NHS
Health Education England

North Central and East London

Foundation Year 2 Surgery

Programme Review (Trainee Focus Group)

Quality Review report

13 February 2019

Final Report

Developing people for health and healthcare

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Quality Review details

Background to review	This Programme Review of Foundation Year 2 (F2) Surgery across North Central and East London was held to explore the decline in feedback received in the General Medical Council (GMC) National Training Survey (NTS) for 2018. This review followed on from a 2017 review of F1 placements in Surgical departments. Given the recognised challenges faced by Foundation doctors transitioning from fully supervised practice to F2 year where a degree of independent practice was expected, the reviews team was particularly keen to explore trainees' experiences of best practice and identify areas for improvement in the learning environment. There were specific areas for comprehensive exploration relating to induction, clinical supervision – in and out of hours, and the impact of work load, team working, supportive environment and culture on education and training. It is anticipated that the recommendations from this review will be adopted across the region leading to sustainable improvement. The following Trusts were invited to participate: - Barking, Havering and Redbridge University Hospitals Trust; - Barts Health NHS Trust; - North Middlesex University Hospital NHS Trust; - Royal Free London NHS Foundation Trust; - University College London Hospitals NHS Foundation Trust; and - Whittington Health NHS Foundation A pre-review electronic survey was conducted, and responses received from 10 trainees. At the Trainee focus group, the review team met with 16 F2 trainees from the participating Trusts. Among the trainees the following Surgical subspecialties were represented: - Colorectal Surgery - General Surgery - Orthopaedic Surgery - Urology - Upper Gastrointestinal Surgery
Training programme / learner group reviewed	Foundation Year 2 Surgery across North Central and East London

Quality Review Team			
HEE Review Lead	Dr Indranil Chakravorty, Deputy Postgraduate Dean, North Central and East London	**Deputy Postgraduate Dean**	Dr Gary Wares, Deputy Postgraduate Dean, North Central and East London

Foundation School Director	Dr Keren Davies, North Thames Foundation School Director	**Head of School**	Mr John Brecknell, Head of School, London Postgraduate School of Surgery
Lay Representative	Kate Rivett, Lay Representative	**HEE Quality Team Representative**	John Marshall, Learning Environment Quality Coordinator
Observer	Chiraag Dave, Quality, Patient, Safety and Commissioning Officer	**Observer**	Ed Praeger, Deputy Manager, Quality, Patient, Safety and Commissioning Manager

Findings

GMC Theme	Summary of discussions	Action to be taken? Y/N
	The review was being undertaken to build an overall picture of the Foundation Year 2 (F2) trainee experience in Surgery rotations across North Central and East London. It was explained to the trainees that the review team was keen to explore common themes relating to the learning environment and collate examples of good practice with a view to developing a set of recommendations for all Trusts hosting F2 Surgery posts. In addition to meeting the generic goals or competencies for Foundation training, the best practice recommendations would be used as a benchmark to achieve excellence in educational and training experience and ensure that F2 Surgery posts were fostering both cohorts of trainees who either wished to pursue future Surgery training and those that may not. From a discussion that encompassed clinical supervision, induction, rota design, access to scheduled teaching, and curriculum coverage the unifying theme that emerged was the '*culture shock'* that was experienced in starting in an F2 Surgery post and the high level of responsibility and expectation on F2 trainees. This feeling was shared among trainees from all the Trusts represented in the group, particularly when working out of hours. It was also evident to the review team that the balance between filling a slot in a clinical rota vs utilising clinical exposure to provide education and training was heavily weighted toward the former, and that this imbalance was having a direct adverse effect on the training experience. Support for trainees at the very start of their rotations was the most prominent concern that the review team identified. Apart from the trainees that had previously completed a rotation in Emergency Medicine (EM), the trainees reported that they had had little pre-exposure to Surgery and working with surgical departments. Those that had worked previously in EM referred to their colleagues in EM as a source of 'secret support' and felt that they had been left to 'fend for themselves' in Surgical placements. It was felt among the trainees that the gulf in expectation and responsibility when moving from foundation year one (F1) to year two was particularly acute when moving into a Surgery rotation. The review team heard that the level of support, clinical supervision and expectations on F2 trainees was variable, and at times dependent on the middle-grade clinician but overwhelmingly perceived to be inadequate. When discussing working out of hours, many of the trainees reported that they were often unsure of the agreed escalation pathways around accepting referrals at night,	

	that it was at times difficult to identify a named consultant for deteriorating patients. Often the handover was inadequate, and in some cases trainees felt a great burden of clinical responsibility that was not commensurate with their competency or level of clinical experience. The review team was pleased to hear that there were examples of good practice from across the area, that if formulated into a cohesive standard operating procedure (SOP) would address trainee concerns and improve the quality of education and training for F2 surgery rotations. These included a phased entry to working out of hours whereby trainees would shadow a senior clinician for two to three shifts in order to orientate themselves with expected duties, handling of referrals received, and escalation pathways. Other examples of good practice included a named middle-grade doctor who, if not present on site, would call in at the beginning of the night shift to introduce themselves and familiarise themselves with any notable issues, offering the opportunity to seek help when needed; whilst in another department there was an effective Hospital-at-night style (multidisciplinary) meeting at the beginning and middle of each night shift to discuss patients and priorities. Regarding induction, the consensus among trainees from across all the Trusts represented, was that the departmental induction that they received, regardless of the subspecialty, did not adequately prepare them for their new roles. The review team were made aware of some trainees rostered to join the out-of-hours on call with no induction. It was also reported that Trust-wide inductions served more to facilitate the completion of statutory and mandatory training rather than cover relevant topics such as HR processes and addressing payroll issues, annual and study leave policies, and policies for exception reporting and reporting clinical incidents. Trainees reported being given a 100-page departmental induction document to read with little or no explanation and with little content that was perceived to be essential to their specific roles. Trainees also reported instances of being asked to complete lengthy online statutory and mandatory training modules, in their own time. Asked what the ideal departmental induction should include, the review team heard that a set of subspecialty-specific guidance that gave an insight into what tasks F2 trainees would be expected to encounter and carry out during a given rotation, would be hugely beneficial. It should also include agreed patient pathways, escalation processes, multi-specialty cross-cover arrangements, and effective, structured handover guidance. The review team was pleased to hear that one orthopaedic trainee had taken it upon themselves to develop a learning matrix for diagnosis and management of common fractures. It was felt that exercises like this, with the support of senior clinicians, could serve as a valuable quality improvement opportunity for F2 trainees to take a lead on for improving the future inductions for their successors. It was also reported that trainees would like their departmental induction to cover what theatre and clinic experience and specialty specific learning opportunities were available to them. The review team heard a wide range of differing experiences about theatre access. The majority of trainees had no access to attending operating theatres or clinics. None of the trainees were aware of theatre time being allocated on a regular basis in their job schedules. However, a clear majority of trainees reported extremely limited opportunities to access theatre experience across the area. There was one example where trainees were encouraged by consultants to get into theatre, if their other duties would allow. When trainees were able to attend a theatre session, they found it very	Yes, please see F2S 1 Yes, please see F2S 2 Yes, please see F2S 3 Yes, please see F2S 4

	supportive and a good learning experience. The review team did not hear of any examples where trainees had attended clinics.	
	The feeling among the trainees was that one protected theatre session per fortnight, if not weekly, would provide the theatre exposure that they felt was needed. This would be beneficial both to trainees either considering pursuing a career in surgery, as well as providing a vital learning experience for trainees who may not be keen on a career in surgery. Exposure to minor surgical procedures (eg suturing), and management of pre and post-surgical patients would be valuable to all.	Yes, please see F2S 5
	The review team heard that access to bleep-free scheduled local teaching sessions and regional Foundation School training days was variable. It was disappointing to hear that trainees frequently had to miss scheduled training due to clinical work load and due to the way that rotas were designed. Even when trainees could make it to teaching session these were not always bleep-free. There were several reported issues where trainees had encountered difficulty booking study leave.	Yes, please see F2S 6 Yes, please see F2S 7
	The review team explored the culture of the learning environment in general. Whilst it was pleased to hear that there were no reported incidences of obvious bullying and undermining, there was a broad agreement on the recognition of a culture of 'dressing down', across many surgical units, especially in handover settings.	
	The review team heard that all trainees expected to work regularly beyond their working hours as a direct effect of the work load and inappropriate timings or length of ward rounds, as well as having to completes clinical jobs following the ward round. It was reported that in some settings trainees were actively discouraged from exception reporting as this apparently demonstrated a 'lack of care for patients'. Some trainees were not clear on how to exception report and had difficulty in accessing the electronic forms. Additionally, there was a general lack of understanding among the group that they could exception report if they had not been released for scheduled local teaching and regional teaching and assessments. There was a general feeling that if they did complete an exception report their supervisors would not be aware of the process to deal with it.	Yes, please see F2S 8
	The review team heard that some trainees were electively undertaking the Systematic Training in Acute Illness Recognition and Treatment for Surgery (START Surgery) course to prepare themselves for managing the clinical expectations in their roles. A few trainees felt that completion of the Advanced Trauma Life Support (ATLS) provider course would help them manage their role in providing the 'primary survey' in trauma calls.	Yes, please see F2S 9
	The review team were disappointed to hear of no instances where surgery specific simulation based teaching or surgical skills training had been provided. There were no examples described of teaching towards the Membership of the Royal College of Surgeons Part 1 examination being provided.	Yes, please see F2S 10
	The review team heard that in several settings trainees did not feel that their local faculty group (LFG) was an effective, timely or valuable forum for raising concerns about their education and training or any clinical concerns that they had.	Yes, please see F2S 11
	The review team were not made aware of any involvement by trainees in clinical governance, participating in Mortality & Morbidity. There was also an apparent lack of	

	a culture of structured learning from clinical incidents, near misses or multi-professional team-based learning. There were no examples of departments providing support and encouragement for trainees undertaking Quality improvement activity, presenting in Surgical grand rounds or participating in research/ publications. The review team did not hear of any instances of surgical teaching ward rounds nor any examples of any teaching provided during ward rounds. Most ward rounds were described as quick and trainees had little opportunity to ask questions or learn about decisions made.	Yes, please see F2S 12 Yes, please see F2S 13 Yes, please see F2S 14

Recommendations (applicable to all departments providing F2 placements in Surgery)			
Req. Ref No.	**Recommendation**	**Recommended Actions / Evidence**	**GMC Req. No.**
F2S 1	**Departmental Induction** In departments without onsite/ resident out-of-hours direct supervision from middle-grades, induction should include a period of supernumerary working / opportunity to shadow an experienced clinician (suggested at least the first two-night shifts) before they are signed off as competent by the ES/CS to join the out-of-hours rota.	Trust FTPD to confirm policy/ arrangements for an agreed period of shadowing/ supernumerary working before signing off to undertake out-of-work shifts in sites where there is no surgical middle-grade cover.	R1.13
F2S 2	Trusts to develop jointly with current trainee representatives, a bespoke specialty specific departmental induction template for foundation trainees in surgical posts. *This should include a list of learning objectives appropriate for F2 trainees (that meets the Foundation School curriculum) and all the essential skills and competencies that is expected when working in the department, out of hours, escalation pathways, cross-cover and formal handover arrangements.*	Trust FTPD/ Surgical Tutor to provide a departmental induction document/ program, co-developed with trainees and signed off by DME.	R1.13
F2S 3	**Statutory Mandatory Training** Trust corporate induction should focus on preparing trainees for their roles and include walk-arounds, identification of key clinical areas, rest and refreshment areas, IT, HR, OH, Guardian of safe working, whistleblowing and signposting to repository of policies. Completion of statutory mandatory training must be provided for within working schedules and separate to the Trust corporate induction.	DME/FTPDs to confirm that induction guidance for all departments and rota coordinators to ensure that all trainees have time protected in the rota to complete their statutory mandatory training outside of the designated Trust-wide induction days.	R1.13
F2S 4	**F2 Surgical PDPs** Departments to develop a set of Surgical Professional Development Plans which are documented in the induction meeting with Educational Supervisors. *These PDPs should include learning orientated to knowledge, behaviours and skills required for management of surgical patients both pre and post-surgery, common surgical presentations, interpretation of investigations (including imaging and pathology) and dealing with emergencies in surgical patients.*	Trust FTPD to provide FSD/HEE with a template Surgical PDP for F2 placements including all the essential elements.	R3.13

F2S 5	**Theatre & Clinics** F2 trainees in surgical rotations should have at least one half-day each of protected and supervised clinic or theatre time every two weeks. This should be developed in conjunction with FTPDs.	Trusts (Surgical Tutors/ FTPDs) to provide to FSD/HEE confirmation of rotas/ job schedules including at least one protected half-day of theatre or clinic time every two weeks	R5.9
F2S 6	**Protected Teaching** Departments to ensure that curriculum mandated (scheduled) teaching sessions are protected in trainee rotas and are bleep free.	FTPDs to confirm that all scheduled teaching sessions are protected in rotas and analysis of attendance at LFGs.	R1.16
F2S 7	**Study Leave** Departments to support trainees with requests for study leave, provided that the study leave is requested within an agreed notice period.	Trust DME/MEM to provide FSD/HEE with a report on the access / uptake of study leave.	R3.12
F2S 8	**Exception Reporting** Departments should regularly review and report in the LFG, the work load and culture around working beyond rostered hours. *There needs to be a clear mandate from senior departmental leaders encouraging exception reporting for excess hours and when training opportunities are missed. The Supervisors should be encouraged to engage with the Trust Guardian of Safe Working to ensure that prevalent culture of under-reporting in surgical departments is expeditiously addressed.*	FTPDs to review Trust GoSWH's analysis of exception reporting and actions at LFGs. These reports should form a fixed agenda item in Local Faculty Group meetings and minutes presented to the Trust Medical Education Committee/DME.	R1.1
F2S 9	**Surgery specific courses** Departments to provide access to courses which includes elements of START Surgery and Minor surgical skills training as considered relevant to Foundation 2 trainees, competencies required to function safely in their clinical role and optionally for F2 trainees keen to pursue a career in Surgery.	FTPD to confirm a suite of Teaching and Learning offers for Surgical F2 trainees. This should be included in the Departmental Induction.	R1.19
F2S 10	**Simulation & Human Factors** Departments to develop Surgery specific simulation and team-based learning activity which promotes multi-professional working in wards and optionally the theatre environment. *Emphasis should be on management of the deteriorating surgical patient, pre or post-operative scenarios.*	FTPD to confirm a suite of Teaching and Learning offers for Surgical F2 trainees. This should be included in the Departmental Induction.	R1.20
F2S 11	**Raising concerns** Trust to provide clear sign-posting of avenues of raising concerns either through trainee forums, LFGs and in confidence to the Freedom to Speak up Guardian(s)	Trust DME to confirm that Whistleblowing policy is shared in all induction programs and this includes confidential access to the Freedom to Speak up Guardian.	R1.3

F2S 12	**Learning from incidents** Departments to develop regular opportunities for systematic learning from analysis of incidents related to surgical patients/ services.	Trust FTPD/ Surgical Tutor to demonstrate trainee access to learning from mortality & morbidity, clinical governance meetings.	R1.15
F2S 13	**QI, Presentations/ Publications** Departments to offer career support, opportunities to undertake QI projects, audit/ short research projects and presentations at conferences.	Trust Surgical Tutors/ Educational Leads to encourage colleagues to support trainees to participate in QI, research, presentations/ publications.	R1.21
F2S 14	**Surgical Teaching/ Grand Rounds** Departments to provde designated Surgical teaching ward rounds and grand rounds where trainees are encouraged to present, consultants have an opportunity to teach and provide high quality feedback.	Trust Surgical Tutors to develop a weekly Consultant led Surgical Teaching round and encourage presentation in surgical grand rounds.	R1.14

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

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	Dr Indranil Chakravorty, Deputy Postgraduate Dean, North Central and East London
Date:	08 April 2019

What happens next?

We will add any requirements or recommendations generated during this review to your LEP master action plan. These actions will be monitored via our usual action planning process. An initial response will be due within two weeks of receipt of this summary report.