NHS
Norfolk and Suffolk
NHS Foundation Trust

Psychiatry Junior Doctor Handbook

Issue 1

Working together
for better mental health

Contents

A warm welcome to Psychiatry!

Dear colleague,

This booklet has been designed with the new trainee in mind. It comes from a compilation of frequently asked questions and feedback from your predecessors to help you settle into your new role.

We know that trainees can be overwhelmed entering unknown territory in Psychiatry, but we hope that this booklet will provide a rough guide to settle the nerves. This booklet doesn't try to replace textbooks or reference works on the practice of Psychiatry; but it hopefully provides a quick local guide that will serve in a pinch.

We've also added some essentials like how to claim expenses, local contacts and maps to find your way initially.

I hope that you will have a happy Psychiatry experience and welcome to NSFT!

Dr Trevor Broughton MBBCh, MRCPsych, LLM
Consultant Forensic Psychiatrist
Director of Medical Education

NSFT values and behaviours

Positively... Respectfully... Together...

Trust strategic goals to achieve our mission

1. Improving quality and achieving financial sustainability
2. Working as One Trust
3. Focusing on prevention, early intervention and promoting recovery

1. Roles and responsibilities of junior doctors

Roles, responsibilities and expectations

Roles	Responsibilities	Expectations
• Psychiatric assessment and care under senior supervision • Physical health care for NSFT inpatients • Out-of-Hours cover	• Act in a professional manner at all times • Maintain confidentiality • Wear appropriate dress as per policy and ID badge at all times	• Learning and training opportunities, including support meeting portfolio requirements • 24hr Senior availability • Weekly personal / clinical supervision

Day job expectations and objectives to be specified in local induction.

On-call guidelines and ward work

On-call duties

- New admissions
- Acute medical problems
- Medication concerns
- Acute psychiatric issues (e.g. agitation)
- Sedation
- Seclusion reviews
- Liaising with other professionals

2. Admission process

This involves:

A. Admission clerking
B. Mental state examination (MSE)
C. Risk assessment
D. Physical health
   - – Venous Thromboembolism (VTE) Assessment Form
   - – Write up medication chart
   - – Bloods and ECG (if urgent)

A. Admission clerking

- Reason for admission
  - – History of presenting complaint
  - – Route of admission
  - – Home / mental health ward transfer / acute hospital
- Mental Health Act (MHA) status – informal / under section
- Psychiatric history
  - – Diagnosis
  - – Recent treatment
  - – Previous admissions – see previous admissions to 2015 on Lorenzo, past letters and tribunal reports have lots of info. It may be worth requesting access to Carenotes / EPEX system for notes prior to 2015
- Past medical history
- Drug history including allergies
- Illicit substance use

- Family history
- Personal and social history
  - Birth, development, childhood, education, occupational history
  - Family relationships, relationship history
  - Current social circumstances including occupation, accommodation, and relationship
- Premorbid personality
- Forensic history

B. Mental state examination

- Appearance and behaviour
  - Self-care / what are they wearing / eye contact
  - Agitation / psychomotor retardation / abnormal movements
- Mood and affect
  - Subjective (how patient tells you it is) and objective (how it looks to you)
  - Do emotions appear appropriate, restricted or excessively changing?
- Speech
  - Volume, rate, quantity and flow
  - Pressured / mutism / spontaneous vs non-spontaneous
  - Presence of neologisms, perseveration, echolalia etc.
- Thoughts – stream, form and content
  - Evidence of thought disorder - thought block / flight of ideas / loosening of associations / derailment
  - Delusions – persecutory / reference / grandiose / nihilistic / passivity / thought possession
- Perceptions
  - Hallucinations in any modality
  - Explore voices – 2nd / 3rd person, derogatory, command / running commentary
- Cognition
- Insight
  - Into diagnosis, current mental state, need for medication, need for admission

Capacity

- If admitted on informal basis patient must have capacity to consent to admission
- This must be documented in admission clerking; if patient lacks capacity, document why not and recorded in the capacity form under the **Other** tab in the clinical notes. If patient lacks capacity consider 5(2) or deprivation of liberties (DOLS)

C. Risk assessment

Current and historic risks to be documented, to consider the following areas:

- Self harm
- Self neglect
- Poor engagement with services
- Risk of non-adherence with medication
- Safegurding of children and vulnerable adults
- Risk of harm from others
- Risk of financial exploitation
- Risk of sexual disinhibition
- Risk to others

Formulation

- Brief summary of salient points from history and mental state
- Include impression and differential diagnosis

Plan

- Level of nursing observations
  - In psychiatric hospitals, patients are checked on a number of times an hour according to their presentation
  - This can be adjusted to manage their risks and are often divided into:
    1. General observations – hourly (this is the minimum)
    2. Intermittent observations – 4-6 times an hour
    3. Constant observations
       a. Eye sight b. Arms-length
- Write a medication card and consider when required (PRN) medication
  - Do not prescribe PRN medication routinely on admission but tailor it to the patient's needs

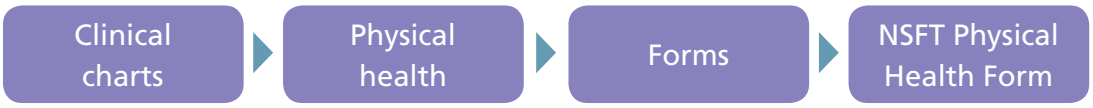
Oral medication which may be used as PRN as a part of a de-escalation strategy:

This is just a guide, please consult up-to-date literature inc. BNF for current regimes

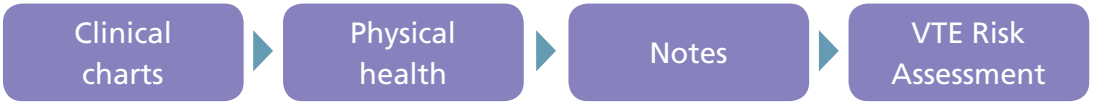
Drug	Route	BNF max	Onset	Duration	Repeat	Problems
Lorazepam	Oral	4mg/day	30-45 mins	4-6 hrs	4 hourly	Respiratory depression
Haloperidol	Oral	20mg/day	1 hr	20 hrs	4-6 hourly	Can accumulate
Promethazine	Oral	100mg/day	30 mins	4-6 hrs	Twice daily	Prolonged sedation, seizures

D. Physical health

Each patient should have a routine physical health check and VTE assessment on admission and six-monthly after that. Findings should be documented in the NSFT Physical Health Form, this can be located by following the tabs indicated below:



A VTE form should be completed for all patients on admission and on any change in their mobility or physical health. This form can be found on lorenzo via the following tabs:



Patients transferred from different hospitals, even those within the Trust, require an updated Physical Health form if it has been more than a week since their previous one.

3. Acute medical problems / psychiatric emergencies

Overdose

- Take a history to assess the exact circumstances of the poisoning or overdose and complete a physical examination
- Consider referral to an acute hospital. Toxbase (available as an app) can be used to obtain information about the toxicity of different substances and the A&E consultant can be contacted for advice
- Refer people who have taken poisons with delayed action urgently to hospital, even if the person appears well and is asymptomatic. Delayed-action medicines include aspirin, iron, paracetamol, tricyclic antidepressants, co-phenotrope (diphenoxylate with atropine, Lomotil) and all modified-release preparations

Self harm

- No suturing equipment is available on NSFT sites, if this is required the patient will need to attend A&E

Ligature

- Assess the severity of the ligature attempt, including the materials used, the physical effect of the ligature (i.e cyanotic) and use of ligature cutters, efforts made to avoid discovery, and the presences of any remaining ligature items

Physical health illness

- Not all staff are physical health trained and psychiatric hospitals are limited in the physical health care they can provide i.e. no IV fluids/antibiotics so have a low threshold for considering admission to an acute hospital
- Patients should be medically fit for discharge to the community prior to transfer back to a psychiatric ward

Alcohol withdrawal

- The Trust policy, Managing Withdrawal Symptoms for Inpatients (C02), can be found on the intranet
- A thorough history and physical examination should be completed and a decision made as to whether the patient needs to be initially managed in an acute hospital
- The severity of alcohol dependence questionnaire (SAD-Q) can be used to assess alcohol dependence:
  - A score of >16 is likely to require pharmacological intervention to manage withdrawal symptoms
  - A score of >30 on the SAD-Q or drinking more than 30 units a day predicts a severe alcohol withdrawal
- The Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar) assesses symptoms of withdrawal:
  - A score of 8 or less typically does not require medication for withdrawal
- Chlordiazepoxide can be prescribed as a reducing regime or PRN to manage symptoms of alcohol withdrawal
- Prescribe vitamin supplementation – IM Pabrinex initially followed by oral thiamine supplementation

Transfer to acute hospital

- Prior to transfer to an acute hospital consider the risks involved, including any risk of harm to themselves or others in that setting and risk of absconsion
- If a patient is detained, emergency leave can be authorised by a doctor or nurse in charge and the responsible clinician / consultant on-call should be informed

Rapid Tranquilisation

- Medication may be required if alternative de-escalation strategies are not successful and the level of risk to self or others remains high
- Please see the Rapid Tranquilisation policy on the intranet (C111) outlining the procedure and how to monitor for and manage significant side effects
- Temperature, heart rate, blood pressure, level of hydration and level of consciousness must be monitored at least every hour for four hours and until there are no further concerns

This chart is an example of common medication used:

Drug	Route	BNF max	Onset	Peak	Duration	Problems
Lorazepam	IM	25-30 micrograms/kg	30-45 mins	1-3 hrs	4-6 hrs	Respiratory depression
Haloperidol	IM	12mg/day	30 mins	4-6 hrs	4-6 hrs	Can accumulate
Promethazine	IM	100mg/day	15-30 mins	1hr	1 hr	Can be very sedating

This is just a guide, please consult up-to-date literature inc. BNF for current regimes

Flumazenil injections and cannula must be available in all areas where lorazepam is used.
IM benzodiazepines should not be given within 1 hour after IM olanzapine or vice versa.
If an adult patient is informal but refusing essential treatment, medication may be administered under the Mental Capacity Act, however, a MHA section should be considered as the patient is likely significantly unwell.

Queries about medication or other concerns should be discussed with a senior on-call.

4. Seclusion reviews

- All junior doctors should familiarise themselves with the Seclusion and Long-Term Segregation policy (C107) available on the intranet
- **First medical review within one hour**
- Medical four hourly reviews thereafter until the first MDT review. Medical review twice in 24 hours following this (One has to be completed by the responsible clinician / On-call consultant)
- Consider your own safety - Discuss with the staff what is appropriate and whether it is safe to open the door or carry out a non-contact examination
- Do not open the seclusion door without a PMA team
- Tabs to follow on Lorenzo to locate the seclusion start / stop form:

- Document:
  - Rationale for seclusion
  - If restraint was used – Assess for any physical injuries secondary to restraint
  - Review medication – What have they had so far? Remember physical health monitoring if rapid tranquilisation used
  - Review the current risks to the patient and others
  - Current mental state
  - You are the patient's advocate – Do they really need to remain in seclusion? Have they been offered drink / food?

5. Electroconvulsive therapy (ECT)

In Norwich this is carried out at the Julian Hospital on Mondays and Thursdays.
You may occasionally be asked to see someone pre or post ECT. They need to have a physical work up beforehand, including bloods and ECG, and benzodiazepine medication is contraindicated.

In Ipswich this is carried out on Tuesday mornings and Friday mornings.

Pre-ECT assessment

- Medical history should highlight items which may have an impact on anaesthesia e.g. cardiorespiratory disease, history of any adverse reactions to anaesthesia
- Early advice from the anaesthetist should be sought for patients taking medication for diabetes, long-term or high dose steroids or MAOIs
- Physical examination including examination for evidence of cardiovascular disease, infection, obesity, or other factors that may restrict airway management
- Extreme caution should be taken in patients with:
  - recent MI or unstable angina
  - recent CVA
  - raised intracranial pressure / untreated cerebral aneurysm
  - unstable major fracture / c-spine injury
  - phaeochromocytoma
  - uncontrolled cardiac failure or severe valvular disease
  - DVT
  - cochlear or brain implant
- Patients with implanted pacemakers can receive ECT, although cardioverter defibrillators should have defibrillation and anti-tachycardia functions temporarily deactivated
- ECT is relatively safe in pregnancy although from second pregnancy consideration should be given to positioning

Possible side effects include:

- Those of general anaesthetic
- Headache
- Muscle ache
- Nausea
- Confusion
- Memory loss (normally transient)

6. The law

Mental Health Act 1983

- Section 5(4) – Nursing staff holding power for 6 hours
- Section 5(2) – Doctor holding power for 72 hours
- Section 2 – MHA assessment, 28 days for assessment / Rx of patient's condition
- Section 3 – MHA assessment, 6 months for Rx of known condition

If the patient has been under section for over three months a T2/T3 (Consent to treatment) form should be in place that will restrict what medication can be administered to that patient. This includes any psychotropic medication including regular or PRN and medication used to treat side effects, it does not include unrelated physical health medication. In emergencies patients can be treated under an emergency section 62 that has to be authorised by a consultant.

Mental Capacity Act 2005

- Applies to all people in England and Wales over 16yrs old
- Statutory Principles:
    1. **A presumption of capacity**
    2. **All practicable steps to help support the individual make their own decision**
    3. **Respect unwise decisions**
    4. **Best interests**
    5. **Least restrictive option**
- When capacity may be lost in future:
    - Court of Protection
    - Power of Attorney
    - Advance Decisions and Advance Statements
- Deprivation of Liberty Safeguards (DoLS)
- Independent Mental Capacity Advocate (IMCA)
- 2-stage test of assessing capacity:

    Stage 1. Do they have an impairment / disturbance in the functioning of their mind or brain?

    Stage 2. The patient should demonstrate an ability to do all four elements of capacitous decision making (on the balance of probabilities):
    - Understand information given to them
    - Retain that information long enough to be able to make the decision
    - Weigh up the information available to make the decision
    - Communicate their decision
- Remember:

    Capacity can fluctuate, even over the course of a single day

    Assessment is decision and time specific

    Anyone with capacity can refuse medical treatment, nobody can legally demand it

7. General work information

Junior Doctor Forum

The junior doctor forum is a construct created by the 2016 contract as a forum to raise any work related issues and share good practice. Dates are released in advances and occur monthly at different locations. This will be attended, where possible, by the Director of Medical Education, Medical Staffing and the Guardian of Safeworking, who is responsible for contractual issues related to junior doctors.

Exception reporting

Initially speak to supervisor, manager and medical staffing to try and resolve informally.

Log exceptions if:

- If cannot be resolved informally
- **If there is an immediate safety concern** – (Trust Datix should also be completed)
- If it is a repeated incident
- A doctor's training is being affected

How to log an exception report:

- Access: https://www.healthmedics.allocatehealthsuite.com/Core/Account
- Obtain log in from medical staffing
- 'My Exceptions' tab
- 'Create New Exception'
- Select the rota the exception report refers to from the drop down box
- Select the supervisor's name
- Select the exception type
- Complete the date and time of the exception
- Complete any relevant information in the free type boxes

Raising a concern

Any concerns can be brought to your clinical or education supervisor. If these concerns are not resolved medical staffing, the Director of Medical Education or the Guardian of Safeworking can be contacted depending on the issue.

Complaints

All complaints should be directed towards the Patient Advice and Liaison Service (PALS) for support for the patient, their friends and family as well as for staff involved. Discuss with line manager, educational and clinical supervisor for support and advice.

Mentoring

All new CT1s should be allocated a mentor who is usually a Core Trainee a year or two above them. Areas where a mentor may be able to support the mentee includes:

- Setting up and queries with the e-portfolio, including workplace-based assessments (WPBAs)
- Annual Review of Competence Progression (ARCP) requirements
- Practical issues or other queries about on-calls
- Difficult situations with colleagues
- Difficult situations with patients (in addition to support from clinical supervisor)
- Deciding placement preferences for Core Training rotations
- Difficulties with personal life, physical and mental wellbeing that are affecting work

Lone working

See intranet for policy Q17 'Lone Working'. It is defined as:

"Any situation or location in which someone works without a colleague nearby; or when someone is working out of sight or earshot of another colleague. Lone working is not unique to any particular group of staff, working environment or time of day."

Situations where a junior doctor should take extra care may include:

- Seeing a patient alone in a room on the ward or in clinic (use of alarm, telling someone where you are, sitting by the door, etc.)
- Travelling to and from a ward on an evening or night on-call (driving to each ward is advised when it is dark, and telephoning when en-route so they know to expect you)

The policy details advice on key areas such as:

- Letting other staff know of your whereabouts beforehand
- Updating your Outlook diary
- Having a charged mobile phone on you at all times
- Code words in an emergency (e.g. "Cancel my appointments for the rest of the day" followed by "Do you need assistance?")
- Tips for vehicle safety
- Safety on foot

Leave

- **Absence reporting for sick leave**
  Your clinical supervisor and covering colleague should be notified if you are not able to attend your shift on a normal working day. Medical staffing should also be contacted if you are on-call so they can find cover. Medical staffing is not available on weekends and, in this case, switchboard should be contacted. If Foundation or GP trainee you should also inform your employing organisation.

- **Annual leave**
  Annual leave should be signed off by your clinical supervisor. Ensure the appropriate portion of annual leave is used each placement. Please discuss with your supervising consultant prior to rotating if there are any outstanding days you wish to carry over.

  Everyone scheduled to work a normal day is off for national bank holidays unless they are scheduled to work an on-call shift.

Queries regarding allocation of annual leave should be directed to medical staffing.

Expenses

- **Study leave**
  All trainees (beyond FY1) are allocated 30 days of study leave per year. Mandatory regional teaching / training days are included in this

- **Study budget**
  See intranet for *'Study Leave Form – Doctors in Training'*. This needs completing with the details of the event / course / conference etc., including signatures from Educational and Clinical Supervisors. Then email to: education.development@nsft.nhs.uk. As of April 2018, the study budget has been centralised within HEE. Courses up to £600 for curriculum requirements as defined by the Deanery can be signed off by your supervisor. For any Aspirational Activity, or courses more than £600, the approval of the TPD will additionally be required using the form on the Deanery website.
  Also see further guidance here: https://heeoe.hee.nhs.uk/Study_Leave

- **Travel reimbursement**
  You need to complete a P9 form that can be found on the intranet under *"Confidential - Staff Appointment Form"*, this needs to be signed by your line manager then sent to payroll

8. Teaching and training

Supervision for all trainees (including foundation doctors and GP trainees) is held weekly for an hour by your clinical supervisor at a time that is convenient. This is a space for you to ask questions, develop your knowledge and highlight personal or clinical difficulties or concerns.

RCPsych Portfolio
All psychiatry trainees will need to subscribe to the eportfolio on the Royal College of Psychiatrists website, which is as follows: http://www.rcpsych.ac.uk
This is charged at an annual rate.

Annual Review of Competence Progression(ARCP)
This review is conducted by an official panel with trainees in attendance following a review of your online portfolio around May - July each year. This is a nation progress and requirements can be found on the Royal College website.

Workplace Based Assessments (WPBA)	**CT1**	**CT2**	**CT3**
Assessment of Clinical Expertise (ACE)	2	3	3
Mini-Assessed Clinical Encounter (mini-ACE)	4	4	4
Case Based Discussion (CBD)	4	4	4
Direct Observation of Procedural Skills (DOPS)	Not required		
Multi-Source Feedback (MSF)	2	2	2
Case Based Discussion Group Assessment (CBDGA)	2	Not required	Not required
Structures Assessment of Psychotherapy Experience (SAPE)	Not required	1	1
Case Presentation (CP)	1	1	1
Journal Club Presentation (JCP)	1	1	1
Assessment of Teaching (AoT)	Not required		

Core Training Requirements
- ARCP requirements as above
- Completion of 12 months in general adult psychiatry and 6 months in old age psychiatry.
- Emergency case log of 55+ cases
- ECT competencies

MRCPsych Teaching
MRCPsych teaching for psychiatry trainees takes place most Tuesdays from 10am-5pm at Fulbourn hospital in Cambridge. A timetable will be sent out at the start of each term. Attendance is mandatory.

9. Area specifics

NSFT Services

The Trust is divided into localities as follows:

- Central Norfolk (CN)
- Child Family and Youth Pathway (CFYP)
- East Suffolk (ES)
- Great Yarmouth and Waveney (GY&W)
- Secure Services (SS)
- Suffolk Access and Assessment (A&A)
- Suffolk Rehab and Recovery Services (SRRS)
- Wellbeing
- West Suffolk (WS)
- West Norfolk (WN)

Sites postcodes and maps:

Site	Postcode	URL
Hellesdon Hospital, Norwich	NR6 5BE	see map
Julian Hospital, Norwich	NR2 3TD	see map
Norvic Clinic, Norwich	NR7 0HT	see map
Northgate Hospital, Gt Yarmouth	NR30 8BU	see map
Carlton Court, Lowestoft	NR33 8AG	see map
Fermoy Unit, King's Lynn	PE30 0WF	see map
Woodlands, Ipswich	IP4 5PD	see map
Walker Close, Ipswich	IP3 8LY	see map
St Clements Hospital, Ipswich	IP3 8LS	see map
Wedgwood House, Bury St Edmunds	IP33 2QZ	see map

Norwich

■ Hellesdon Hospital (CN)

Site:

- **Thurne** – Acute admission ward (Male and female)
- **Glaven** – Male acute ward
- **Rollesby** – Psychiatric intensive care ward (PICU)
- **Waveney** – Female acute ward
- **Whitlingham** – Female medium and low secure forensic ward
- **Yare** – Male forensic ward
- **Mother and Baby Unit** (as of January 2019) – 12 beds, may be asked about obstetric and neonatal concerns so will need to consider core (e.g. resus) competencies and liaise with NNUH colleagues as required

Parking:
Free parking available on site.

On-call room:
Junior doctor room located on site with computers and tea making facilities, key accessible from reception.

■ Julian Hospital (CN)

Site:

- **Sandringham** – acute functional, **Beach** – acute organic
- **Rose** – community
- **Reed** – community

Parking:
Free parking permits can be obtained for staff parking during normal working hours.

On-call room:
Oncall room on site, key accessible from Hellesdon reception.

■ Norvic Clinic (SS)

Site:

- **Male medium secure forensic unit**

Please follow the procedure – No keys, bags or mobile phones are allowed on the unit. Please inform switchboard you are there so that you can continue to be contacted if needed. Electronic prescribing is used (EMA) – Out-of-hours you can use paper prescribing if you do not have access.

Parking:
Free parking is available on site.

On-call room:
No on-call room located on this site.

On-call Shift Pattern - Norwich Tier 1:
Weekend day on-calls: 09:00 – 21:30, handover 09:00.
Evening on-calls (Mon-Fri, excluding bank holidays): 17:00 – 21:30, handover 21:00.
Nights: 21:00 – 09:00

There are two people on-call for Norwich during the evening on-calls and weekend day on-calls. It is divided into Line 1 and Line 2. Line 1 covers the Hellesdon site, and line 2 covers the Julian hospital, the Norvic clinic and A&E if extra support is required. On nights these sites are covered by one person.

Norwich local teaching:
Thursdays: 13:00 – 15:00
Balint group is held weekly on Tuesdays 15:00 – 16:00 at Hellesdon Hospital, this is mandatory for CT1 doctors, but foundation doctors and GP trainees are also welcome. Senior balint group (for CT2 and above) has started being held monthly on Tuesday 14:00 – 15:00 as per availability. Psychotherapy supervision is carried out for CT2-CT3s who are undertaking long case psychotherapy on Thursdays, 15:30 - 17:00 in Spixworth, Norwich

Great Yarmouth and Waveney

■ Great Yarmouth (GY&W)

Site:

- **Northgate hospital** – One mixed adult acute ward

Parking:
Free parking is available on site.

On-call room:
Oncall room situated in Flat 6, key to be collected from Northgate reception at the start of rotation.

■ Lowestoft (GY&W)

Sites:

- **Laurel** – Old age cognitive impairment
- **Fernwood** – Old age female ward
- **Foxglove** – Old age male ward
- **Dragonfly unit** – Adolescent ward (CYFP)

Parking:
Free parking is available on site.

On-call room:
No on-call room located on this site.

On-call Shift Pattern - Great Yarmouth / Lowestoft Tier 1:
Weekend day on-calls: 09:00 – 21:15, handover 09:00.
Evening on-calls (Mon-Fri, excluding bank holidays): 17:00 – 21:15, handover 21:00
Nights: 21:00 – 09.00

Local teaching:
Wednesday 1-2pm at Northgate Hospital

King's Lynn

Site:
The Fermoy Unit – Acute mixed ward (WN)

Parking:
Free parking is available on site.

On-call Shift Pattern – Kings Lynn Tier 1:
Weekend day on-calls: 09:00 – 21:15, handover 09:00
Evening on-calls (Mon-Fri excluding bank holidays): 17:00 – 21:15, handover 21:00
Nights: 21:00 – 09.00

Local teaching:
Thursday 12:30 at the Fermoy Unit

East Suffolk

Sites:

- **Woodlands Unit, Ipswich Hospital:**
  Poppy Ward – Adult acute
  Avocet Ward – Adult acute
  Lark Ward – PICU
  Willows Ward – Old age
- **Walker Close:**
  Bungalow 3 – Male neurodevelopmental
  Bungalow 4 – Female neurodevelopmental
- **St Clement's site (Foxhall Road):**
  Suffolk Rehabilitation and Recovery Service
  Foxhall House – Low secure forensic unit

Parking:
On call doctors can obtain a parking permit from Woodlands reception that enables parking in any car park (staff and patient) on the Ipswich Hospital / Pearson Rd site, with the exception of the green, yellow and disabled parking bays. There is free parking available at the old St Clement's site.

Local teaching:

- Takes place on Thursday afternoons
- Balint group is held from 12:30 to 13:30 in the large meeting room in Woodlands
- The Academic programme starts at 14:00 in rooms 7 and 8 in the Education Centre in Ipswich Hospital

On-call room:

- Junior doctor's office is located off reception at Woodlands
- Kitchen facilities are located in the shared services corridor
- The Trust is in the process of renovating an on-call flat on Pearson Road for use after hours

On-call Shift Pattern - East Suffolk:

- Weekend / bank holiday day on-calls: 09:00 – 21:15, handover at 09:00 and 21:00
- Evening on-calls (Mon-Fri excluding bank holidays): 17:00 – 21:15, handover at 21:00
- Nights: 21:00 – 09:00, handover at 21:00 (handover at 09:00 only on weekends / BH)
- It is the responsibility of the doctor starting shift to contact the doctor on shift via switchboard to arrange handover
- This is a resident on call-duty and doctors should be based on the Woodlands site

West Suffolk

Site:

- **Wedgwood House:**
  Northgate Ward – Adult acute
  Southgate Ward – Adult acute
  Abbeygate Ward – Old age

On-call room:
Located at Wedgwood House

On-call Shift Pattern:
West Suffolk Tier 1 (GP, F2 and CT1-3)
Full shift doctors need to be based on site
Weekend day on-calls: 09:00 – 21:15, handover 09:00
Evening on-calls (Mon-Fri excluding bank holidays): 17:00 – 21:15, handover 21:00
Nights: 21:00 – 09:00

Suffolk Tier 2 Countywide (ST4-7 and SAS) on-call Weekdays 17:00 to 09:00, weekends 09:00 to 09:00

On-call Information:
It is the responsibility of the doctor starting shift to contact the doctor on shift via switchboard to arrange handover. Handover may be by telephone between shifts.

In the event that out-of-hours duties can not be covered Tier 2 doctors may need to step down to Tier 1 full working shift.

Compensatory off days – If you work a daytime on-call over the weekend the Thursday before and Monday after are compensatory off days. If you work nights over a weekend the Thursday before and Tuesday after are compensatory off days.

An oncall registrar and / or consultant will also be available at all times via switchboard.

10. Useful Numbers

Medical Staffing:
Tel: 01473 266386
medical.staffing@nsft.nhs.uk

Education and Development:
Tel: 01603 421541
education.development@nsft.nhs.uk

ICT Service Desk:
Tel: 01603 421284
itservicedesk@nsft.nhs.uk

Hellesdon Hospital main reception and Trust-wide switchboard:
Tel: 01603 421421

Guardian of Safe Working Hours:
Dr Chris Jones
GuardianOfSafeWorking@nsft.nhs.uk

Director of Medical Education:
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Notes

Norfolk and Suffolk NHS Foundation Trust values and celebrates the diversity of all the communities we serve. We are fully committed to ensuring that all people have equality of opportunity to access our service, irrespective of their age, gender, ethnicity, race, disability, religion or belief, sexual orientation, marital or civil partnership or social and economic status.

Patient Advice and Liaison Service (PALS)

NSFT PALS provides confidential advice, information and support, helping you to answer any questions you have about our services or about any health matters.

IN TRAN® communication for all

If you would like this leaflet in large print, audio, Braille, alternative format or a different language, please contact PALS and we will do our best to help.

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