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Quality and Regulation Team (London and South East)

North Middlesex University Hospital NHS Trust Foundation Focused visit

Quality Visit Report

16 March 2016

Final Report

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Visit Details	
Trust	North Middlesex University Hospital NHS Trust
Date of visit	16 March 2016
Background to visit	At the time of the visit there were 42 foundation year one (F1) trainees and 45 foundation year two (F2) trainees. The Trust was last visited for a specialty focused visit with foundation trainees in surgery, medicine and emergency medicine (EM) on 9 October 2014. There were a substantial number of actions still open for foundation from this previous visit at the time of the 16 March 2016 visit. The visit team was keen to explore issues that had been highlighted in the General Medical Council National Training Survey (GMC NTS) for 2014-2015 as well as the outstanding open actions from the previous visit and to ascertain how far these had been resolved. The Trust generated 40 red outliers in the GMC NTS in 2014-2015, including 23 for foundation training. These were made up of 11 for EM F2 (a triple red recurring outlier for 'clinical supervision' as well as 'handover' and a double red outlier for 'access to educational resources'), three for medicine (F1 and F2) and nine for surgery (F1 and F2). Regarding the triple red outlier for F2 'clinical supervision' in EM, 50% of trainees felt they were supervised by someone who was not competent on a weekly basis and 79% of trainees felt forced to cope with problems beyond their experience on a daily or weekly basis. Furthermore, the red outlier for 'clinical supervision out of hours' in EM for F2s found that 64% of trainees felt they were supervised by someone who was not competent on a daily or weekly basis, 93% of trainees felt forced to cope with problems beyond their experience on a daily or weekly basis and 36% of trainees rated the quality of supervision as 'very poor' or 'poor'. The triple red outlier for 'handover' in EM for F2s demonstrated that 64% of trainees reported that before a night duty the handover was informal, a further 21% of trainees reported there were no arrangements and 50% of trainees reported that after a night duty the handover was informal. Furthermore the red outlier for F2 'workload' in EM found that 93% of trainees rated the intensity of work as 'heavy' or 'very heavy' by day and night and that 86% of trainees had worked beyond their contracted hours on a weekly or daily basis.
Visit summary and outcomes	The visit team would like to thank the Trust for accommodating the visit. The visit team met with 20 F1 trainees from a range of specialties including endocrinology, renal medicine, gastroenterology, respiratory medicine, cardiology, geriatric medicine, trauma and orthopaedics, urology, general surgery, colorectal surgery, psychiatry and paediatrics. Furthermore, the visit team also met with nine F2 trainees from specialties including emergency medicine, paediatrics, renal medicine, trauma and orthopaedics and geriatric medicine. Furthermore, the visit team met with the director of medical education (DME) and two foundation training programme directors (FTPD). Each FTPD covered a particular remit with one covering general surgery and trauma and orthopaedics, another covered paediatrics, emergency medicine, obstetrics and gynaecology, and finally geriatric medicine and general practice. The visit team also met with 17 educational and clinical supervisors from a range of specialties including general surgery, stroke medicine, gastroenterology, obstetrics and gynaecology, geriatric medicine, rheumatology, acute medicine, renal medicine, histopathology and trauma and orthopaedics. The visit team appreciated the very open, honest and insightful conversations it was able to have with both supervisors and trainees. The overall feeling from the whole team was that there was a tangible improvement in many areas in the light of a challenging work environment. The visit team heard however that there were serious concerns regarding foundation training, including: • A lack of feedback and learning from incident reporting. The culture and support around incident reporting needed to be significantly improved. The visit team found that trainees were actively discouraged from using Datix and that the culture around incident reporting was not one of openness. • Reports from all of the trainees that the porter service at the Trust was extremely poor, especially regarding taking patients to the radiology department for chest x-radiation (x-ray) scans. Trainees often transported patients to the radiology department themselves. This was an on-going

	problem that was found at the previous visit in 2014 and had not since been resolved. • The phlebotomy department was 'not fit for purpose' and that out of 15-20 daily requests for blood work, four or five were completed. This meant that the physician assistants on the wards completed the majority of the blood work. However, many of these posts were due to be withdrawn at the end of March 2016. Additionally, there were various areas for improvement highlighted by the visit team which included: • The steep hierarchy that existed between senior and junior staff members in some areas. There was also a lack of recognition, in some areas, to the barriers to getting F1 jobs completed. • There were areas within specialties that had a serious lack of supervision, including a lack of regular consultant-led ward rounds (this was principally in the ED and in one of the geriatric medicine teams). There was a lack of supervision within the ED at night and within psychiatry with learning disabilities. • The visit team heard that workload was extremely high especially within the ED, geriatric medicine, gastroenterology and areas of surgery. There were concerns raised over the diary card monitoring exercise that had been completed in January 2016, primarily in general surgery. • The trainees advised the visit team that there were various barriers to working, including: ➢ A lack of clinical prioritisation of scans, with at least one reported patient safety issue. ➢ An inability to transfer patient notes onto a computerised system following discharge. There seemed to be no beneficial impact of investment in the electronic patient record system throughout the Trust. ➢ An issue of 'bouncing work' within the radiology department with no clear pathways for working and a lack of personal responsibility and accountability. • The visit team heard that there were inconsistencies in the quality of handover due to poor IT systems. At times when general surgical trainees covered trauma and orthopaedic surgery (T&O) at night, handover was felt to be especially weak. • There were reports within geriatric medicine that senior consultant review was non-existent in one team. There were areas within general surgery and trauma and orthopaedics where consultant ward rounds could be unexpected and ad hoc. The visit team also heard that in general consultants, higher trainees and nursing staff were supportive across specialties. Paediatrics was noted as an especially well organised department and the T&O department received good feedback for supervision and experience. All of the foundation trainees noted that the Director of Medical Education, Nick Rollitt, was supportive and approachable. It was noted that despite issues within the radiology department in general, radiologists were supportive of foundation trainees and open to receiving requests from them.

Visit team			
Lead Visitor	Dr Dan Farrar, Director, North Central Thames Foundation School	**External Representative**	Dr Ritwik Banerjee, Foundation Programme Director
Foundation School Administrator and Data Manager	Tereze Bogdanova North Central Thames Foundation School	**Trainee Representative**	Dr Simrit Nijjar, North East Foundation Training School foundation year two trainee representative

Lay Member	Jayam Dalal, Lay Representative	**Scribe**	Kate Neilson, Learning Environment Quality Coordinator
GMC Representative	Alexandra Blohm, Education QA Programme Manager, Visits and Monitoring Team, Education and Standards Directorate		

Findings			
Ref	**Findings**	**Action and Evidence Required.** **Full details on Action Plan**	**RAG rating of action**
GMC Theme 1) Learning environment and culture			
F1.1	**Patient safety** The visit team heard from the foundation year one and year two trainees (F1 and F2) that there were significant concerns around patient safety in various areas. Regarding the phlebotomy service, especially within the Tower Block, there was a lack of responsibility around the urgency of some blood work and trainees reported that out of 15 to 20 requests per day, only five were completed. The F1 trainees reported that most days there were a couple of urgent requests that had been overlooked. The phlebotomy team did not notify the patients' teams that they did not bleed them, which caused extra delays, as the teams usually did not realise until early afternoon which bloods had not been done, delaying clinical decision making. As a result of the unreliability of the phlebotomy service, physician assistants on the wards carried out the majority of the blood work although funding for some of these posts was due to cease in March 2016. There was concern around who would carry out this work once this funding had been withdrawn. The F1 and F2 trainees confirmed that they had good working relationships with the radiologists at the Trust and that radiologists were receptive to receiving requests from foundation trainees. However there were issues with the porter system and prioritisation of scans within the radiology department. It was reported that foundation trainees had to transport patients to the radiology department for urgent x-rays up to four times a day due to a lack of porters for x-ray. This was due to the fact that magnetic resonance imagining (MRI) and computerised tomography (CT) scans were higher priorities than x-rays so x-rays, even those marked as urgent were regularly delayed for more than 24 hours. The trainees noted that these instances happened too often to complete a Datix form each time. Furthermore, the foundation trainees informed the visit team that the radiologists appreciated these problems. There was at least one incident reported where a patient had waited three days to receive a chest x-ray which was a patient safety concern. The foundation trainees informed the visit team that there were no standardised guidelines or Trust policy for	The Trust is required to confirm the Trust policy on checking the nasogastric (NG) tube placement with the foundation trainees, including who makes the final decision on this. This was a requirement from the previous visit	Mandatory Requirement

	chest x-rays, and the correct placement of nasogastric (NG) tubes and who should make this decision. There was a lack of clarity around whether this was decided by a consultant or a higher trainee. The visit team heard from the foundation trainees that the Trust operated paper-based systems for patient notes, ordering blood work and prescribing. The foundation trainees raised concerns around the fact that there was no easy access to patient notes once they had left the North Middlesex Hospital site and these could take up to a week to be returned. This meant that there was no access to post-operative notes should the patient be re-admitted following discharge. The visit team was informed by the foundation trainees that these issues were easy to rectify by streamlining processes but that there was an endemic culture across the Trust that was adverse to change. However it was noted that an electronic patient record system was being rolled out within the radiology department. The visit team heard from the educational and clinical supervisors that from 16 March 2016, all x-ray requests were due to be computerised, which should help to resolve the issues. The visit team were informed by the F2 trainees that within the ED there were various direct and indirect patient safety concerns. These related to the high levels of patients and a lack of senior clinicians as well as broken and missing equipment, a lack of drugs, computers, printers and sticker machines not working which caused delays. The trainees noted that it would have been useful to have a consultant or middle grade Trust doctor available within the ED at night to support and give advice rather than see patients.	and has still not been resolved.	
F1.2	**Serious incidents and professional duty of candour** The visit team heard that although foundation trainees regularly reported incidents, including serious incidents, via Datix there was a complete lack of feedback and learning from serious incident (SI) reporting. It was also noted by foundation trainees that there was no induction to Datix. The visit team was informed that the culture around incident reporting was not one of openness and that there were numerous reports of foundation trainees being actively discouraged from using Datix to report incidents and in some cases, were berated for having done so. In cases where foundation trainees had received feedback from Datix submissions, the responses were usually very brief and did not address the issue. Furthermore, foundation trainees reported that they had also emailed consultants with concerns that were either not responded to or they were told 'that's how it happens at North Middlesex'. There were also reports from F1 trainees who had been involved in serious incidents that they had received no support, including pastoral support, or feedback from senior clinical colleagues.	The Trust is required to review the culture and support surrounding incident reporting. This must include an urgent investigation into the recent incident involving three F1 trainees. There should be an investigation of the support received by trainees and the governance process of reporting and escalation when an adverse incident involving trainees occurs.	Mandatory Requirement
F1.3	**Appropriate level of clinical supervision** The visit team heard from all of the F1 and F2 trainees that the frequency and quality of clinical supervision was variable. It was noted that there was more clinical supervision during the day on weekdays than at night or weekends, due to the fact that there were more consultants available		

	onsite during these times. Furthermore, between the hours of 9am to 5pm on weekdays there was usually at least one consultant per department onsite for the foundation trainees to contact, if required. After 11pm on weekdays there was no consultant onsite but there was at least one Trust middle-grade doctor in the ED. However, some foundation trainees noted that the Trust middle-grade doctors in the ED were of varying competency so would only approach particular individuals. It was noted that the foundation trainees with experience of EM could also contact senior colleagues within other specialties for advice and they were generally supportive and willing to help, although could not always physically see the patient so were dependent upon phone advice. The foundation trainees with experience of EM reported that seeking advice from other departments when working in the ED was extremely time consuming and that they often felt unsupported due to the lack of senior supervision. The visit team heard that there had previously been a resident paediatric higher trainee within the ED but at the time of the visit, this was no longer the case. At the time of the visit, there was a paediatric consultant available within the ED on weekdays between the hours of 2pm and 10pm but outside of these times there was no senior paediatric supervision available. As a result, F2 trainees were required to make decisions around discharging patients despite the fact that they may not have had paediatric experience. The foundation trainees reported that there were clinical guidelines and pathways to be followed in these instances. F1 trainees within respiratory medicine and gastroenterology reported that clinical supervision was good when they had it but that it was intermittent. Furthermore, these trainees noted that they often reviewed patients by themselves which was intimidating at first but that at the time of the visit they were four months into their placement so were used to it by then. Regarding the respiratory ward, it was noted that this was split into two and that a consultant visited every day but only one half of the ward. The trainees reported that regarding gastroenterology, higher trainees spent a lot of time in the endoscopy clinic so were not available on the ward. The visit team heard that three of the geriatric medicine teams were based on the Pymmes block and that each team was made up of an F1 trainee, F2 trainee, GP trainee, core medical training (CMT) trainee, higher trainee and a consultant. The visit team were informed that consultant supervision on one ward was very poor. There was a lack of decision making at a senior clinician level, patients were not regularly reviewed by consultants and that no full ward rounds had taken place in the four months prior to the visit. Additionally foundation trainees regularly missed teaching sessions as they could not leave the ward. These trainees reported that they had requested support from senior staff but that no plan had been put in place for this. As a result the trainees felt pressurised to stay past 5pm to ensure that all patients were seen, at least by the foundation trainees. However the visit team heard that there were instances where patients were not reviewed for up to four days. The foundation trainees reported that this environment was extremely stressful and that they rarely left the ward on time in four months. Although they should have finished at 5pm, they usually left between 6pm and 6.30pm or 8pm at the latest. It was also noted that trainees on the Pymmes block felt isolated and that there was not much cross-cover between wards as each ward had its own consultant. It was widely recognised that trainees	The Trust is required to investigate and improve the situation on the geriatric ward within the Pymmes block so that foundation trainees are adequately supported.	Mandatory Requirement

	covering one of the geriatric wards received poor consultant support. The foundation trainees advised the visit team that the staffing levels on the ward in question had improved within the previous three weeks prior to the visit in comparison to the three months before that. It was reported that the foundation trainees within psychiatry learning disabilities did not have access to supervision from a clinical or educational supervisor and only had access to a higher trainee and nursing staff. The visit team heard that the trainees on the acute medical wards felt supported and that there was always at least one consultant as well as a higher trainee available on the ward. Similarly, the cardiology service was very senior-led so the F1 trainees reported that they did not get experience of clinical work such as taking histories and tended to complete administrative work instead. The renal medicine F1 trainees stated that they received sufficient clinical supervision and that there was usually a consultant available on the ward. Moreover ward rounds were usually consultant or higher trainee-led but could be foundation trainee-led, if neither consultants nor higher trainees were available.	The Trust is required to review the consultant clinical supervision arrangements within psychiatry (learning disabilities). This may require re-location of foundation trainee attachment to another area within psychiatry.	Mandatory Requirement
	The visit team heard from the F1 trainees within general surgery that not all consultants did regular ward rounds but would do ad hoc rounds with minimal prior warning. The trainees within general surgery confirmed that clinical supervision was available most of the time and that they could usually contact a higher trainee. It was reported by the trainees within T&O that they had regular ward rounds and senior clinicians were supportive and approachable. Regular weekday ward rounds were held within the urology department with a higher trainee-led ward round every morning as well as consultant-led ward rounds a few times a week. At weekends ward rounds within the urology department were unstructured. The foundation trainees within paediatrics informed the visit team that there was a consultant-led ward round every day including at weekends and that clinical supervision within the specialty was good. All of the foundation trainees reported that clinical guidelines were accessible through the Trust's intranet but that it could be time consuming to find relevant information as some documents were over 90 pages long. These trainees suggested that a summary page would be helpful to simplify these documents. It was also noted that there were no guidelines for acute care common stem (ACCS) or for Non ST-segment elevation myocardial infarction (NSTEMI). Moreover the foundation trainees felt that the antibiotic guidelines were not detailed enough. The visit team heard from the educational supervisors that the antibiotic guidelines were particularly good and that NSTEMI guidelines were available on the intranet. Furthermore the visit team heard that the foundation trainees had not received a junior doctors' handbook, which the trainees felt would have been helpful especially at the beginning of their placements. The visit team was informed by the F1 trainees that they found the Dr Toolbox inaccessible as the interface at North Middlesex University Hospital NHS Trust was inadequate. The foundation trainees noted that staff members at all levels and across specialties were approachable. The F1 trainees stated that the higher trainees within surgery were particularly	The Trust is required to review the timetable for surgical consultant ward rounds to ensure that these are planned and structured.	Mandatory Requirement

	supportive. Moreover, it was noted that the DME knew all of the F1 trainees and was extremely approachable and supportive.		
F1.4	**Responsibilities for patient care appropriate for stage of education and training** There were numerous reports from both F1 and F2 trainees that they were given responsibilities and carried out tasks well beyond their level of training and competence. The visit team heard that there were instances when F1 trainees had been asked to perform incisions, drainage, and site markings by higher trainees. Additionally there were reports of F1 trainees being asked to administer cytotoxins. All of the trainees informed the visit team that they had declined these requests. The visit team heard that F1 trainees had administered methotrexate under the supervision of a consultant. The visit team confirmed to the trainees that all of the duties outlined above were inappropriate for foundation trainees to perform. It was noted that F1 and F2 trainees did perform site markings but only under close supervision from a consultant. Additionally there were also reports from F2 trainees that they had covered the ED out of hours without adequate supervision, including senior staff onsite not responding to calls or bleeps and consultants refusing to travel to the ED. This then led to F2 trainees performing primary examinations on patients, despite not being trained to do so. It was confirmed that foundation trainees would complete a Datix form in these instances.		
F1.5	**Taking consent** The visit team was informed by the F1 and F2 trainees that there were instances where they had been asked to consent patients for procedures (e.g. endoscopy) by consultants and higher trainees, despite the fact that this was above their level of competence and experience. In all cases the foundation trainees confirmed that they declined these requests which the visit team confirmed was appropriate for them to do.	The Trust is required to provide clarity on the roles and responsibilities of foundation trainees. This should include the following: • Trust to email foundation trainees and supervisors reminding them of the restrictions. • Trust to display a printed copy of guidelines in all relevant departments. • Trust to install reminders “F2 and above only” on hospital prescription system.	Mandatory Requirement
F1.6	**Rotas** The visit team heard that workload was extremely high for both F1 and F2 trainees, especially within the ED, geriatric medicine, gastroenterology and areas of surgery. The majority of trainees confirmed that they worked late on a regular basis in order to finish tasks. The foundation trainees often stayed until 8pm instead of 5pm, as they did not want to hand over duties to the on call foundation trainees, as they had their own workload. Trainees within paediatrics confirmed that the situation was better there than elsewhere as there was a robust handover system and that there was a consultant onsite until 10pm every day. At the time of the visit, the department was understaffed due to maternity leave, and there was difficulty obtaining a locum to provide cover so		

	it was hard for foundation trainees to take annual leave. The visit team was informed by the F1 and F2 trainees that although the rotas were fully European Working Time Directive (EWTD) compliant, the reality of their working hours was very different. The F1 trainees raised concerns over the diary card monitoring exercise that had been completed in January 2016 which had concluded that trainees' working hours were EWTD compliant. However the F1 trainees reported that regarding general medicine, the monitoring exercise took an average time across departments despite the fact that some sub-specialties were much busier than others. Moreover trainees were called on the wards and told to go home at 5pm during the monitoring exercise and extra consultants, higher trainees and physician assistants were available on the wards during this time which skewed the results. Trainees felt that they had received accusations of inefficiency leading to late finishes. The foundation trainees raised concerns around the coordination of the medicine rota as it was a rolling rota across 12 months rather than four months so some trainees did more on call and had less rest days than others. It was noted that this was not such an issue with the surgical rota. The educational and clinical supervisors confirmed that the rota coordination was carried out in a robust manner including long meetings with trainees, the rota coordinator and a consultant breast surgeon to ensure that it met the EWTD and in order to minimise clashes. It was noted that the rota was worked out on a 12 month rolling basis as it would have been too complicated to do it over a four month period. The visit team heard that there were plans in place to ensure that trainees received the surgery rota six weeks in advance, rather than three weeks. The F2 trainees advised the visit team that the workload within the ED was unmanageable which was due to the fact that there were too many patients in the first instance and that these patients were not moved out of the ED. Furthermore, there was no major or minor queue, no proper triage system and inadequate space to examine patients, with patients often being reviewed in corridors. The visit team heard that the nursing staff within the ED were very good and went above and beyond the call of duty. It was noted that there were times when there were no senior clinicians within the ED. It was noted that the Trust had not been able to investigate these instances due to lack of information. The DME advised the visit team that there were significant challenges within the ED due to the fact that it was the busiest ED in London and that there had been four vacancies at a consultant level for the previous two years. Furthermore, as a new management structure had recently been introduced at the time of the visit and a new clinical leadership team had been appointed, the DME was hopeful that the situation within the ED would improve and that the consultant vacancies would be appointed to. It was noted that consultant recruitment had been undertaken on several occasions but suitable candidates had not been identified. The visit team was informed by the trainees that the main barrier to foundation trainees leaving at 5pm was the time consuming issue around the lack of porters for x-ray, although the paper-based ordering systems and the phlebotomy issue were also factors. There was also a culture, especially within the radiology department, of a lack of personal responsibility and accountability for work and there were no clear pathways for duties. Furthermore, the foundation trainees advised the visit team that the endoscopy department was overwhelmed due to a backlog of	The Trust should conduct a diary card exercise to ensure compliance with EWTD for foundation trainees within medicine and EM. This should be carried out in collaboration with foundation trainee representatives to ensure that the exercise is a fair reflection of trainees' activities and hours worked. See report for Emergency Department review for actions regarding this issue.	Mandatory Requirement

	waiting times so requests were often lost and there was a lack of access to reports online. Regarding the high workload of foundation trainees within geriatric medicine specifically, the educational and clinical supervisors informed the visit team that this was due to the closure of the Chase Farm Hospital site, resulting in over 40 extra beds being opened at North Middlesex University Hospital with no additional funding. It was noted that while beds within other firms had been closed, it was more of a challenge for geriatric medicine as there was nowhere to transfer the patients. The patients received from the Chase Farm Hospital site were more elderly than the Trust had predicted. The visit team heard from the educational and clinical supervisors that more physician's assistants and pharmacists on the wards would help to ease the foundation trainees' workloads. Furthermore they advised that trainees should leave on time and not feel guilty about handing over duties. It was also noted by the educational and clinical supervisors that foundation trainees often missed out on learning opportunities as they did not give their supervisors sufficient notice of requests for specific procedures or duties they wished to receive training in. The foundation trainees advised the visit team that the system for requesting and approving x-rays was extremely inefficient and could be better streamlined. However the Trust was not receptive to improving this. The system was very time consuming and foundation trainees spent much time waiting outside examination rooms for consultants to sign paper request forms. There was no procedure to request an urgent scan in an emergency.		
F1.7	**Induction** The visit team heard that the foundation trainees had an induction at the beginning of the year based on the firm that they started in but not for subsequent firms. The F1 trainees noted that an induction to on call would be useful as the arrangements were not clear between firms. All of the F1 trainees reported that they knew who their educational and clinical supervisors were and that they were all on track with their ePortfolios. However there was no formal induction to the ePortfolio or how to link this to the foundation curriculum. The F1 trainees noted that they had had an informal session on the ePortfolio with an F2 trainee which was set up by this trainee and was not during bleep-free teaching.	The Trust is required to ensure that ePortfolios and serious incident reporting are included within the foundation trainees' induction.	Mandatory Requirement
F1.8	**Handover** The visit team heard from the F1 and F2 trainees that handover across specialties was variable in frequency and robustness. It was noted that there was no 5pm handover, except for within medicine on a Friday for the weekend handover. The F1 trainees informed the visit team that the weekend medicine handover was in the form of a Microsoft Access database and although this handover was useful as it itemised tasks, sometimes there was too much information (which F1 trainees entered themselves) and it was on an old system that was not available on newer computers within the Trust. Furthermore the visit team heard that there was an incident when there had been no access to this database at the weekend due to a server issue so the rota coordinator had since printed a hard copy at 5pm on a Friday.	The Trust is required to review the handover	Mandatory

	The visit team heard from the F1 trainees within urology and T&O that there was cross-cover between the specialties but that there was no formal weekend handover. The F1 trainees reported that there was a handover database within general surgery and a twilight telephone handover. Furthermore there was an 8pm daily handover meeting that trainees noted worked well. All patients within surgery were seen every day. There were isolated reports of patients being lost within surgery but it was not a systemic problem. The visit team was informed by the F1 trainees that the handover within the Acute Medical Unit (AMU) could be problematic due to the intense bed pressures within the department.	within urology and T&O.	Requirement
F1.9	**Protected time for learning and organised educational sessions** The F1 trainees informed the visit team that they had clinical teaching sessions once a week, although these had been cancelled once in every six weeks. It was noted that some of the teaching sessions were not pitched at the right level and that some sessions were irrelevant as too much time was spent on certain topics, including infection control, coding, discharge summaries. Although teaching was supposed to be bleep free, this was not always the case. The visit team heard from the F1 trainees that the Trust was more service driven which detracted from its educational provision. Regarding departmental teaching, the F1 trainees informed the visit team that the acute medicine teaching was good. However it was noted by the F1 trainees that there was no departmental teaching in general medicine and within surgery, the handover was considered part of teaching. The visit team heard that more than half of the F1 trainees within surgery would recommend the training programme at North Middlesex University NHS Trust and the rest were ambivalent. The F2 trainees within T&O would recommend the training programme. Furthermore, none of the F2 trainees within the ED would recommend the training.		
GMC Theme 3) Supporting learners			
F3.1	**Behaviour that undermines professional confidence, performance or self-esteem** The visit team heard from the F1 and F2 trainees that overall there was no evidence of a culture of bullying and undermining at North Middlesex University NHS Trust although there were isolated incidents of trainees being undermined, especially within the ED and general surgery. However the foundation trainees reported that there was a systemic culture of apathy and lack of responsibility within the Trust. The visit team also heard that staff morale within the Trust, and the ED in particular, was poor and that rates of sickness absence were high. It was noted by trainees within general surgery that there was a steep hierarchy between senior clinicians and trainees and a top-down approach to resolving issues which could be seen as undermining behaviour.	The Trust is required to review the steep hierarchy that exists within the Trust.	Recommendation

	The majority of foundation trainees confirmed that they were aware of the whistleblowing policy within the Trust but had concerns around using it as they felt they may not be supported in doing so. On a broader basis, trainees felt supported by their consultant and middle grade colleagues.		
F3.2	**Access to study leave** The foundation trainees informed the visit team that they were granted study leave, should they request it, but that they were reluctant to do so due to the staffing levels within the Trust.		
GMC Theme 4) Supporting educators			
F4.1	**Sufficient time in educators' job plans to meet educational responsibilities** The visit team heard that there were three Foundation Training Programme Directors (FTPD) at the Trust who each covered different areas that were made up of; general surgery, T&O; paediatrics, emergency medicine and obstetrics and gynaecology, geriatric medicine and general practice. It was noted that each FTPD received 1 programmed activity (PA). The clinical and educational supervisors confirmed that they each received 0.25 PAs per trainee with a maximum of four trainees which was found to be sufficient. They also noted that they attended Local Faculty Groups (LFGs).		
GMC Theme 5) Developing and implementing curricula and assessments			
F5.1	**Regular, useful meetings with clinical and educational supervisors** All of the foundation trainees noted that they had regular meeting with their educational supervisors to complete their ePortfolios. It was noted that some educational supervisors were more familiar with using the system than others and that foundation trainees often showed them how to use it. It was noted that a training session may be beneficial for them. The visit team heard that foundation trainees would escalate issues regarding their training to their educational supervisors, in the first instance.		

Good Practice	Contact	Brief for Sharing	Date

Other Actions (including actions to be taken by Health Education England)	
Requirement	**Responsibility**

HEE to provide further detail of the incident involving foundation doctors to the Trust Medical Director in order to support investigation.	Ian Bateman – Head of Quality and Regulation
Signed	
By the Lead Visitor on behalf of the Visiting Team:	Dr Dan Farrar
Date:	13 April 2016