Perry/Besser - Alternate weeks 9 am. (Clinic 33) (ADD GAF GAF)
Dr Rachel Jones / Dr David Jayne – vasculitis clinic, 9am (clinic 12)
Dermatology – Dr Pamela Todd (pamela.m.todd@googlemail.com) – Clinic 7

PM

DME – Dr Mason – Clinic 2 – 1.30, every 2nd Tuesday (ADD CAM CAM)
Hepatology – 2pm – Clinic 12 – General – Dr Gelson
Renal - Dr Bradley/Torpey – general, 2pm, clinic 12 (ADD JRB JRB and ADD NRP NRP)

Dermatology – Dr Pamela Todd – (pamela.m.todd@googlemail.com) – Clinic 7

Wednesday

AM

Gastro – Clinic 12 – 9am – Dr Lisa Sharkey
Hepatology – 9AM – General – Clinic 12- Dr Griffiths/Gimson (ADD ALA GFM)
Renal – Transplant clinic – Clinic 12, Dr Nicholas Torpey, 9-12.30

PM

Geriatrics –Dr Wallis – Clinic 2 on alternating Wednesdays (ADD SJWA SJWA)
Lymphoma - Dr George Follows - 2pm. (Oncology outpatients)
Renal - Dr Fry/Wilcocks/ Ojha – general - 2pm- clinic 12 (ADD ACF ACF)
Clinical Pharmacology – Clinic 2 email Dr Kevin O'Shaughnessy or James Goodman (ADD KMO KMO)

Thursday

AM

Pituitary/thyroid - 9am – IMS/ATC – Dr Mark Gurnell
Emergency/ first seizure clinic - 9.30 am - R3
Renal – Transplant clinic – Clinic 12
Thrombophilia clinic

PM
Stroke/TIA – 14.00 - R3 (Ext 216021 on the day to check patient numbers or code ADD TIABPT PJM3)
Hepatology – new patients – Clinic 12 – Dr Allison/Gelson/Leithead (ADD HEPNEW MEDA)
Neuro - Dr Amanda Cox – general, 2pm, clinic 13
Renal - Dr Ojha/Pritchard – low clearance, Clinic 12
Respiratory – CMT led OPAT clinic (for CMTs attached to resp firm) - clinic 2a

Friday
AM
Acute Medicine Follow Up Clinic Clinic 2, Fridays 9-1pm (Dr Burton/Dr Lebus) (ADD AMFU PDF)
Dr Rachel Jones/Jayne – vasculitis, 9am, clinic 12 (ADD DRWJ DRWJ)
Endocrine - Fridays 9am – IMS ATC, 9am, Dr Mark Gurnell
Neuro – Emergency clinic – 11am – Clinic 43 – email Stevan Wing or Mark Manford

PM
Stroke/General DME – Clinic 2 – 1.30 pm, Dr O'Brien (Ext 217786 to check – ADD EOB EWOB)

Oncology
The following consultants have indicated they are happy to accommodate CMTs in clinic:
Deborah Gregory - deborah.gregory@addenbrookes.nhs.uk
Simon Pacey - simon.pacey@addenbrookes.nhs.uk
John Latimer - john.latimer@addenbrookes.nhs.uk (surgical gynae-oncology clinic)
Peter Baldwin - peter.baldwin@addenbrookes.nhs.uk (surgical gynae-oncology clinic)

Tips for Completing Quality Improvement Projects (QIPs)

A Quality Improvement Project (QIP) plan, report and QIP Assessment Tool (QIPAT) need to be evidenced at ARCP every year.

Remember the 3 questions for every QIP

1. What is the area that I want to improve?

   (e.g. patient safety or patient experience; wasted time or resources due to inefficiency; poor educational opportunities?)

2. How will I be able to show that quality is improving?

   (i.e. what will I be able to measure? e.g. better adherence to guidelines; more patients seen on call; shorter OPD waiting times; less potential drug errors; discharges earlier in the day; more CMT clinics attended; cost savings on unnecessary blood tests etc)

3. How can we make this happen?

   (i.e. the **P**lan stage of the PDSA cycle). Who do I need to talk to? Consider a root cause analysis of the area of poor quality – why is it not happening now? Then, brainstorm for ideas of how to make it happen. Select only a small number of interventions for the first PDSA cycle. Some of these will be effective but it is likely that several will be quickly disregarded as impractical or ineffective. Then come up with a new improved system for the next cycle. Aim to continue until things are clearly working well, the change has been embedded or it is taken on by a colleague.

Remember for an improvement in quality to continue, it cannot just rely on the individual enthusiasm and engagement of particular individuals who are often only transiently working in individual firms. Consider how an effective new system (e.g. handover, ward round or discharge summary template, restructuring of timetable/daily schedule, new technology) could be embedded for the long term benefits of patients and staff.

QIP Dos

Plan in advance – a project should take at least 4 months and require several data measurements during this time.

Strongly consider a QIP in an area related to your future specialty – it is likely to improve your chances at interview later on. QIPs are commonly submitted to national specialty meetings as poster presentations and good ones can be published.

Consider buddying up with other CMTs/FY1s/SpRs/AHPs

Consider a combined project with the outgoing or incoming CMT to your post – (you can find out who via the RCP Tutor although be aware that the other CMT may have different ideas)

Keep it realistic and simple to measure – you don't have to measure **all** data – small frequent measurements every 4 to 6 weeks should suffice e.g.10 cases every 6 weeks

Remember your data needs to be measureable – e.g. a %, cost-saving, time spent doing something. You will need to generate a run chart showing these measurements. The different PDSA cycles should be clearly labelled. You may want to set targets to aspire to.

Involve the main players – invested consultants, pharmacists, other junior doctors, ward clerks, ward sisters etc – it is unlikely that your QIP will be especially effective without their buy-in.

Consider educational QIPs – e.g. numbers of clinics attended – some of these will be continous rolling CMT projects – contact the CMT committee/RCP Tutor for details.

QIP Don'ts

Be discouraged if things don't improve especially initially – this is realistic and all part of the PDSA process. An excellent QIP may not necessarily lead to consistent quality improvement. There may still be very valuable learning to be gained nonetheless.

Overcomplicate things – if you are overambitious and try to measure too much, you could well find that you are not in a position to repeat the same measurements when you move post, sit for exams etc. It is unlikely incoming CMTs will want to take on projects that involve repeated onerous data collections and complicated analyses.

Leave it to the end. If you haven't commenced your QIP within the first months of your second rotation at the latest, it is probable you may run into trouble at ARCP next year.

Medical doctors on call – contact details out of hours

***Doctors' handover occurs 9-9.30pm; please do not bleep during this time unless an emergency**

Patient's primary team on EPIC	6-9pm	9pm-8.30am*
Hepatology	152 241	152 241
Renal	152 241	152 241
Rheumatology	152 241	152 241
Dermatology	152 241	152 241
Diabetes and endo	152 409	152 241
MSEU	152 409	152 172
Gastroenterology	152 409	154 240
ID	152 409	154 240
Cardiology	154 240	154 240
Respiratory	154 240	154 240
AME	152 172	152 172
DME	152 172	152 172
Stroke	152 172	152 172
Patient with no primary team (just transferred from ED)	152 172	152 172

(At time of writing on 2/2/18, many of these out of hours bleep numbers are incorrect on Rotawatch/Switchboard. We are working to correct this but in the meantime please use this sheet).

Individual Specialty Tip-Sheets

Acute Block	
Home Ward	A&E shifts or Ward Cover (as per main rota)
Normal working hours	**A&E** A&E Day shift: 8am-6pm A&E Late Shift: 4-11pm (there can also be a 2-9pm shift) A&E Night Shift: 9pm-9am **Ward Cover**

Acute Block	
	Day Weekend Cover: for individual specialty (see main rota for allocation) 8:30am-9pm Ward Cover Nights: 9pm-9am – 3x SHOs on-call
Clinic Opportunities	• No specific clinics here to attend but whilst working in A&E you can identify appropriate patients to be referred directly/followed up in ambulatory clinics (inc. EAU3) • To be aware of EAU3 referral pathways
Educational opportunities	• Clerking – perfect opportunity for Mini-CEX/CBD/ACATs • If post PACES – opportunity for senior medical reviews • If preparing for PACES – opportunity to practice examinations/presentations to consultants with feedback • Link cases to e-portfolio curriculum
Procedural Opportunities	• Be prepared to be flexible and watch the track board for any potential procedures being done in A&E – make the A&E consultants and SpRs aware that you would like to be involved Most common procedures done: DCCV, chest drain insertion, LPs, occasionally central lines, and ascitic taps. EAU5 and C4 have allocated LP drawers/cupboard in their clean sterile and treatment rooms respectively (remember to log equipment out if using for other wards away from C4/EAU5). All A wards are also stocked with LP drawers.
Nurse Specialists	RRT nurses are available for assistance in A&E and the wards
Tip Sheet Author	Dr Megan Offer (CT2 2017)

Cardiology	
Home Ward	K3/CCU
Normal working hours	0830-1800 On call commitments as per the master general medical rota

Cardiology	
Clinic Opportunities	<u>General Cardiology Clinics – Clinic 2</u> Monday AM (Dr. Rosemary Rusk)- Clinic 2A Tuesday AM (Dr. Michael O'Sullivan) Wednesday AM (Prof Bennet/ Dr. Sinha) Thursday AM (Dr. Mark Belham), alternate Thursday PM (Dr. Rudd) Friday AM (Dr. Peter Pugh) <u>Specialist Cardiology Clinics:</u> Obstetric Cardiology (Dr. Mark Belham), 2nd Friday 13:30 Rosie Hospital Fabry Clinic (Dr. Rosemary Rusk), 1st Tuesday 08:30 Clinic 2 Joint Genetics (Dr. Rusk + Dr. Heck) 2nd Wednesday 13:00, clinic 33 ATC Heart Failure Clinic (Dr. Catriona Bhagra)- Friday PM but on maternity leave from Feb 2018
Educational opportunities	Cardio-Radiology MDT Thursday 13:00 N3 Seminar Room
Procedural Opportunities	• Elective DC Cardioversion lists – contact Dr Wilson • Cardiac catheterization/ Pacemaker insertion multiple times in a week on an as and when required basis + elective cases on K2. Check with nursing staff on K2 in the morning (for procedures scheduled later in the day) <u>Weekly Schedule:</u> Monday- TOE/ DCCV list (Dr. Belham) Tuesday- TOE list 13:00 (Dr. Belham) Wednesday – Stress Echo list Thursday – Stress Echo list
Nurse Specialists	Richard Park, Richard Bird, Kathryn Carver and lots of others
Clinical Leads	Dr Peter Pugh
Tip Sheet Author	Dr Susan Mathai (CT2 2017), checked Pawel Klementowicz 2018

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Diabetes and Endocrinology	
Home Ward	F6

Diabetes and Endocrinology	
Normal working hours	0830-1800 On call commitments as per the master general medical rota
Clinic Opportunities	Endocrine and diabetes clinics every day in the Wolfson Diabetes & Endocrine Centre (WDEC) in the ATC. Also ask the consultant on call if you can assess patients in ambulatory care (e.g. those with new diagnosis of diabetes)
Educational opportunities	Monday 13:00–14:00 = diabetes meeting in the seminar room of the WDEC. Varied presentations including M&M meetings and teaching. Thursday 08:30-09:00 = D& E SpR teaching, WDEC Thursday 13:15 – 15:00 = Post endocrine clinic discussion, WDEC Thursday 15:00 – 16:30 Xray meeting, Radiology Friday 12:00-13:00, Rosie = diabetes/endocrinology SpR teaching (SHOs welcome to attend), rotates with MAXIM Or Friday 13:0-14:00 IMS, Level4, MAXIM, D & E Academic Seminars Tuesday 17:00 – 19:30 = diabetic foot round, F6. This ward round of vascular surgeons, orthopaedic surgeons, podiatrists and diabetes consultants is a learning opportunity but does, unfortunately, often lead to a late finish on a Tuesday Alternate Tuesday 17:30-19:00, Pituitary MDT, Rosie
Clinical Leads	Dr Eleanor Gurnell, Diabetes, Prof Chatterjee Endocrinology
Other info	The diabetes and endocrinology team look after patients on base ward F6 and outliers. Named outlying wards are A block and R2. The team is divided into two – a diabetes and endocrine team: Consultant , SpR and FY1 and a General Medicine team: Consultant, SpR and FY1. The CMT in theory should be attached to the specialist side, but staffing and patient numbers call for flexibility. Daily F6 board round immediately after morning report, patients allocated to most appropriate team and daily handover from ward sister. Ward timetable and other housekeeping information emailed prior to start of job by Dr E Gurnell, who is the clinical/educational supervisor for all CMT's and FY1's on F6. It is common for patients to be admitted directly from the diabetic foot clinic. In these cases, the FY1 covering the diabetes/endo (rather than the GIM) team will go down to the clinic to clerk the patient while they await a bed.

Diabetes and Endocrinology	
Tip Sheet Author	Dr Katrina Andrews (ACF CT2 2017)

Gastroenterology	
Home Ward	M4
Normal working hours	0830-1800 On-call commitments as per the master general medical rota
Clinic Opportunities	Monday PM: Dr Middleton (General and acute IBD) and Dr Corbett Tuesday PM twice monthly (2nd and 4th Tues): Coeliac clinic Tuesday PM: Dr Modelell, Intestinal Failure and Transplant clinic Wednesday AM: Dr Parkes (IBD), Dr Sharkey (general) Friday PM: Dr Parkes (IBD), Woodward/Massey/Cameron (General)
Educational opportunities	• GI radiology meeting: Monday 12:15pm Level 4 by vascular access • Gastro teaching: Tuesday 12:30pm E7 seminar room (free lunch) • Histopathology meeting: Thursday1pm (clashes with CMT teaching), ATC seminar room 6A • Journal club: Friday 8am (bacon rolls!) Hutchison MRC building
Procedural Opportunities	• Ward procedures as they arise and as competent: LPs • Invited to attend endoscopy if interested (ERCP Thursday and Friday morning, PEGs Tuesday morning / Thursday afternoon)
Clinical Nurse Specialists	• Helen Lawrence/Lynn Russell (Intestinal failure) 152050 /157302 • Stoma nurses and IBD nurses • PN and Gastro Dieticians: Becky and Emma 152543
Clinical Leads	Dr Lisa Sharkey
Other info	The gastro ward cover arrangements have recently changed; the team is split into 3 teams: Gastro 1, 2 and Intestinal Failure (IF). Gastro 1 and 2 predominantly deal with luminal/GI bleeds/IBD patients in addition to general medical patients within the ATC (wards L4, M5 and L5). The two teams alternate daily with taking the new patients and the one consultant accompanies the team taking new patients. There is an SpR and junior on both gastro 1 and 2 daily. Minimal levels of staffing for the firm are 2 SpR's and 2 junior doctors The IF team predominantly deal with intestinal failure related

Gastroenterology	
	problems. There is an IF consultant and a junior (variably an SpR) on this team. They have a limited number of patients under them (~8 patients) however they have an extended list of patients they review through the hospital which they round twice a week (Monday and Thursday) with the dietician and Intestinal Failure Specialist Nurse. On the weekends there is usually a gastro 1&2 ward round (consultant, SpR and junior) and an IF ward round (Consultant and SpR).
Tip Sheet Author	Dr Eleanor Earp (ACF CT1 2017)

Geriatric Medicine	
Home wards	C4, C6, F4, G3, G4, G6
Normal working hours	0830-1800 On call commitments as per the master general medical rota
Clinic Opportunities	Daily RADAR clinic on EAU 3 – Dr Diver and Dr Hampton Syncope clinics (EAU 3) Tuesday am – Dr Hampton and Wednesday am (Dr Wilson and Dr Wallis alternating) Monday afternoon – Parkinson's clinic – Dr Mackett and Forsyth (Cl. 12) Tuesday afternoon – Dr Mason (every 2nd Tuesday) and Dr Biram and Dr Romero-Ortuno (alternating weeks) – all clinics in Clinic 2 Wednesday afternoon – Dr Wallis and Dr Keevil (alternating weeks- Cl 2) Thursday afternoon – Dr Wilson and Dr D'Souza (alternating weeks- Cl 2) Friday afternoon – Dr O'Brien (Clinic 2) Numbers are small in DME clinics and SpRs tend to go too – it works better if the CMT either goes to EAU 3 or to a different consultant clinic to the ward teams so that SpR and CMT aren't both gone at the same time. Email the consultant in advance to ensure they have space and enough patients for you. **If trouble getting to clinic in DME email Dr Mason!**

Geriatric Medicine	
Specific educational opportunities	X ray meeting: Friday 12.30 (ask for directions!) DME department teaching: Fridays 1.15 – J3 SR (Free lunch!) Lots of opportunity for CbDs and post take patients – consultants very willing to do SLEs and ACATs. Lots of teaching of medical students Lots of MDT working
Procedural Opportunities	Geriatric medicine is not a procedure-heavy specialty but there are ad hoc opportunities for LP and NG tubes in particular
Clinical Leads	Dr Richard Biram The RCP Tutor for CMT is Colin Mason and is a Geriatrician.
Tip Sheet Author	Dr Colin Mason (RCP Tutor 2018)

Haematology	
Home Ward	C10 & D6 Also: C9 (Teenage & Young Adult ward), Haematology Day Unit
Normal working hours **(No general medical commitments)**	- Normal weekday 08:30-17:30 - Evening cover (Mon-Thurs) 17:30-21:00 – cross cover oncology (D9) - Weekend (Friday-Sunday) 08:30-21:00 - Night 20:30-09:00 – cross cover oncology (D9)
Clinic Opportunities	Clinics every day. Particularly good for CMTs are: - Tuesday AM: General haematology/haemostasis - Tuesday AM: MPD - Tuesday PM: Lymphoma/CLL - Wednesday PM: Lymphoma
Educational opportunities	- Haematology lunchtime seminars: Mon 12:00 (venue varies) - Radiology meeting: Wed 08:15 Berridge Room (Radiology) - Morphology meeting: Wed 09:00 Barrett Room (Level 1 Pathology) - SpR coagulation teaching Thursday 08:00 SpR room (Haematology) - Morphology teaching Friday 08:15 Barrett Room (Level 1 Pathology)
Procedural Opportunities	LP (e.g. for intrathecal chemotherapy) on Haematology Day Unit BMA and trephine (inpatients wards & Haem. Day Unit)

Haematology	
Clinical Nurse Specialists	Specialist nurses for bone marrow transplant (BMT), myeloma, MDS/MPD, acute leukaemia and lymphoma/CLL - names and numbers are listed in C10 and D6 doctors' offices.
Clinical Leads	Dr Charles Crawley (malignant), Dr Martin Besser (general)
Other info	There are two primary ward teams, one covering the C10 transplant unit (16 beds) and the other covering D6 (11 beds) and outliers. Each team has an FY1, SHO, SpR and consultant. Consultants rotate on a monthly basis and generally round on Mondays and Thursdays. C9 (TYA) and Haematology Day Unit are covered by dedicated Senior Clinical Fellows during normal working hours; at nights and weekends, these units are covered by the on-call team. If these fellows are away, the ward juniors will be called to prescribe products or review patients, some of whom may need admission. At night and Mon-Thurs evenings, the on call SHO covers haematology and oncology inpatients and clerks acute admissions in ED, as well as elective admissions for chemotherapy. Unplanned admissions should be discussed with the haematology or oncology SpR on call. Morning and evening handovers take place at 08:30 and 20:30 in D9 oncology doctors' office. Representatives of both the C10 and D6/outlier teams should attend each morning to take handover from the night SHO. **Leave is coordinated by a senior ward registrar and should be approved by him or her so that adequate levels of ward cover are maintained.** Weekly meetings: - Monday 08:45 Handover meeting (SpR office, Haematology) -Thursday 14:00 WR and micro/MDT (D10 seminar room) - Friday 16:00 Weekend handover meeting (D6 doctors' office)
Last updated	Dr Uttenthal, Feb 2018

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Hepatology	
Home ward	D5
Normal working hours	0830-1800 On call commitments as per the master general medical rota
Clinic Opportunities	There are daily Hepatology clinics in Clinic 12

Hepatology	
Specific educational opportunities	• Mon: 1:30-2:30 Teaching - various locations (free lunch) • Fri: 2:30 Liver Transplant Assessment meeting (J3 SR)
Procedural Opportunities	• Ascitic taps occur frequently on D5; you should become independent at doing these quite quickly • Patients attend electively (and acutely) for paracentesis. You can perform drainage by liaising with Aileen Inte/ Fiona Smith
Clinical Nurse Specialists	Tracy Woodall HCV/HBV Rachel Bates HCV Aileen Inte Alcohol-related Liver Disease Sally Edwards Liver Tumours Emma Bateman Liver Tumours Marie Roat NAFLD/NASH Fiona Smith Ascites/Liver biopsy/Fast-Track Jaundice
Clinical Leads	William Griffiths
Any other information	The hepatology team looks after 20-35 patients; the majority of which are based on D5. The hepatology department at Addenbrooke's is a tertiary referral centre and as well as local acute admissions and takes in complex patients from other hospitals in East of England, East Midlands and Wessex. In addition to looking after acute admissions (acute liver failure/injury, complications of chronic liver disease, hepatobiliary cancer and patient requiring ERCP/EUS), there are several elective admissions to the ward on a weekly basis. The majority of these are for liver transplant assessment, liver biopsy (transjugular or percutaneous), transarterial embolization (for HCC), abdominal paracentesis or percutaneous transhepatic cholangiography. It is vital that clotting is checked and corrected with appropriate blood products and prophylactic antibiotics are prescribed (where needed) prior to these patients procedures. A list of elective admission is emailed to all doctors on the 'hepatology doctors' mailing list at the start of the week; ensure you are added to this mailing list when you start on D5. There is a morning board meeting in the D5 doctors' office at 9am with nurses and therapists. Often the consultant on the ward will want to see any new patients between 8:30-9am prior to this meeting.

Hepatology	
	Additionally, there is a comprehensive hepatology handbook that will be given to you at induction that gives more detailed information about the hepatology job from a junior doctor perspective.
Tip Sheet Author	Dr Oscar Swift (CT2 and Associate College Tutor 2017)

Infectious Diseases	
Home ward	D10
Normal working hours	0830-1800 On call commitments as per the master general medical rota
Clinic Opportunities	Monday afternoon - General ID Clinic Tuesday morning - General ID Clinic Wednesday afternoon - SpR HIV clinic Friday morning - General ID clinic (Profs' Clinic) (All in Clinic 1a) OPAT clinics – most days.
Specific educational opportunities	Monday 1pm 'General' ID teaching (Consultant/SpR, may be cases, may be research, may be M&M. Usually free lunch) Wednesday 10am - Weekly MDT [it is the responsibility of the ward SHOs to make sure that the lists, and computers are prepped for this] Wednesday 4pm - HIV MDT Friday 1pm - 'Case based teaching' either Dr Moore, or Dr Carmichael. Friday 2pm - Radiology meeting (All in D10 Seminar room except HIV MDT [Clinic 1a] and Radiology meeting [In radiology - you need a guide!])
Procedural Opportunities	Lumbar punctures aplenty
Nurse Specialists	TB nurse specialist Emma Cooley HIV nurse specialist Fiona

Infectious Diseases	
Clinical Leads	Elinor Moore Effrosynni Gkrania-Klotsas
Tip Sheet Author	Dr Kat Sharrocks (CT2 2017), checked Dr James O'Brien, CT2, Feb 2018

Intensive Care Rotation/John V Farman Intensive Care Unit Note that there is already a comprehensive ICU Doctors' Induction Document that is emailed to all CMTs before their rotation that has lots of useful information	
Home Ward	JVF-ICU (D3 15 beds, D4 5 beds)
Normal working hours	Standard Day 0800-1700 Long day 0800-21.00, handover at 20.15. Carry bleep 156 2330 Nights 2000-0900
Clinic Opportunities	Post-ICU care follow up clinic (Dr Monica Trivedi leads) Happy with CMTs going to medical clinics as well Discuss with Dr Ford early in the rotation – he is aware of the CMT clinic requirement and will attempt to build clinic days for you into the rota (you will need to find medical clinics to attend on these days)
Educational opportunities	Wednesday PM teaching: 1500-1600 Lots of consultant exposure: excellent "on the job" learning opportunities
Procedural Opportunities	Excellent Opportunities Arterial cannulation Central venous cannulation DC Cardioversion LP Echocardiogram – Dr Milena Georgieva runs weekly bedside FICE Echo training for trainees
Clinical Nurse Specialists	1:1 Nursing. Nurses are highly trained and good teachers. If asked to do RRT duties then exposure to the excellent RRT nurse team
Clinical Leads	Dr Andrew Johnston
Other info	A thorough handover takes place at 0800 and 2000, lasting 30-45 mins. The day involves 2 ward rounds, commencing at 0900 and 1500. There are 2 consultants present in the day time (0800-2000) with a third RRT consultant present for advice. The support is excellent.

Intensive Care Rotation/John V Farman Intensive Care Unit Note that there is already a comprehensive ICU Doctors' Induction Document that is emailed to all CMTs before their rotation that has lots of useful information	
	Some consultants will be happy for CMTs to review patients on their own, others will ask you to round with them. There are opportunities to leave the round to perform procedures or accompany patients to scan. Carrying the 2222 bleep allows you to get experience of cardiac arrest and resuscitation scenarios on the ward. Cardiac arrests are led by the RRT Fellow. RRT is an excellent chance to gain experience with arrest and peri-arrest patients. The team comprises 2 CNS, one RRT fellow, and a RRT consultant. You can ask Dr Ford if he can allow tyou to shadow the on call RRT Fellow (he will help to find opportunities in the rota to facilitate this). As a CMT you will always be on with a senior trainee ST3+/SpR grade who is usually (but not always) of an anaesthetic background. Urgent anaesthetic assistance, e.g. for airway issues, can always be sought from the 2nd on call anaesthetic SpR. You will have opportunities to intubate should you wish. This job will make you more competent at dealing with seriously unwell patients, it generates excellent feedback.
Last revised by	Will Jenner, Asha Gray, Anthony Martinelli, Dimitra Krexi - 2018

Nephrology	
Home Ward	C5
Normal working hours	0830-1800 On call commitments as per the master general medical rota
Clinic Opportunities	General: Tuesday PM (Willcocks/Bradley/Firth) Wednesday PM (Ojha/Fry/Jones) Low Clearance Clinic: Thursday PM (Pritchard/Ojha/Fry) – takes place in the Cambridge Dialysis Centre off-site on Newmarket Road so impractical to attend unless on training week Tues and Thurs 1.30 pm. Clinic 33 – recurrent stone formers and renal tubular genetics. Prof Karet always amenable to trainees, has lots of space to see your own patients and teaches very well.

Nephrology	
Educational opportunities	Friday: All day vasculitis clinic – Dr Jones, Dr Willcocks, Dr Jayne Journal Club: Tues 1-2pm: - various locations (free lunch) Priority meeting (dialysis planning) Mon 2pm Nephrology Portacabin Biopsy Meeting: Fri 3pm Gynae-onc Seminar Room, Rosie
Procedural Opportunities	CVC insertions (approx. 1-5/week on an "as-needed" basis) in the C5 treatment room or in vascular access Dedicated line list on Monday mornings – liaise with dialysis SpR. This tends to be more complex and tunnelled lines rather than temporary.
Clinical Nurse Specialists	• Stella Burns (vasculitis) • Helen Burns (renal anaemia) • Nicky Moncrieff (low clearance)
Clinical Leads	Dr Nicholas Pritchard
Other info	The renal team is split into C5 and 'outlier' teams. The patient cohort on C5 is a mixture of renal and GIM patients and numbers around 25 patients. The outlier patient cohort is entirely unselected (mainly GIM) and can vary between 20-50 patients located on various wards throughout the hospital. The winter months (November to February) are a particular busy time for the outlier team! Additionally you look after/do jobs for any vasculitis and rheumatology inpatients (usually only 3-5 patients). Nevertheless you should aim to attend a clinic once per fortnight during your ward attachment, perform vascath insertions on inpatients when the opportunity arises and attend the educational meetings as outlined above. You should include these opportunities in your work schedule when you draw this up with your Educational Supervisor.
Last updated Feb 2018	Dr Niki Veale, Dr Andy Stewart - CT2s

Neurology

Neurology	
Home Ward	A4, A3 (inpatients and CAMPATH day cases), A5, and outliers
Normal working hours	08:00-1800 (on a master neurosciences rota with neurosurgery and NCCU SHOs) On-call: (6pm-8pm, 8pm-8am, and weekends covering neurology and neurosurgery; will also do one or two 8am-4pm NCCU weekends)
Clinic Opportunities	Monday PM: Neuroinflammmatory (clinic 12) with Dr Cox and Prof Coles (meet on A5 consultant offices at 1:30 to discuss list) Thurs AM: General - Dr Cox (R3)– **all SpRs aware this is the allocated SHO clinic!**
Educational opportunities	Tuesday 12:45-3: Neurology ground round (B-spur LT) – lunch provided Friday 1:30: – Neuroradiology meeting (on level 4 interventional radiology)
Procedural Opportunities	LPs – at least 1-2 per day. All A wards are stocked with LP drawers. C4 and EAU5 have allocated LP drawers/cupboard in their clean sterile and treatment rooms respectively (remember to log equipment out if using for other wards away from C4/EAU5). Try and shadow one of the neurophysiologists (next to SHO room on level 3) – excellent for understanding NCSs and EMGs.
Clinical Nurse Specialists	Elizabeth and Harriet (help with liaising with family, procedures (LP), arranging scans, muscle biopsies, and cognitive assessments, etc.).
Clinical Leads	Dr Mark Manford – epilepsy specialist
Other info	**Handover –** SHO handover at 8am in SHO Office opposite A3, then check bloods and prepare neurology ward list. Most importantly check with A3 staff how many CAMPATH patients there are for the week – they attend on a daily basis for 5 days for the 1st cycle, 3 days for 2nd cycle. They need to be clerked in and discharged everyday. Likewise, on Mondays check with A4 staff if there are any telemetry patients for the week – they need to be clerked (check with epilepsy CNS what the plan for their medication is). SpR handover at 9 am in A4 staff room – pick up urgent discharges and LPs for the day. There will be multiple SpR ward rounds (5 firms) so usually pick one with most number of patients to attend. Ensure regular contact with SpRs throughout the day so jobs are done in a timely manner. NB: SpRs will usually bleep,

Neurology	
	call or text you re: jobss **Consultant Ward rounds** -Monday 10am and Thursday 2pm for neuroinflammatory team -Tuesday afternoon (after ground round) and Friday afternoon (after neuroradiology team) for all other teams. During the day: attend above clinics, meetings and if on top of jobs try and see referrals with the on-call SpR. **Emergencies to be aware of:** acute neuromuscular failure (GBC, MG – make sure they have regular FVCs), status epilepticus, encephalitis, coma, acute relapse of MS, meningitis, stroke, SAH, acute cord compression and cauda equina. Neurosurgical emergencies will be covered at the neurosurgery induction. **Annual leave/SL:** As there are only two neurology SHOs and one is nearly always on annual leave or nights, there is only one neurology SHO for most of the rotation. It's therefore difficult to get S/L. Plan far in advance, liaise with the rota coordinator (currently neurosurgical SpR) and might have to ask one of the SHOs on NCCU/neurosurgery to cover you on neurology for a day as a favour.
Tip Sheet Author	Dr Negin Holland (ACF CT2 2017)

Oncology	
Home Ward	D9
Normal working hours	0830-1730 On call commitments as per the oncology/haematology rota. Email Deborah Gregory in advance of attachment with any leave requests and to get a copy of the rota: deborah.gregory@addenbrookes.nhs.uk
Clinic Opportunities	Oncology and haematology clinics daily in oncology outpatients
Educational opportunities	Tues 8:30am: – X-ray meeting (one SHO must take handover from night team before attending) 8:30 am teaching in D9 doctors' office – this is frequent and times are variable but a timetable will be available on arrival
Procedural Opportunities	Opportunities for NG tubes, ascitic drains, pleural procedures

Oncology	
Clinical Nurse Specialists	Specialist nurses for each cancer team accessible via switchboard
Other Info	Handovers for onc and haem are at 8:30, 17:00 and 20:30 in the D9 doctor's office (although frequently the haem team will just bleep with jobs rather than attend at 17:00). The on call consultant of the day will arrive at 9am for a daily board round with the nurse in charge and allied health professionals. After this, the ward SpR and consultant usually do the post-take ward round of any new admissions while the ward SHOs see the existing patients. Around twice a week, each inpatient will be seen by their team consultant or SpR (e.g. the breast team, the head and neck team, etc.). A timetable for these ward rounds should be up on the board in the D9 doctors' office but they can be a bit erratic. If in doubt about the plan for the patient, there is a list of bleep numbers for each SpR (the breast SpR, the head and neck SpR, etc.) in the doctor's office. There is also the general ward SpR who can help with queries in the first instance. There are usually 2-4 oncology juniors on the ward on any given day. On Monday to Thursday evenings and on all night shifts, the oncology SHOs cross cover haematology. During the day on weekdays (until around 7pm), there is an extra on call registrar in the cancer assessment unit who takes all referrals (ED and external) and does all emergency admission clerking. SHOs are expected to clerk and take referrals after around 7pm on weekdays, during night shifts, and all day on weekends. SHOs should not take external referrals from other hospitals (please re-direct these to the on call SpR). Any ED referrals where you are not sure if the patient should be admitted under oncology, you can also discuss with the on call oncology SpR before accepting. On Mondays, one of the ward SHOs will need to clerk patients being admitted for radio-iodine treatment (ask for a protocol). There are several discharge summary templates (e.g. radio-iodine treatment admission) - please ask for these to be shared with you on arrival.
Clinical Leads	Dr Deborah Gregory
Tip Sheet Author	Dr Katrina Andrews (ACF CT2 2017)

Palliative Medicine	
Home Ward	Inpatient Unit, Arthur Rank Hospice
Normal working hours	0900-1700 On-call commitments overnight (non-resident) and 1 in 4 weekends as per the palliative medicine OOH rota
Clinic Opportunities	OPD in Arthur Rank Hospice: Tues, Thurs and Fri mornings. Pain clinic (Fridays) MND clinic (Alternate Fridays) Lymphoedema clinic (varying weekdays) - I believe that the normal practice now is for CMTs to have an Addenbrooke's contract with an honorary Arthur Rank contract, rather than the other way around (this was definitely the case when I was there) Outpatient Visits to Patient's Homes with Clinical Nurse Specialists Monday to Friday that can count towards clinic time.
Educational opportunities	• Palliative Care Inpatient MDT Wednesday 11am • Monthly Palliative Care Journal Club Wednesday 12 noon • Consultant led teaching on key topics in Palliative Care monthly • Weekly consultant ward round providing patient based teaching and an opportunity for regular WBPAs. • Consultants prioritise your attendance at weekly CMT teaching at Addenbrooke's: Wednesday 8.15am-9am and Thursday 1pm-2pm • Complexity of patients admitted to the inpatient unit provides plenty of opportunity for further ad hoc teaching and discussion. • Management of inpatients over a weekend provides an opportunity for independent practice with senior advice and regular ACATs. • Regular opportunities to teach medical students
Procedural Opportunities	Although less opportunities, occasionally patients require ascitic drains that can be performed on the unit supervised by the SpRs or consultants.
Clinical Nurse Specialists	Large Specialist Palliative Care Home Team (SPCHT)
Clinical Leads	Dr Sarah Grove (Educational Supervisor and IPU Consultant)
Other info	The newly-built Arthur Rank Hospice is a 5 minute cycle or drive from Addenbrooke's. The Inpatient Unit consists of 18 beds -12 "specialist" and 6 "nurse-led". Patients are admitted from home or transferred from hospital and there is normally around one new

Palliative Medicine	
	admission per day. There is a focus on MDT management of each patient and you will work closely with the MDT as patients admitted often have a number of complex needs. During your time, you will become confident in complex symptom management and pain control, end of life care and advanced care planning discussions. You will also become more aware of medical ethical issues surrounding clinical decisions. Regarding clinics, you should aim to get a morning per week to attend clinic or go on home visits, you will be informed the best time to do this. The environment should enable you to complete a good Quality Improvement Project and the consultants are very keen for these to be performed with lots of ideas. CMTs have an Addenbrooke's contract with an honorary Arthur Rank contract
Tip Sheet Author	Dr Jennifer Murray CT1 2017 Anna Street CT2 2018

Respiratory	
Home Ward	N3 Outlier wards – D6 and D8
Normal working hours	0830-1800 On call commitments as per the master general medical rota
Clinic Opportunities	<u>Respiratory OPAT Clinic</u> FY2/CMT led: Thursday 14:00 in G2, (Dr Clare Sander) <u>General Respiratory/Asthma Specialist clinic</u> Monday AM (Knolle) Monday PM (Gore) Wednesday AM (Asthma only) (Gore/Knolle/Nasser) <u>COPD Clinics</u> Monday AM (Stinchcombe/Mahadeva) Monday PM (Fuld) Thursday AM (Stinchcombe/Mahadeva) <u>Cancer pathway/Nodule Specialist</u> Wednesday AM (Ruparelia) Thursday PM (Ruparelia) There is also opportunity to attend more specialist clinics eg: PE,

Respiratory	
Educational opportunities	Pneumothorax, Pleural, ILD. More information can be sought from Neil Starling (see details below). • Pleural MDT Monday 13:00, N3 seminar room • Respiratory Journal Club 08:00 Friday, N3 seminar room • Lung Cancer MDT Thurs: 13:00, AV conference room level 1 • Respiratory Journal Club Friday 08:00, N3 seminar room • Respiratory Radiology meeting Friday 13:00, N3 seminar room
Procedural Opportunities	Pleural aspirations/drains in N3 treatment room – led by Pleural team
Clinical Nurse Specialists	• Pleural Team (Hannah Collins, office on N3, Keshav Sharma, pleural SpR) • ART Nurses (Pager 07623 625625, ext 2647) • OPAT nurses (Bleep 156-2203) • Lung Cancer Nurses, (Clem Butler ext 3541, bleep 157-125) • ILD Nurse Specialist (Caroline Owen - Pager) • NIV Specialist Physiotherapists (Office on N3)
Clinical Leads	Asthma – Dr Gore; Bronchiectasis / respiratory immunology – Dr Sander; COPD – Dr Mahadeva; ILD – Prof. Chilvers; Lung cancer – Dr Ruparelia; Respiratory Physiology – Dr Sylvester; TB – Dr Stinchcombe
Other info	• The Respiratory team is split into N3 and 'outlier' teams and consists of a mixture of respiratory and general medical patients. • Respiratory OPAT smart phrase to aid referral information required for clinic on discharge letters: Please use '.respopat' • To organize outpatient follow up clinic appointments, please email Neil Starling on neil.starling@addenbrookes.nhs.uk. Please state what clinic and when you would like to book an appointment • Patients sometimes come in for elective bronchoscopy on ward D5 or G2 and require clerking and discharge paperwork • EPIC order ('referral to lung cancer MDT') to refer to the Lung Cancer MDT • CMTs often get calls for CT guided biopsy day cases for clerking and for chest x ray review before discharge
Tip Sheet Author	Dr Sonia Sharma (CT2 2017). Last checked and updated Dr Ahmed Osman, CT1 2018

Stroke	
Home Ward	R2 and Lewin Rehab ward (one CT or FY for each - swap half way through so both cover R2 and the Lewin unless any strong preferences)
Normal working hours	8:30-18:00 On-calls for CTs usually only at weekends (check rota for wards covered)
Clinic Opportunities	Tuesday PM: TIA clinic on R3 with Dr O'Brien Wednesday PM: TIA clinic on R3 with Dr Hannon Thursday PM: TIA clinic on R3 with Dr Peter Martin Friday PM: Stroke F/U & DME clinic with Dr O'Brien All consultants will be happy for you to join them in clinic though this may require co-ordination with the other CT/FY on the ward - usually easier if you are allocated to Lewin.
Educational opportunities	Mondays: Journal club at 1:30 in the Lewin Seminar Room Tuesdays: Neuroradiology meeting 08:30-09:00 in the Lewin Seminar Room Neurology teaching 13:00-15:00 in the Neurology Seminar Room Thursdays: Neuro-imaging meeting 11:00-12:00 in the Lewin Seminar Room Try and shadow the on-call SpR and practice doing the NIHSS score in acute stroke. Consultants generally keen to facilitate projects for presentations at conferences etc.
Procedural Opportunities	NG tube daily. LPs approx monthly (for patients who probably should have been under Neurology).
Clinical Nurse Specialists	There is a whole group of stroke nurses who hold the thrombolysis bleep
Clinical Lead	Dr Eoin O'Brien
Other info	Handover – evening handover is to the DME & Stroke ward cover junior who will cover both Lewin and R2 Ward patients. Bleep on Rotawatch. Weekends: likely allocated to varying teams, but for the stroke weekend you cover all stroke patients on R2/Lewin (not outliers).

Stroke	
	Consultant Ward rounds R2: most commonly patients are seen by the consultant every day. There is a PTWR template to follow. There are two MRI slots for stroke per day but only registrars can get these approved. Lewin – variable frequency of patient review - usually full WRs on Monday and Friday. MDT meeting: Lewin 12:00, R2 12:00, Tuesday 11:00 on Lewin in addition Discharge summaries – there is an extremely long template for discharge summaries which can be shared with you - it is not clear that this is appropriate for all patients. Annual leave/SL: Arrange in advance - minimum staffing is of 2 CTs/FYs and consultants can be quite insistent on this, often leading to lengthy negotiations regarding allocation of service needs doctors.
Tip Sheet Author	Dr Negin Holland (ACF CT2 2017), revised A Martinelli 2018

Training Week	
Normal working hours	0900-1700 **The Training Week is currently only available to trainees whose rotation includes an attachment to the acute on call rota** (therefore is unfortunately not yet included in the Haematology, Oncology, Neurology, ICU or Palliative Care rotations)
Arrangements	The training week is primarily in place in order to allow CMTs to achieve their curricular requirements. In particular, it is anticipated that most CMTs will spend the majority of this week attending pre-arranged clinics or achieving procedural competencies. The clinics can be any medical clinics that the CMTs would like to attend and are often taken from the “List of clinics willing to accommodate CMTs” – see earlier on in the handbook.

Training Week	
	In circumstances where a CMT is already well on track for ARCP, this week can be used flexibly in preparation for your registrar post after CT training. **All training week plans must be submitted to Dr Mason, the RCP Tutor beforehand and afterwards, a summary of training week achievements must be emailed to him too.** If your training week is late in the year or after ARCP, it is possible to swap your training week with an annual leave week. However, you will need to be mindful that this will likely lead to several trainees being on their training week at the same time and you will need to careful not to overwhelm services (in particular, the pleural and ascites teams). If you intend to swap your training week with an annual leave week, you must let Dr Mason know
Tip Sheet Author	Dr Colin Mason (RCP Tutor, 2017)

Transplant	
Home Ward	G5 / F5 (HDU)
Normal working hours	Day – 08.00-17.00 LD – 0800 – 20.30 N – 2000 – 0800 No participation on master general medical rota. On call duties as per transplant rota.
Clinic Opportunities	Renal Transplant Mon/Wed(clinic 5)/Thurs mornings Hepatology Post Transplant Mon/Wed(clinic 1A)/Thurs mornings Hepatology Pre Transplant Tues mornings All in Clinic 12 except those stated in brackets
Educational opportunities	Renal • Nephrology/immunology/transplantation seminar – Fri: 1300, various locations • Renal meeting – Fridays, 1430, Rosie seminar room 6 • Transplant meeting – Fridays, 1530 Rosie seminar room 6 Hepatology • Educational meeting – Mondays, 1300, various locations • Radiology – Fridays, 1145, Berridge Room • Histopathology - Fridays 1330 ATC 6A MDT – Fridays, 1430, Seminar room J3

Transplant	
Procedural Opportunities	• Can assist with renal biopsies. Occasional ascitic taps, drains, NG tubes. Occasional line insertions.
Transplant Coordinators	• Renal Transplant Coordinator (Recipient and Live Kidney Donor) • Liver Transplant Coordinator • Small Bowel Coordinator Their office is located outside F5 & G5. During out of hours there is only one coordinator on call who you can contact via switchboard.
Clinical Leads	Dr. Nicholas Torpey – Medical Mr. Paul Gibbs – Surgical
Other info	Overall an excellent, exciting job with lots of learning opportunities. CMTs shouldn't cover multi-visceral transplant patients during the day job – a long-standing agreement of this post. They do, however, cover all transplant patients on call. There are no FY1 doctors so you will need to do all the jobs including discharge letters and running around organizing scans and bloods as below. Usually you only look after one organ during the day but OOH you cover all three. MV has a team of clinical fellows who basically take care of all of their patients. Renal have 2 WR/day (inc weekends) and liver only one. Bloods • Almost all patients need daily bloods including Tacrolimus levels if they are on this (most). Please order these for new admissions • If bloods are important/urgent you should deliver them personally to the lab. Bleed the patient yourself if no PAs readily available. • There is a battery of bloods tests needed for new admissions for transplant, all of which must be personally delivered to the various labs. Scans/Biopsies • Patients often need US of transplanted organs. It is always best to phone about these to ensure they are done promptly. • Always phone to discuss CTs/MRIs. • Renal biopsies are usually done by the Reg on the ward. Ensure clotting is done at 6am or sooner the day before a potential biopsy.

Transplant	
	• Liver biopsies are done in US. These need to be agreed by the consultant/reg doing the list and almost never happen OOH. Best is to go down to US, ask who is around who can do a biopsy and when, find that person and ask them to add the patient to their list. Always check clotting/platelets in advance. **<u>Discharge letters</u>** Important things to include are: Reason for transplant, details of the donor organ (DBD/DCD, CMV status etc), key operative details (anatomy, complications), Post op complications, and discharge immunosuppression/prophylaxis. You should aim to attend 3 to 4 clinics during your placement, to insert NG tube and vascath as opportunities may arise and attend the educational opportunities as outlined above. Also, the department has produced handbooks for kidney, liver, small bowel, SPK transplant and EPS which you can find on Merlin and you should read before commencing your placement.
Tip Sheet Authors	Dr Dimitra Krexi and Dr Chris Oldroyd (both CT1s 2017), checked and update Callum Wright Feb 2018