CORE SURGICAL TRAINING (CST) PLACEMENT QUALITY REVIEW 2023

Northern Ireland Medical and Dental Training Agency
REPORT COMPILED BY DR SA PHILLIPS & MISS JR LOCKHART

Review members

Dr Sally Anne Phillips (Associate Dean for Placement Quality)

Miss Jessica Lockhart (ST4 General surgery, ADEPT Clinical Leadership Fellow 2023/24)

Mr Khoshraviani (Associate Dean for Visits)

Dr Jackie Rendall (Associate Dean for Visits)

Mr Trevor Thompson (Head of School, Surgery)

Mr Niall McGonigle (Deputy Head of School / Core Surgery Training Programme Director)

Contents

Executive Summary

Recent years have seen a steady reduction in the proportion of doctors entering directly into training programmes following the completion of their foundation training. Pre-pandemic, the last published career destination report from the UK Foundation Programme Office (UKFPO) in 2019 showed that only 34.3% of F2 doctors had entered directly into a training programme; a significant fall from a figure of 70.9% in 2011[(1)].

The pandemic period also brought about changes in recruitment methods for the Core Surgical Training Programme enforcing a move from local to national recruitment. This had a significant impact on the number of core surgical trainees appointed into the programme, with only 49.4% of core surgical posts being filled during 2022/23. This context must be taken into account, when we consider the findings of the Placement Quality Review of this cohort of trainees.

Placement Quality (PQ) Reviews were introduced in 2018, with Core Surgery being reviewed in 2020. PQ reviews provide information additional to that gathered by Deanery visits and the GMC National Training Surveys (NTS), so giving a more specific and tailored overview of the quality of local training provided in the region. This PQ review is a revisit to the CST programme to assess progress made on the recommendations made in 2020.

For this re-survey, we considered the previous 2020 PQ Report and re-examined the initial PQ survey to make any alterations and additions required to address expectations resulting from changes to the CST curriculum and post pandemic practices since the last review. The framework of questions was aligned with the educational curriculum as set out by the Joint Committee for Surgical Training (JCST). The survey was approved by the Head of School, Training Programme Director and the Specialty School Board at NIMDTA, prior to being distributed to all the core trainees in post during the period February to July 2023. The survey was open for 6 weeks in June/July 2023.

The survey regional response rate was 70% (30/44 trainees). The balance of respondents was 67% CT1 trainees, 30% CT2 trainees and 3% CTR trainees. There were responses from 7 sites across Northern Ireland; of note there were no respondents from Craigavon Area Hospital, meaning there was no representation of the Southern HSC Trust in these results.

This reports compiles the results of the survey, highlighting key recommendations for development and improvement. This report is also informed by visits carried out alongside NIMDTA Deanery Visits to multiple sites.

Section 1: Analysis and Recommendations

1. Post Information, Rota Allocations and Induction

Post Information

Trainees were asked if they felt they had sufficient information about the available posts when making their preferences.
More information was requested by 93% of all respondents (Table 1).

Table 1: Desirable post information and percentage of respondents requesting this

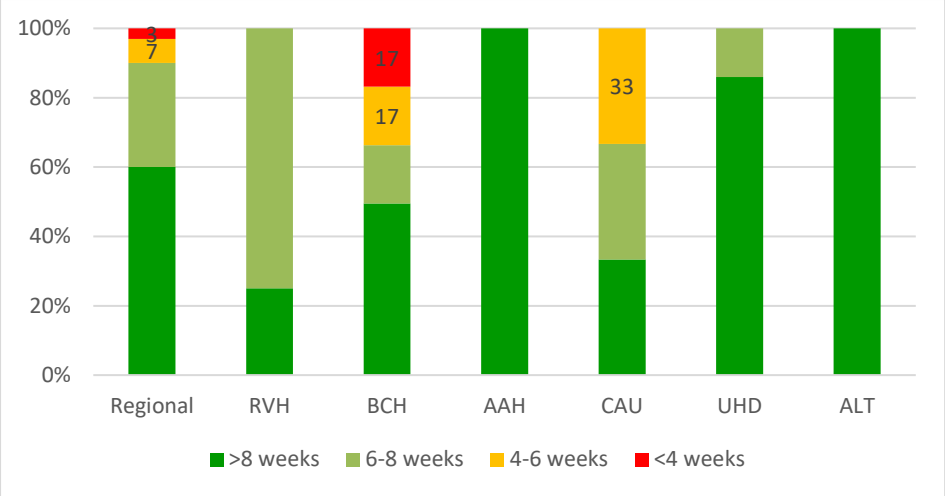
Rota pattern	23%
Number of theatre sessions/week	60%
Number of OPCs/week	40%
Specialist services	27%
Unit demographics	27%
Salary & banding	50%

Rota Allocations and Vacancies

The Learning and Development Agreement between NIMDTA and the Local Education Providers (LEPs) requires the they be informed of the trainee allocations at least 8 weeks prior to changeover. Trainees are also notified by NIMDTA of their posting and the LEP is then expected to inform the trainees of their out of hours (OOH) rotas within 6 weeks of commencement of the post.

The majority of trainees (90%) received their posting allocation from NIMDTA within 6 weeks of changeover, with 60% of trainees getting at least 8 weeks' notice. The breakdown of post notification by hospital site is detailed below (Figure 1).

Figure 1: Regional NIMDTA allocation of post by hospital site

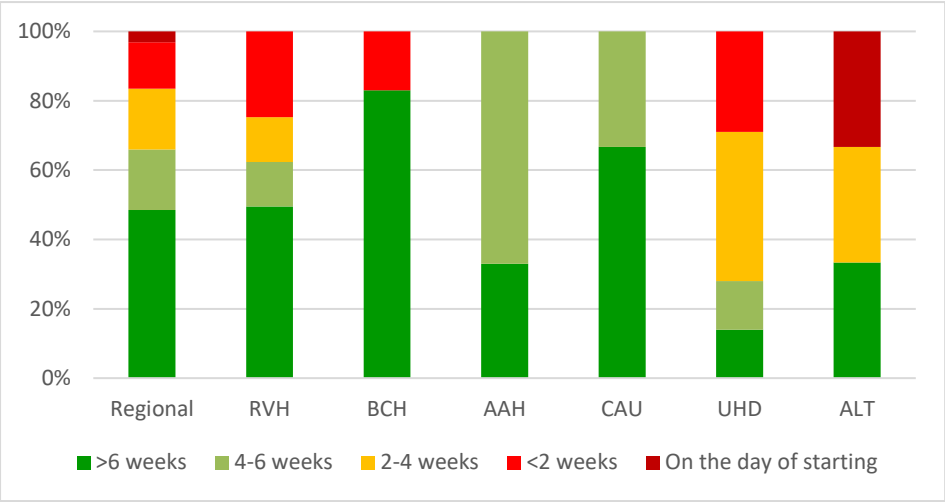


Trainees report poorer compliance with the Learning and Development Agreement in regard to notification of their OOH rotas, with only 47% of respondents receiving their OOH rota more than 6 weeks prior to commencement of the post. This is only marginally improved from 42% in the 2020 review.

Variation by hospital site can be seen in Figure 2. On the BCH, CAU and RVH sites 83%, 66% and 50% of trainees respectively reported having the required 6 weeks' notice of their OOH rota with the majority getting their OOH rota at least 4 weeks before starting their post. In contrast to this, in the

UHD and ALT sites, the majority of trainees reported less than 4 weeks' notice, with a third of respondent in ALT indicating that they received their OOH rota on the day of post commencement. Regionally, 37% of respondents felt they did not have sufficient time to make personal or situational adjustments.

Figure 2: Regional notification of OOH rota by hospital sites



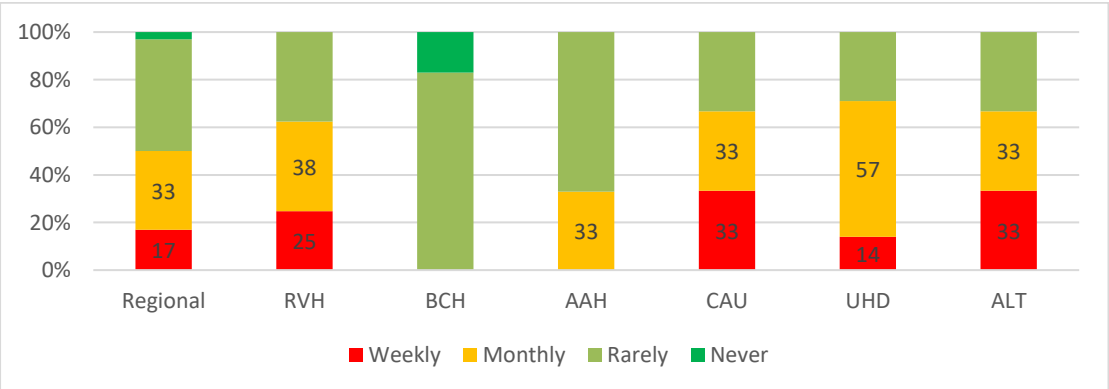
There was a significant shortage of core surgical trainees at the time the PQ review took place, with only 49.4% of posts filled. As a consequence, a significant number of gaps were reported on rotas across the region; 63% of respondents reporting at least one vacancy on their rota when they started their post. Trainees reported that this had a largely negative impact on their training, with almost half of all trainees reporting increased workload and missed training opportunities as a result (Table 2).

Positive impact	10%
Increased workload	47%
Missed training opportunities	47%
Difficulty attending teaching	27%
Difficulty getting study/annual leave	17%
No impact	27%

Table 2: Impact of rota gaps reported by % of trainees

There was variation in how these vacancies were dealt with across different hospital sites, with a combination of short and long-term locums, in conjunction with requirements for trainees to provide additional in-house cover (Figure 3).

Figure 3: Frequency with which trainees were asked to cover rota gaps



Rota Coordination

Coordination of weekly allocations and day-to-day clinical sessions is done by a spectrum of individuals, with some units allowing a core trainee (32%) to do it themselves, sometimes a more senior trainee (37%) is responsible and the remainder of the time these allocations are made by a specialty doctor (13%) or administrative member of staff (10%). Of note allocation of core trainees to clinical sessions is rarely decided by a consultant (8%).

When trainees were asked if they felt they were given priority for training opportunities over non-training grades on the same rota, over half (57%) felt that they were not.

Multiple trainee comments are reflected below:

> *"…main role is service provision…don't feel our training is taken into account a lot of the time"* (General S, UHD)
>
> *"Locum trainees who want to do ENT will get ahead of CST"* (ENT, RVH)
>
> *"…locum SHO's are given **more** training opportunities that trainees..."* (T&O, RVH)
>
> *"Locum doctors are being given equal opportunity for the theatres."* (*EMSU*, RVH)
>
> *"Long term locums have the same priority for theatre"* (General S, BCH)
>
> *"Surgical trainees often have to give up theatre time for emergencies to locums and non-trainees."* (General *S, ALT*)
>
> *"Locums scheduled for equal theatre slots as core trainees"* (T&O, RVH)

Induction

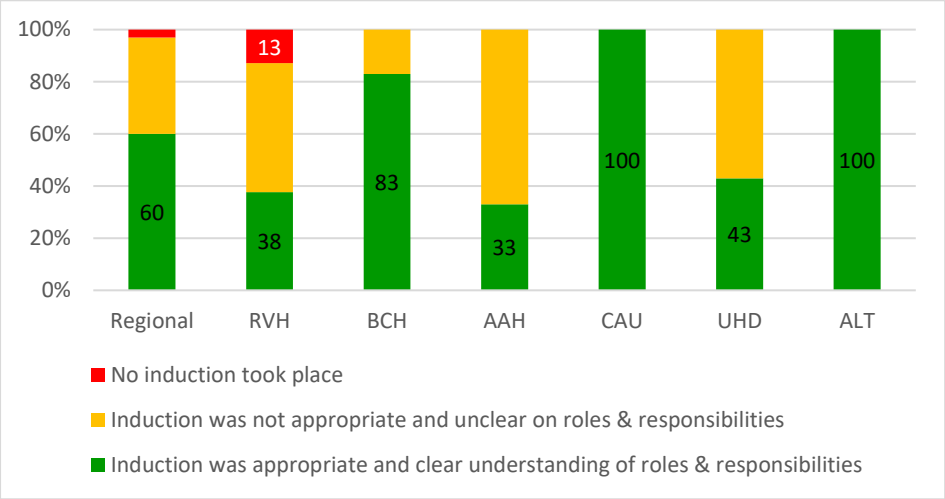
The GMC's Promoting Excellence guidance document outlines the requirement of all Trusts (LEPs) to provide an appropriate induction at the beginning of a placement, with clearly defined aims. The GMC describes this as below:

"Organisations must make sure learners have an induction in preparation for each placement that clearly sets out:

a. their duties and supervision arrangements
b. their role in the team
c. how to gain support from senior colleagues
d. the clinical or medical guidelines and workplace policies they must follow
e. how to access clinical and learning resources. [2]"

Overall only 60% of trainees reported finding induction appropriate, and outlining a clear understanding of their role and responsibilities. This is a fall from the figure of 73% reported in the 2020 PQ review. There was variation across hospital sites with all respondents in the CAU and ALT sites reporting induction as appropriate. In the RVH one trainee working in ENT reported no induction took place at all (Figure 4).

Figure 4: Regional breakdown of quality of local induction



Multiple trainee comments are reflected below:

"…only covered general surgery. No induction from urology or orthopaedics which we cover OOH…knew my roles… as I worked here before but inadequate for those newly rotating…" (General UHD)

"I had worked there before so I already had a good understanding. Not sufficient for those who hadn't worked there before. No in-person induction from urology and orthopaedics, which we cover OOH." (General UHD)

"No in-person induction from urology or orthopaedics." (General UHD)

"no formal induction given by consultant or registrar level regarding how the unit function and the systems." (General AAH)

"GS induction included only a tour and handout of a handbook." (General AAH)

"There was no induction, I had to email to find out where to go for day 1, just joined a ward round on arrival and was left to own accord to figure things out." (ENT, RVH)

"…an induction day specifically for vascular surgery and roles would have been beneficial. I did receive this for General surgery." (Vascular, RVH)

"There was no practical induction e.g. how to perform FNE which is key to the job and largely you work alone." (ENT, RVH)

Key Recommendations for Post Information, Rota Allocations and Induction

- ✓ Development of a Core Surgical Prospectus for each unit being allocated trainees
- ✓ Earlier rota notification by LEPs to ensure all trainees have at least 6 weeks' notice of their OOH rota
- ✓ Improved local (department/ward) induction to carefully outline roles and responsibilities in the unit
- ✓ Trainee prioritisation for training opportunities over non-training grades on the rota

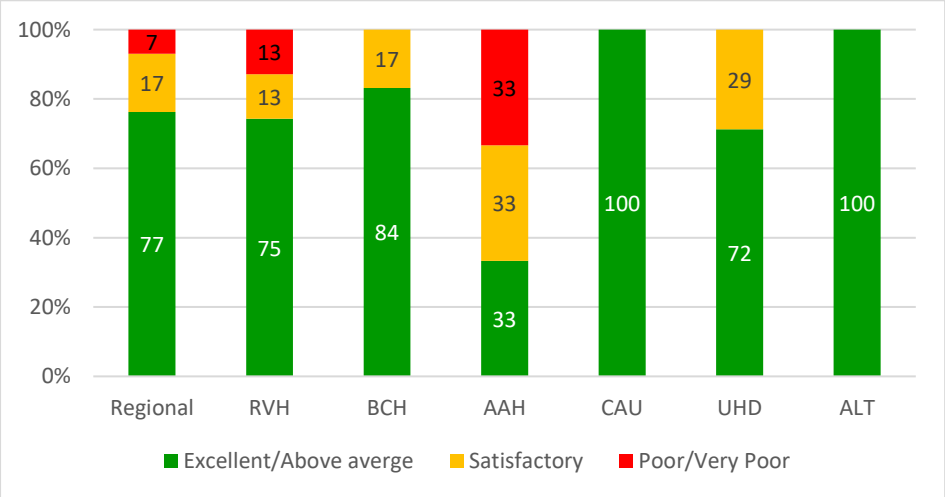
2. Educational Supervision, Clinical Supervision and Feedback

Educational Supervision

Assigned Educational Supervisors (AES) are expected to be allocated and communicated to the trainee within 2 weeks of commencement of a new post and the initial meeting with the AES should be carried out within 6 weeks of changeover; only 63% and 83% of respondents respectively, reported achieving these targets. This is an area which needs attention.

The initial meeting with their AES was reported by 93% of respondents a successful in setting out clear educational objectives for their post and the majority (97%) of trainees reported having a midpoint review meeting. An optional midpoint MCR (multi-consultant report) was however reported by only 53% of trainees. The quality of educational supervision reported across the region was high with 75-100% of trainees rating it as excellent/above average in all but one site (Figure 5). In AAH however a third of respondents indicated Educational Supervision to be poor/very poor.

Figure 5: Quality of Educational Supervision across the region by hospital site



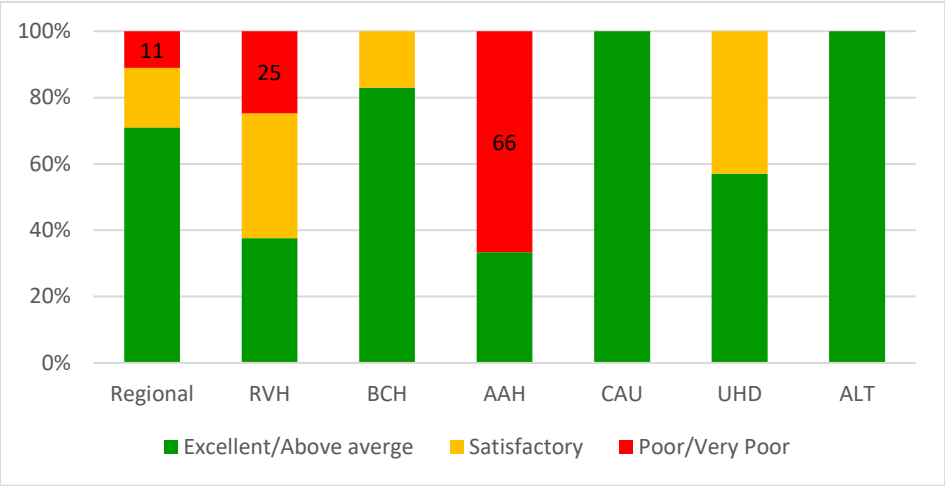
E-Portfolio

When asked about use of the online ISCP (Intercollegiate Surgical Curriculum Programme) portfolio, only 50% of trainees reported a clear understanding of how to use it and what their required competencies are and 83% reported being confident in how to upload evidence to the portfolio.

Clinical Supervision

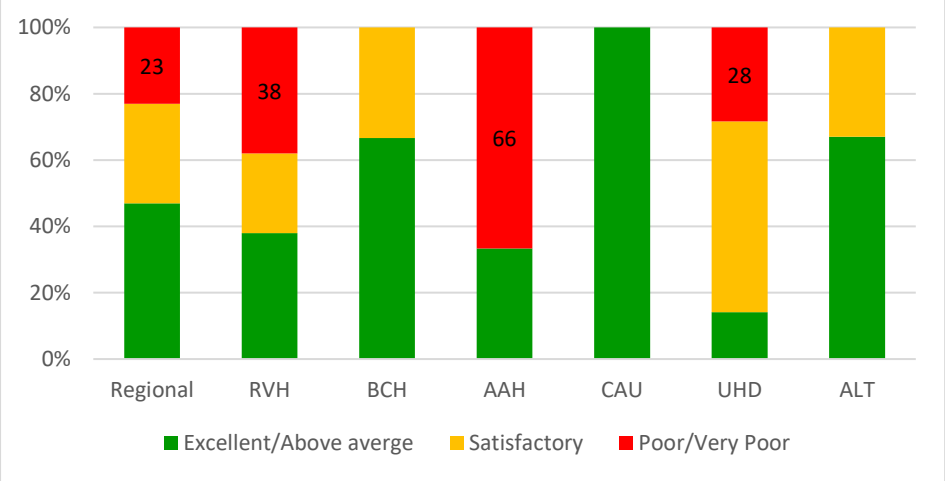
Clinical supervision (CS) was separated into in- and out-of-hours supervision. The majority of respondents (89%) reported that clinical supervision during daytime hours was at least satisfactory, with 71% rating it as excellent/above average. There are some hospital sites which are consistently performing well (CAU, BCH and ALT) where 100%, 83% and 100% of trainees report CS during daytime working hours as excellent/above average. Areas of concern are AAH and RVH where two thirds and a quarter of trainees respectively report daytime CS as unsatisfactory (Figure 6).

Figure 6: Quality of clinical senior supervision during daytime working hours across hospital sites



In the majority of hospital sites, the quality of senior clinical supervision remained high regardless of day time or out of hours working, with 77% of trainees reporting OOH supervision as satisfactory. In the RVH and AHH sites however the quality of senior supervision was reported as less than satisfactory by 38% and 66% of respondents respectively OOH (Figure 7).

Figure 7: Regional quality of clinical senior supervision during out of hours across hospital sites



<u>Feedback</u>

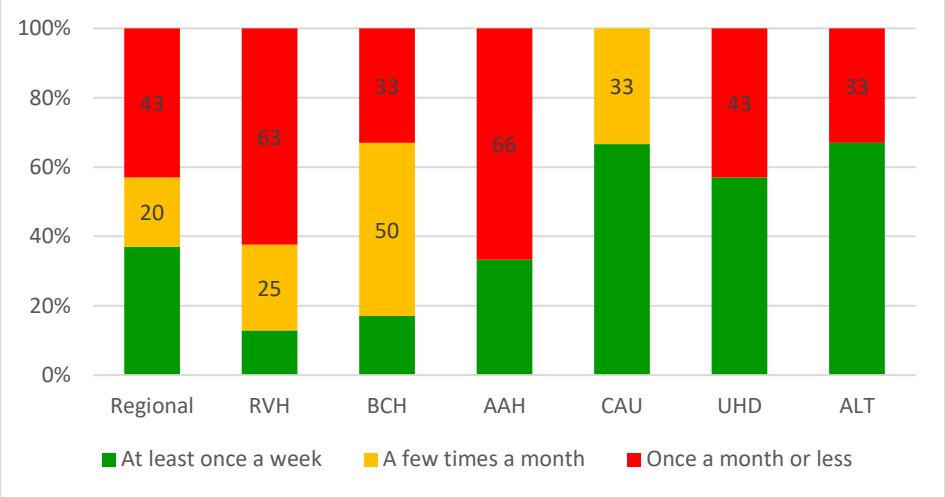
Feedback is important tool in effective training, and the GMC guidance *Promoting Excellence: Standards for Medical Education and Training* states that "learners must receive regular, constructive and meaningful feedback on their performance, development and progress at appropriate points in their medical course or training programme, and be encouraged to act on it." [(2)] The delivery of feedback is documented as part of the clinical supervisors' role by the ISCP. What may be less defined, and could inform the results, is the definition of feedback. The trainees were asked about both formal and informal feedback collectively, and the understanding of informal feedback has not been clearly defined and may be subjectively interpreted.

When asked about the quality of feedback received, 60% of respondents reported that when feedback was given it was both constructive and supportive; 47% reported feedback which improved their clinical practice; but 17% of respondents reported receiving feedback which was unsupportive and affected their confidence.

Regionally however, only 37% of core surgical trainees indicated that they had received feedback at least once a week on their performance with 43% reporting feedback once a month or less (Figure 8). There was however variation in results between sites, with two thirds of trainees in the CAU and ALT sites and 57% in the UHD site reporting receiving feedback at least once a week. In the AAH and RVH sites results were significantly below the regional figures with 66%, and 63% respectively indicating they had received feedback only once a month or less.

NIMDTA recognises this as an area requiring development and believes that trainees receiving feedback on their performance at least a few times a month should be the target for all training sites. During this survey, only 57% of trainees currently achieve this.

Figure 8: The frequency of feedback in hospitals across the region



Key Recommendations: Educational Supervision, Clinical Supervision and Feedback

- ✓ Timely allocation of AES

  In accordance with the JSCT Quality Indicators for core surgery, trainees should be assigned an educational supervisor and have negotiated a learning agreement within 6 weeks of post commencement to allow timely progress throughout the placement and to provide focused and directed learning.

- ✓ Improved Senior Support and Supervision

  A safe and supportive environment improves the learning that can take place in a work-based setting.

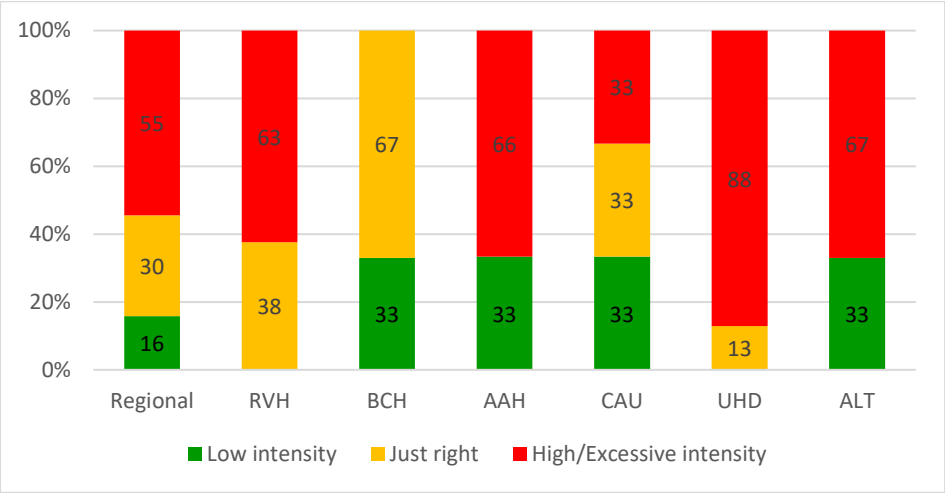
- ✓ More frequent feedback

  Timely midpoint and final MCR provides a built-in structure for formal feedback within the portfolio; this not does take away the many clinical educational opportunities that also require contemporaneous and informal feedback in the workplace. Feedback is an important aspect of the learning process and, when given correctly, provides specific focused learning outcomes.

3. Clinical Workload and Work Intensity

In the 2020 PQ survey over half of all core surgical trainees felt that their work load was 'just right' both in hours and out of hours across the region. In contrast, regionally only 30% of respondents in the current survey reported work intensity as being 'just right' in hours with over half (55%) reporting workload as high/excessive; this figure was highest in the UHD site where 88% of respondents reported a high workload (Figure 9). In contrast two thirds of respondents on the BCH site reported daytime workload as just right, with a further third indicating low intensity.

Figure 9: Work intensity by site during daytime, in hours working



Workload intensity at night and at weekends was higher with workload regionally being reported as just right by only by 25% and 29% of trainees respectively, however there was significant variation across hospital sites (Figures 10 and 11). In the BCH and CAU sites, workload was reported as being predominantly low intensity or 'just right, 'both at night and weekends. In contrast, in other sites trainees reported workload as predominantly high or excessive intensity at night and at weekends, RVH (63% N; 100% WE), UHD (76% N; 66% WE), ALT (67% N; 67% WE) and AAH (67% WE).

Figure 10: Work intensity by site during night shift working

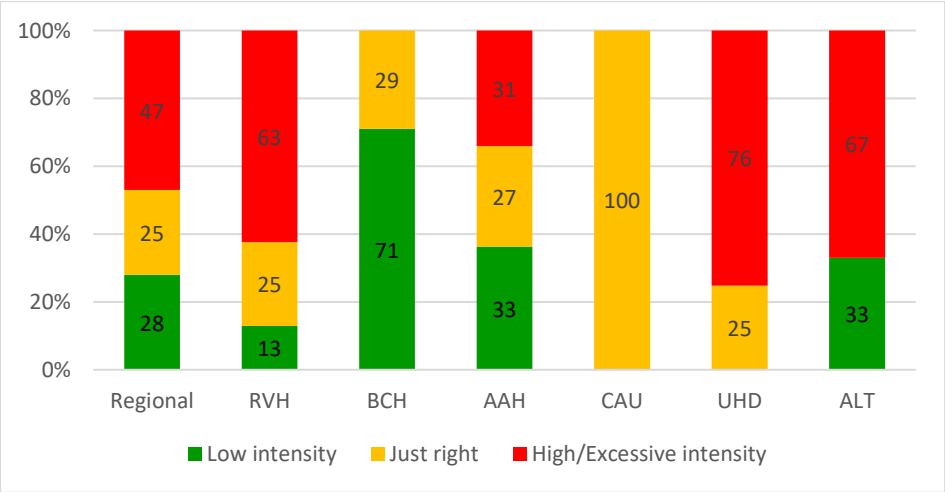
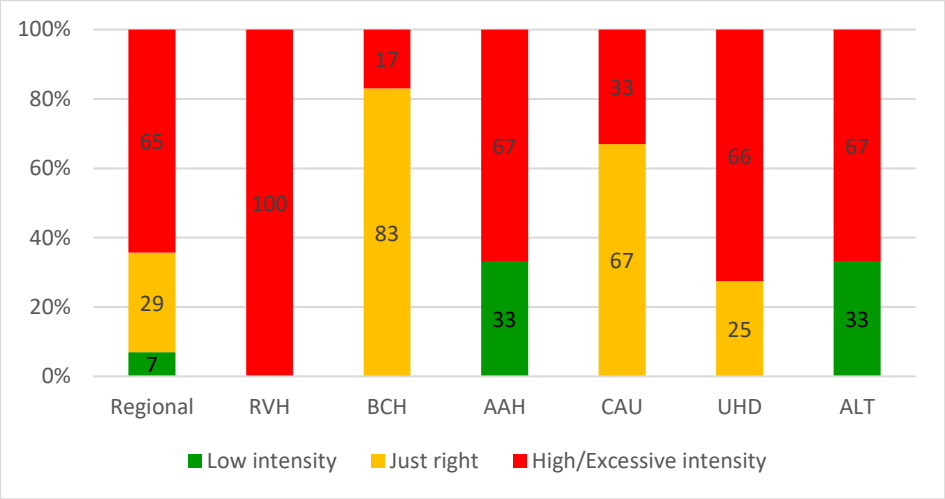


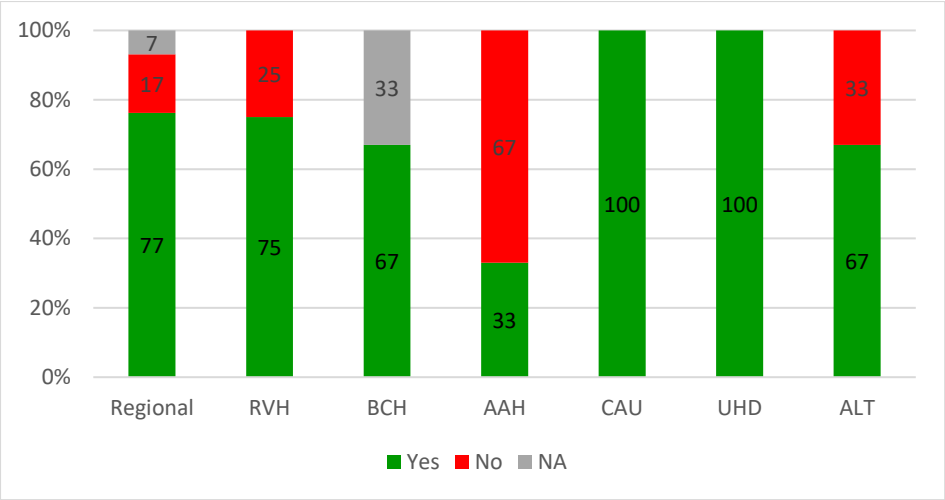
Figure 11: Work intensity by site during weekend working.



Senior Support

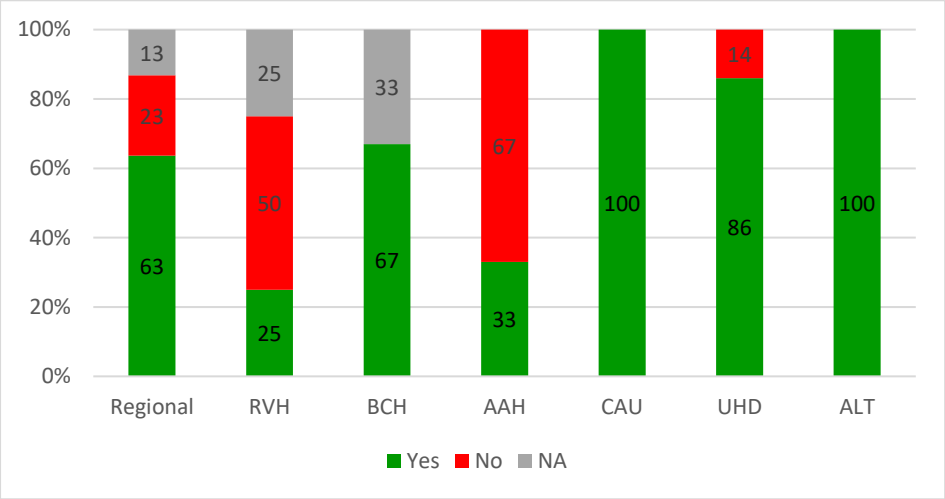
Trainees were asked about senior support during periods of high work intensity. Due to the construct of rotas and grades working in particular units, there were some respondents who stated senior trainee support was not applicable to them. For the most part, the majority of trainees (77%) felt that they were well supported by their senior trainees, with only Antrim Area Hospital being an obvious outlier, where two thirds of respondents reported feeling poorly supported by senior trainees (Figure 12).

Figure 12: Trainees reporting feeling well supported by senior trainees during high work intensity



When asked about consultant support during periods of high work intensity; 63% regionally reported being well supported with figures for the UHD (86%), CAU (100%) and ALT (100%) being well above the regional figure. It is noted that this appears to be an area of concern on the RVH and AAH sites where 50% and 67% of trainees respectively reported not feeling well supported by their consultant (Figure 13).

Figure 13: Trainees reporting feeling well supported by consultants during high work intensity



Key Recommendations for Clinical Workload and Work Intensity

- ✓ Improved Senior Support and Supervision

  A safe and supportive environment improves the learning that can take place in a work-based setting.

4. Formal Teaching and Educational Opportunities

Both the GMC and the JCST in their written guidance consider protected time for teaching as an essential part of any training programme.

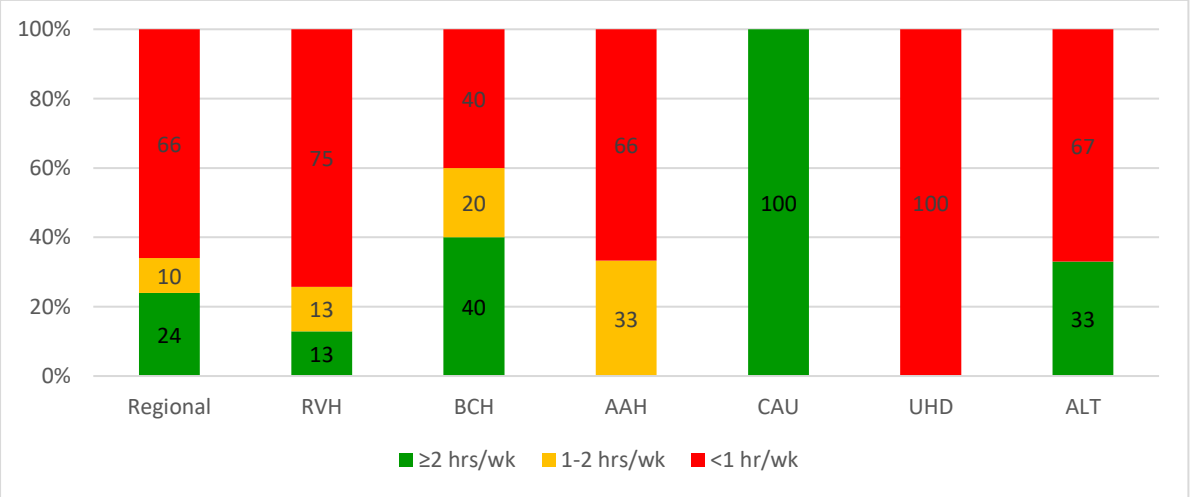
Formal Local Teaching

The amount of formal local teaching expected, is outlined by the Specialty Advisory Committee (SAC) and the JCST in their Quality Indicators for core surgical training [3]. This states that "Trainees in surgery should have at least 2 hours of facilitated formal teaching each week (on average)". Formal teaching being defined by the JCST as "locally/regionally/ nationally provided teaching, educational induction, simulation training, specialty meetings, journal clubs, x-ray meetings, MDT meetings". [4]

Results from the current survey indicate that regionally only 24% of trainees are achieving this, with two thirds of respondents reporting less than 1 hour per week of formal teaching (Figure 14). Even more concerning is that almost a third (31%) of respondents in the current survey indicated that local teaching did not occur; a number significantly below the figure of 14% reported in the 2020 survey.

While there is some variation between hospital sites, only one unit stands out as performing well in regard to the provision of formal teaching, with all respondents on the CAU site reporting at least 2 hours of formal teaching each week.

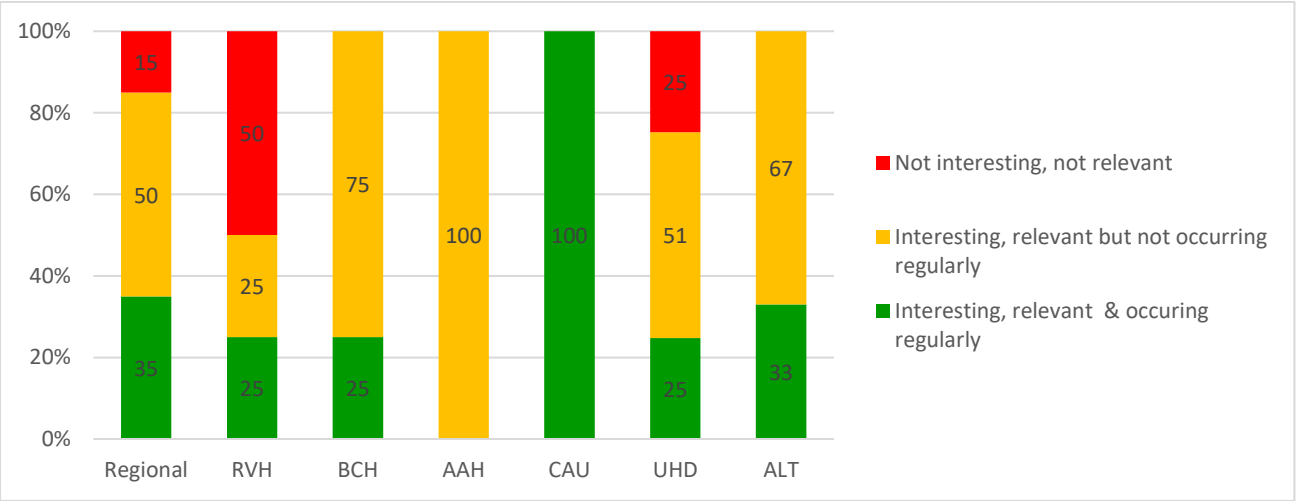
Figure 14: Average amount of formal local teaching regionally and by site



When formal teaching occurred, the quality reported was variable. While most sites are reported to be delivering teaching that is both interesting and relevant this is not being provided on a regular basis (Figure 15). It is noted that on two hospital sites (RVH and UHD) teaching was reported as being not interesting or relevant by 50% and 25% of respondents respectively. Both of these sites have a number of different departments represented by these figures. In the RVH, the trainees who reported teaching as 'not interesting, nor relevant' were working in T+O and cardiothoracic, and in UHD, in plastic surgery.

Consultant attendance at local teaching was reported as good (usually or always) by only 52% of trainees across the region.

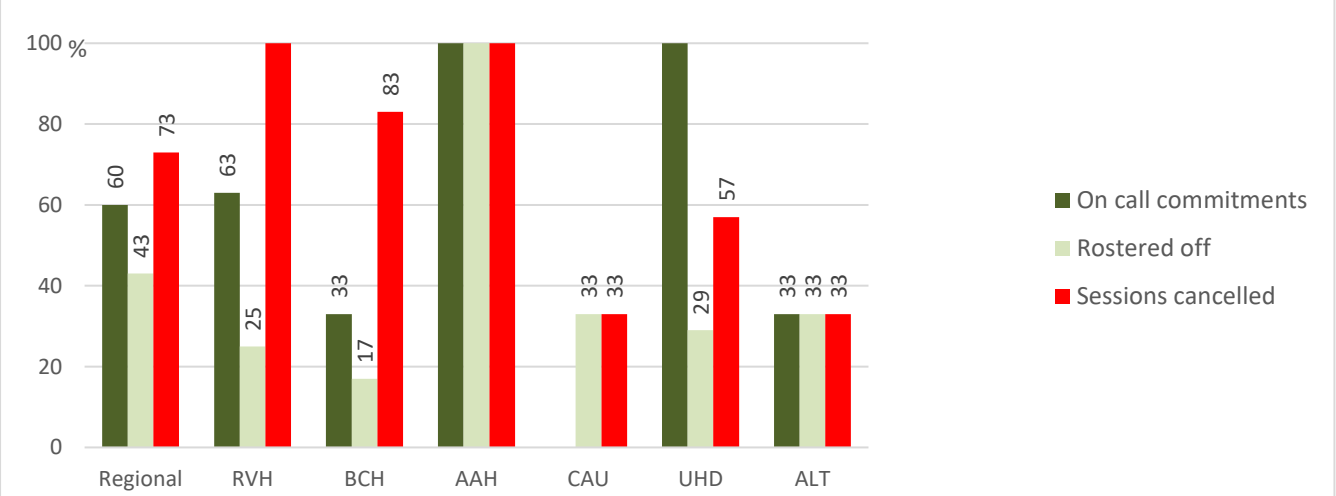
Figure 15: Quality of teaching provided regionally and by hospital site



Regional Teaching

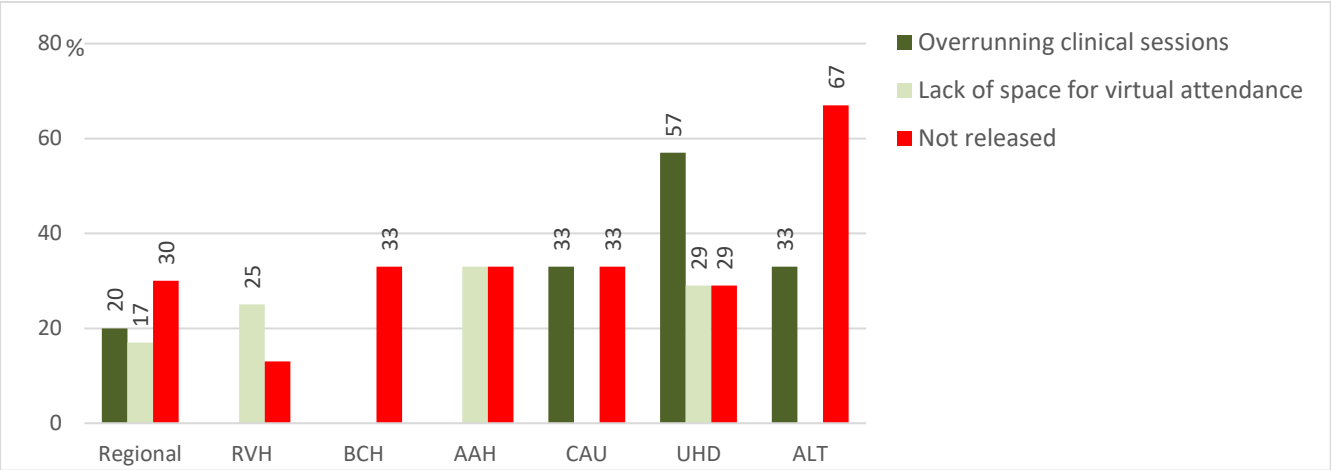
Regional teaching takes place for all the Core Surgical Trainees. The majority of trainees (77%) reported facing difficulties attending these sessions. The main barriers to attendance at regional teaching were reported as on-call commitments, being rostered off pre or post-nights and teaching sessions being cancelled (Figure 16a). In Trust D it was noted that not being released to attend regional teaching was reported by 60% of respondents.

Figure 16a: Barriers to attending regional teaching by hospital site



Other barriers to attendance at regional teaching included; over running of clinical sessions, reported by 20% of respondents regionally, but by over half of all trainee (57%) on the UHD site and a third on the ALT and CAU sites; a lack of space in the department for virtual attendance and not being released to attend regional teaching which was reported by a third (30%) of all respondents. It is noted that on the ALT site two thirds of core trainees reported not being released to attend regional teaching (Figure 16b).

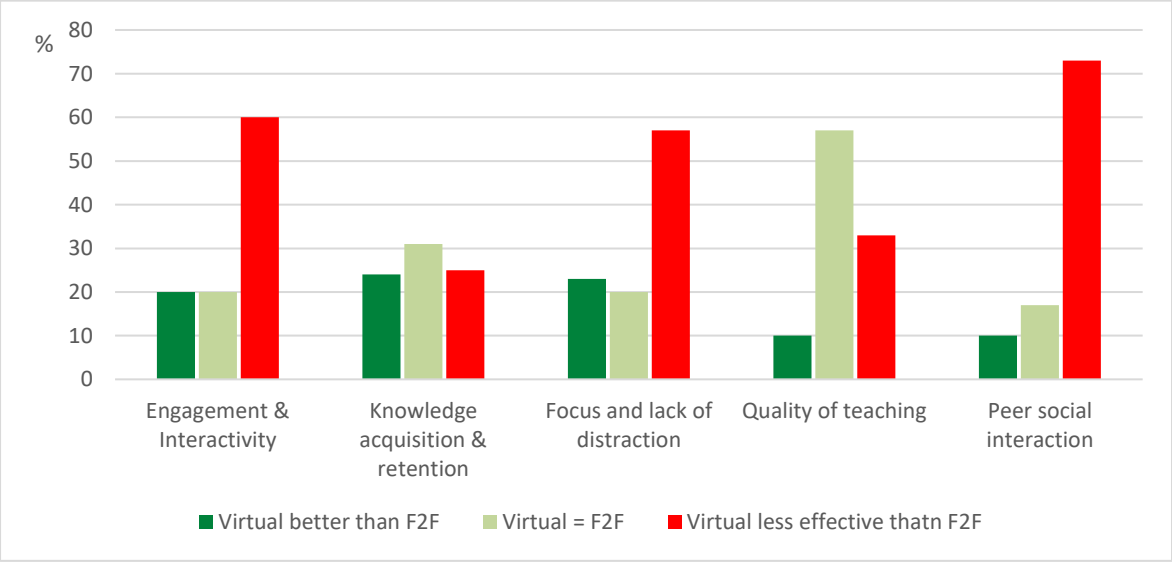
Figure 16b: Barriers to attending regional teaching by hospital site



The 2020 PQ survey was carried out immediately before the global Covid-19 pandemic, and subsequently to ensure continued provision of regional teaching, changes were made to its method of delivery. Throughout the pandemic, and for a significant period of time thereafter, regional teaching took an online virtual format, whereas prior to this it had been a meeting in person with mandatory attendance. There were both advantages and disadvantages to this change and so in the current survey trainee feedback was sought on the effectiveness of face to face versus virtual delivery of regional teaching sessions.

Feedback from core surgical trainees was that virtual teaching is felt to be less effective than face-to-face teaching, with less polarising feedback in relation to knowledge acquisition/retention and the quality of the teaching (Figure 17). Regarding engagement/interactivity and peer social interaction, there is a strong opinion against virtual teaching.

Figure 17: Opinions of virtual delivery of regional teaching versus face-to-face teaching



Educational Opportunities

The current core surgical training curriculum came into effect in August 2021 and describes core capabilities in practice as the learning outcomes for the trainees [3]. The essential clinical sessions, providing key training opportunities and the quality of the training taking place in each setting formed the framework for the survey questions.

In the current curriculum there are no indicative or suggested numbers of sessions that should be attended by the trainee. The focus instead is on competency, which is assessed by the Multi-Consultant Report. As a guide however, we can consider the previous core surgery curriculum published in 2017 for reference figures, whilst acknowledging that this is not a current active recommendation. These recommendations were, that the aim should be to provide at least one and no more than two clinic sessions and 3 to 4 operative sessions to all core surgical trainees in an average working week.

Theatre/Day Procedure Unit (DPU)

Only 53% of trainees responding to the current survey reported that they were achieving the 3-4 consultant lead operative sessions on an average week; this number has fallen slightly from the 2020 figure of 59% (Figure 18). Of concern, in the BCH and ALT sites, the reported access to theatre/DPU operative sessions was significantly below the regional figures, with 80% of respondents in BCH and 100% in ALT reporting only 1-2 sessions a week. The complex nature of surgical cases in BCH is noted, which may be influencing the findings on this site.

When asked about training needs, over a third (36%) of all trainees were concerned that they would not have access to sufficient operating sessions to meet their training needs.

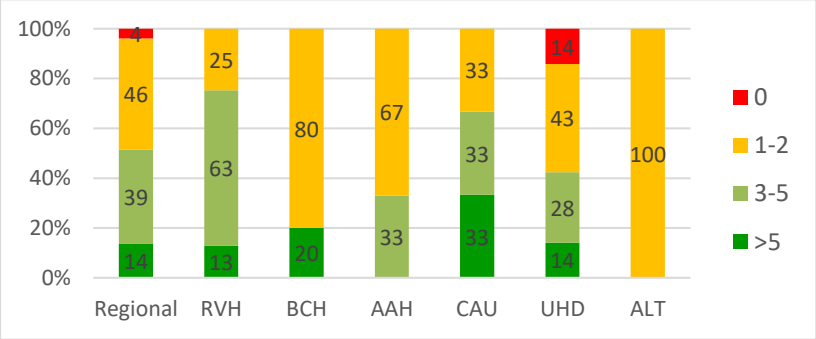


Figure 18: Average number of theatre/DPU consultant lead sessions per week

When able to access operative sessions in either theatre or DPU, 68% of respondents regionally rated the quality of teaching as excellent or good (Figure 19). In 3 sites, BCH (80%), CAU (100%), and ALT (100%), the number of respondents reporting the quality of teaching as excellent or good was higher than the regional figure.

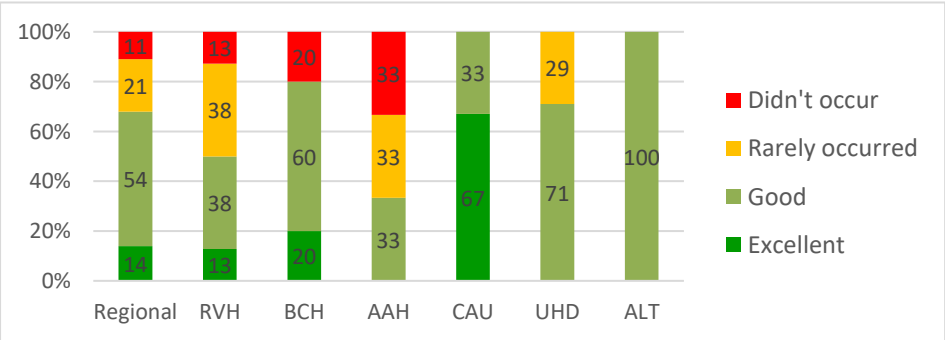


Figure 19: Quality of training at theatre/DPU consultant lead sessions

Out Patient Clinics

Regionally a quarter of respondents are not meeting the target of 1-2 OPC per week (Figure 20). This is an issue on 3 sites (RVH, AAH & UHD), with AAH site being a concern, where two thirds of respondents reported attending no OPCs. In contrast on the BCH, CAU and ALT sites all trainees are meeting the target with good access to OPCs reported.

When we consider the quality of training reported in the OPC setting, those sites where trainees report that training 'didn't occur' or that it was 'not applicable' mirror those sites where access to OPCs is poor (Figure 21).

It is noted that only 54% of trainees feel that they are able to access sufficient outpatient opportunities to meet their training needs.

Figure 20: Average number of consultant lead OPC sessions per week

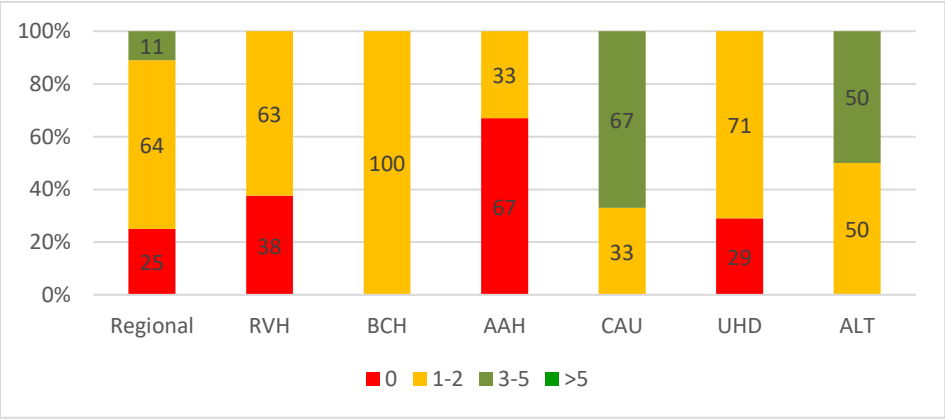
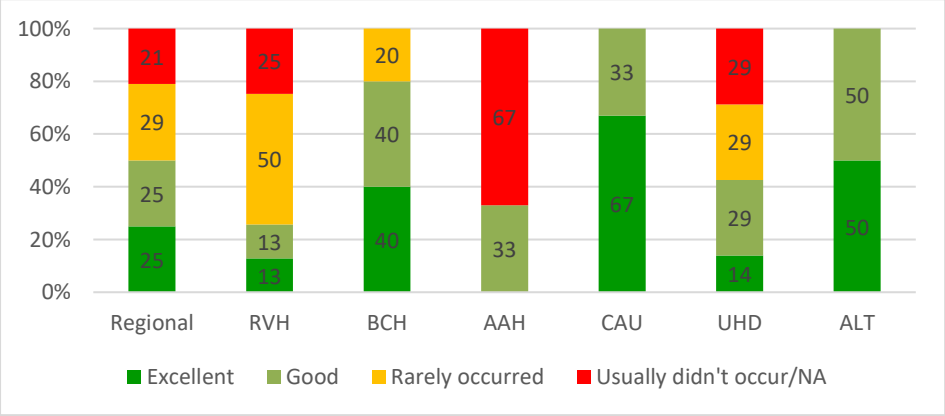


Figure 21: Quality of training at outpatient consultant lead sessions.



Ward Rounds

There are no suggested targets for the number of ward rounds attended, and since it is usual in a surgical job to have a role in the ward round on most days, prior to attending scheduled elective sessions, it is not unexpected that the majority (81%) of trainees reported being involved with at least 3 ward rounds per week on average (Figure 22).

Of note, the educational value and training opportunities at these ward rounds were variable between sites. Regionally only 50% of respondents reported training as being 'good' or 'excellent',

with all respondents on the ALT site reporting that teaching on ward rounds did not occur (Figure 23).

Figure 22: Average number of consultant lead ward rounds attended per week

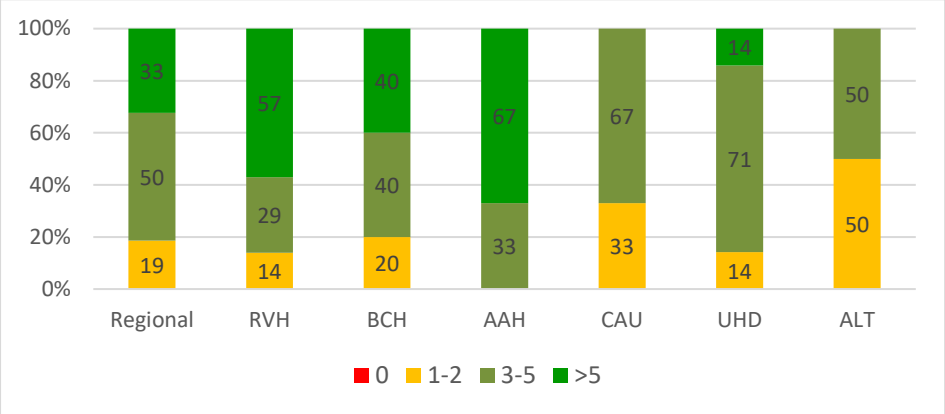
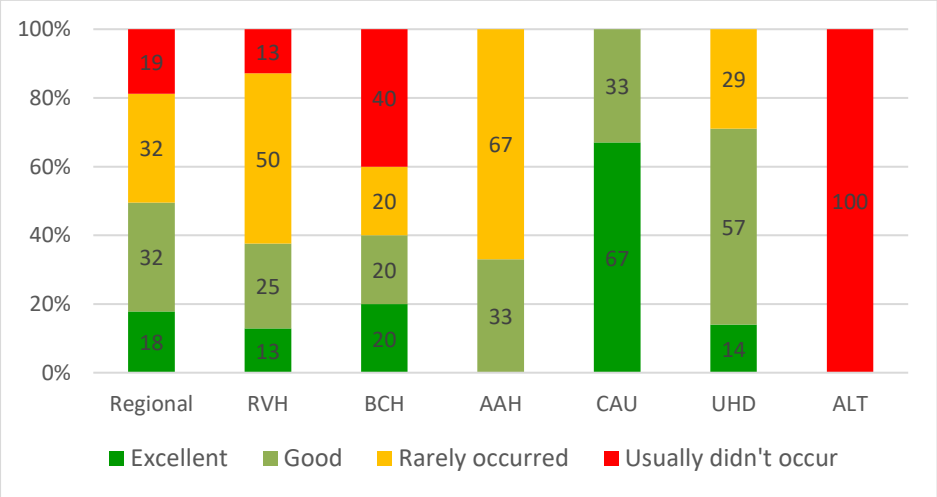


Figure 23: Quality of training at consultant lead ward rounds

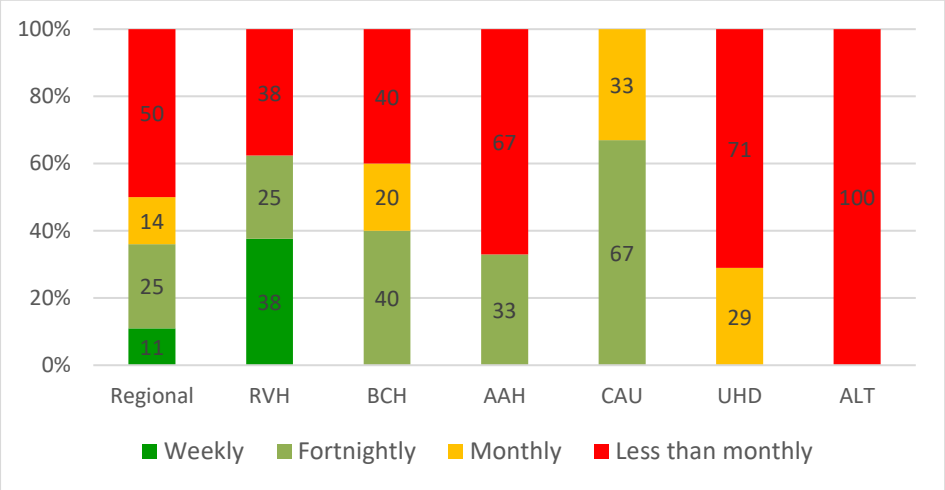


Additional Educational Opportunities

MDT Meetings

Multi-disciplinary meetings were poorly attended across the region, with 50% of trainees reporting attending less than one MDT per month and only 11% reporting attending 1 per week. This is significantly poorer than on the last PQ survey, where 43% reported attending 1 to 2 MDTs every week. The spread of attendance at MDTs in the region can be seen in figure 24.

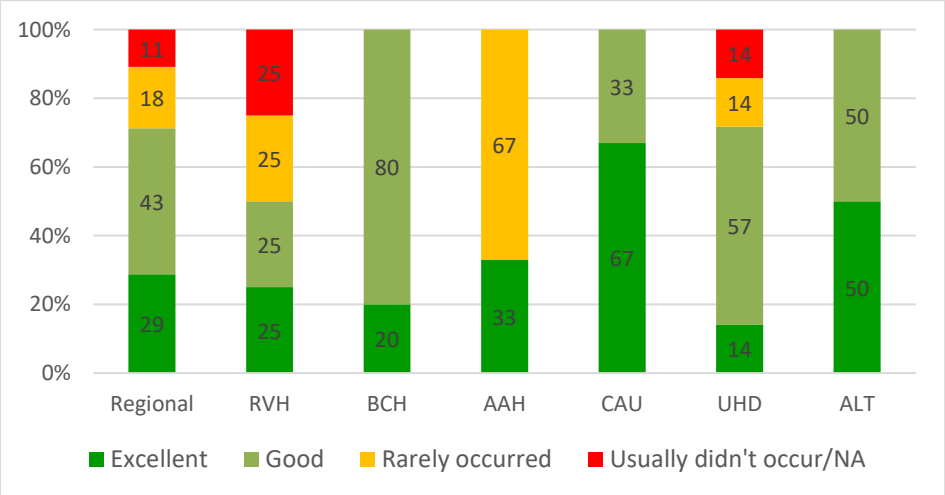
Figure 24: Average number of MDT meetings attended



Managing the Emergency Take

Another learning outcome detailed in the portfolio capabilities in practice is the management of the unselected emergency take, which presents many learning opportunities. Trainees were asked to report on the quality of learning taking place in this setting. In general, respondents regionally reported training did occur when managing the unselected take, with particularly good/excellent training noted in the BCH, CAU and ALT sites (Figure 25).

Figure 25: Quality of training occurring when managing the unselected emergency take by hospital site



Morbidity and Mortality Meetings

Across the region, 79% of respondents said they were able to attend monthly morbidity and mortality meetings, with 71% reporting they had the opportunity to present at these meetings.

Priority for training opportunities

When asked if they felt trainees were being given priority for training opportunities over non-trainees (locum doctors/physicians associates), over half of all respondents (57%) indicated that they felt that this was not the case. This is backed up by many of the comments left by trainees on this question:

"…main role is service provision…don't feel our training is taken into account a lot of the time."

"Locum trainees who want to do ENT will get ahead of CST"

"Locum doctors are being given equal opportunity for the theatres. "

*"…locum SHO's are given **more** training opportunities that trainees…"*

"Long term locums have the same priority for theatre"

"Locums scheduled for equal theatre slots as core trainees"

"Surgical trainees often have to give up theatre time for emergencies to locums and non-trainees"

Simulation

Trainees were asked about their experience with, and exposure to, simulation-based training. Regionally 79% of respondents felt they did not receive adequate exposure to simulation training, with all feeling that they would benefit from more access to this mode of training delivery. Almost all respondents (97%) indicated that an enhanced surgical induction would be beneficial at the beginning of the core training programme and only 10% of trainees felt that their current exposure to simulated surgical training adequately prepared them for the MRCS exam or interviews for higher surgical training.

Key Recommendations for Formal Teaching and Educational Opportunities

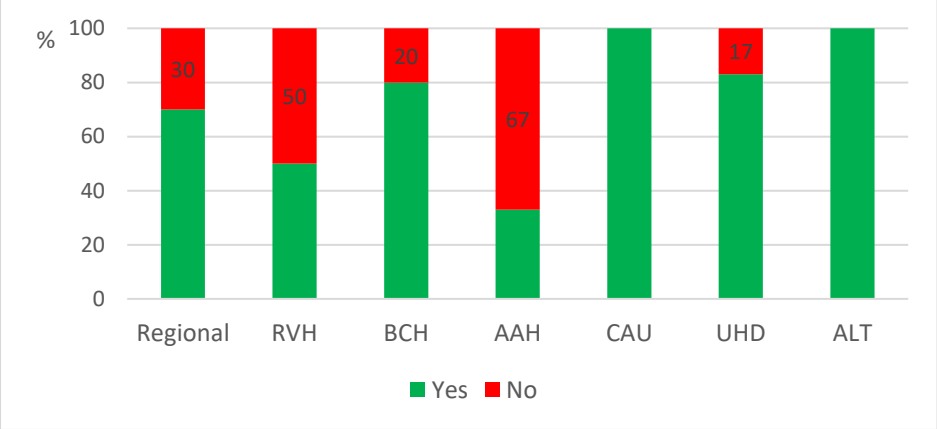
- ✓ Increased frequency of local teaching
- ✓ Development of a CST prospectus to help trainees tailor their job preferences towards their training needs in a more accurate fashion
- ✓ Trainee prioritisation for training opportunities over non-training grade doctors and physicians associates working on the same rota
- ✓ More frequent feedback on performance

5. Training Environment, Bullying, Harrassment and Undermining

Training Environment

When asked about the training environment, 70% of respondents on this survey felt they were valued and part of the team, however there was significant variation across hospital sites (Figure 26).

Figure 26: Training Environment: Trainees are valued and part of the team



Regionally, the majority of respondents (78%) stated there *was* a culture of training safety concerns within their unit, which while a positive result falls below the expected target of 100%. Only 30% of respondents reported being shown how to use the incident reporting system, demonstrating a disconnect between the culture of raising concerns and the practical ways in which this can be done. Regionally, 26% of trainees in the survey reported feeling that at times their post did compromise their personal safety. Comments from the respondents on this question highlighted concerns about feeling overworked and too tired to be able to safely drive home following a nightshift.

Bullying, Harassment and Undermining

Regionally, 30% of trainees reported experiencing behaviour that undermined their professional confidence and 19% reported having witnessed bullying, undermining or harassment (Figures 27& 28). This is an area of concern.

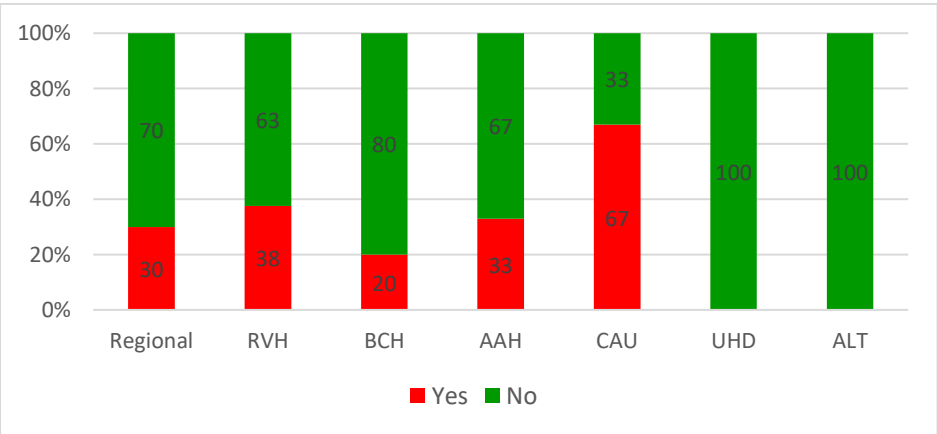
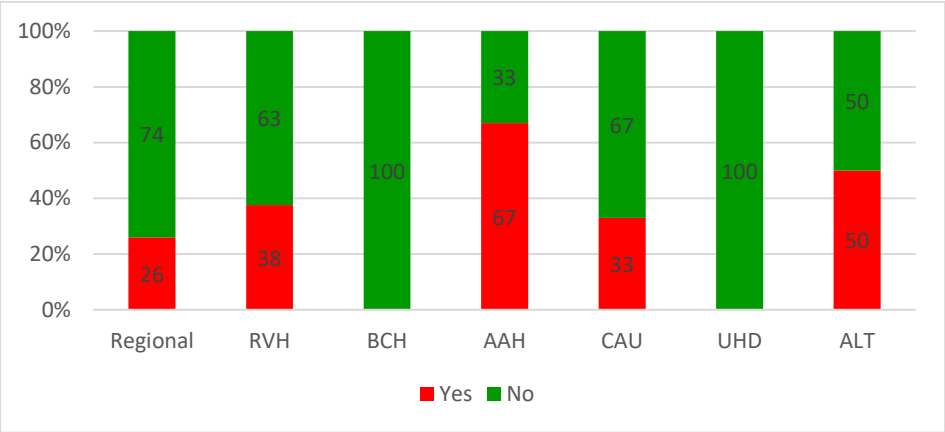


Figure 27: Percentage of trainees reporting having experienced behaviour that undermined their professional confidence or self-esteem

Figure 28: Percentage of trainees reporting having witnessed behaviour that was bullying, harassment or undermining



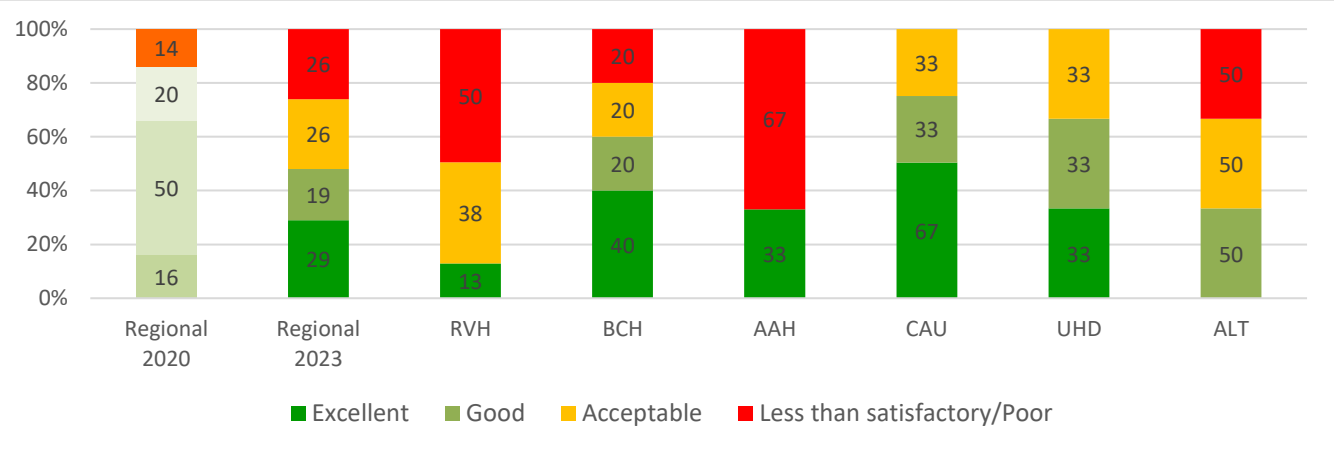
Key Recommendations for Training Environment, Bullying, Harassment and Undermining

- ✓ Eradication of bullying, undermining and harassment
- ✓ Local induction should include signposting or instructions for completing incident reports
- ✓ Earlier rota notification to ensure adequate preparation for OOH shifts
- ✓ Development of a CST prospectus to better inform trainees of the frequency of on call work and how busy the unit is, so fully informing their choice of placements

6. Overall Opinions and Trainee Suggestions for Improvement

Overall, core surgical trainees' global assessments of their placements were positive, with 48% of respondents considering their placement as a good or excellent training opportunity and a further 26% reporting it as acceptable (Figure 28). These figures when compared to the 2020 PQ review, when 66% and 20% of trainees respectively rated their placement as good/excellent or acceptable, show that trainees' view the training opportunities provided in their placement less favourably than 4 years ago.

Figure 28: Overall global assessment of placement as a training opportunity by sites



Positive trainee comments:

"Excellent training in elective breast clinic and theatre." (General, ALT)

"Sufficient time to study for surgical royal college exams" (General, BCH)

"Exposure to elective theatres" (General, CAU)

"Good clinical exposure" (RVH)

"Excellent theatre training and extremely nice team" (Vascular, RVH)

"I have felt extremely supported…all of the seniors have been very supportive" (General, CAU)

"Good trauma clinic experience" (Plastics, UHD)

"Good senior support" (UHD)

"Exposure to OPD" (General, CAU)

"I did specifically choose to come back and work here again" (General, UHD)

Negative trainee comments and suggestions for improvement:

"Covering 3 specialties overnight can be overwhelming." (General/Urology/T+O, UHD)

"Very poor circulation of rota" (???, UHD)

"A lot of service provision" (RVH)

"Intense and frequent on calls" (RVH)

"Poorly organised theatre rota…not much…training opportunities in theatre" (RVH)

<u>Suggestions for improvement</u>

"Protected teaching time" "Regular teaching"

"More staff during the night" (UHD, RVH)

"More training…in theatre. Seniors must guide and take the time out and effort to teach and train…" (T&O, RVH)

"More staff to support the on-call rota, including a supporting registrar dedicated to the take during the day." (T+O, RVH)

"Trainees should be given preference over non-training doctors." (BCH, RVH)

"Priority to core trainees in training sessions" (General, BCH)

"Remove trainee from department" (General, AAH)

"…protected admin time…" (RVH)

Section 2: Key Recommendations and Actions

The following 9 key recommendations have been developed:

1. Earlier rota notification
2. Development of a core surgery training prospectus
3. Focused local unit induction
4. Timely allocation of Assigned Educational Supervisors
5. Prioritisation of trainees for training opportunities
6. Improved senior support
7. Increased frequency of feedback
8. Regular local teaching
9. Eradication of bullying, harassment and undermining behaviour

1. **Earlier rota notification**

   This recommendation is due to the widely reported late dissemination of the on-call rotas reported in the current survey, highlighting a breach of the recommended 6 weeks' notice of on call duties outlined in the BMA's Code of Practice [5].

2. **Development of a core surgery training prospectus**

   The majority of respondents indicated that they would have liked further information to be available prior to ranking their preferences for the jobs available. Examples of such information were rota patterns, number of theatre and clinic sessions per week, specialist services in the unit, staff demographics in the unit and salary banding. All of this information could be assimilated together in a prospectus-like document which could be available to trainees on the NIMDTA website, both prior and during their core training.

3. **Focused Local unit induction**

   Local unit inductions were variable depending on hospital site. The reported areas where induction was most problematic, were those where trainees were required to cover multiple specialties/sites out of hours. Care must be taken to ensure that all trainees working on the OOH rota are provided with the appropriate induction material for all relevant specialties. Coordination of departments within a hospital site should take place in order to facilitate this.

4. **Timely Allocation of Assigned Educational Supervisors**

   Timely allocation is defined by the JCST, as having undertaken the initial learning agreement within 6 weeks of starting in post. In order to be able to do this, the trainees must therefore have their AES allocated promptly on commencing their post.

   The LEPs are aware of the trainees who will be coming to the unit and therefore prior consideration should facilitate early identification of supervisors.

5. **Prioritisation of trainees for training opportunities**

The majority of cores surgical trainees surveyed felt that their training needs were not being prioritised over other non-training grades. Given these results and trainee concerns about not having enough operative exposure to enable them to meet their training needs, it is recommended that all LEPs are asked to prioritise doctors in training posts for educational opportunities.

6. **Improved Senior Support**

Senior support, particularly in times of high work intensity, was not as highly reported as would be desirable. It is felt that a target of ≥75% should be achievable for this in every site. The regional figures for good support by consultants and senior trainees was 63% and 77% respectively in the current survey.

7. **Increased Frequency of Feedback**

Timely midpoint and final MCR provides a built-in structure for formal feedback within the portfolio; this not does take away the many clinical educational opportunities that also require contemporaneous and informal feedback in the workplace. Feedback is an important aspect of the learning process and, when given correctly, provides specific focused learning outcomes. It is therefore appropriate that trainers should ensure that all trainees are being given feedback on their performance at least a few times a month.

8. **Regular local teaching**

The JCST determines in their quality indicators that all core trainees should have access to at least 2 hours of teaching per week. Compliance is poor regionally in the sites surveyed, with only 24% of respondents achieving this. Changes therefore need to be implemented, to ensure that regular local teaching is being delivered enabling the target for ALL trainees, of 2 hours per week of formal teaching set by the JCST, to be achieved.

Trainee feedback from the current survey is that trainees in general, prefer face-to-face rather than virtual teaching; it is therefore suggested that regional teaching sessions return to the pre-pandemic in-person format. There may be specific, individual circumstances which may mean there could be a continued virtual element, but this should be strictly monitored on an individual basis.

9. **Eradication of Bullying, Harassment and Undermining behaviour**

Although 70% of respondents on this survey felt that they were part of the team; 30% reported experiencing behaviour that undermined their professional confidence and 19% reported witness bullying, undermining or harassment.

All LEPs should strive to ensure that all trainees feel part of the team. There is zero tolerance of bullying, undermining and harassment in the NHS and so there is room for improvement in this area within core surgical training.

References:

1. UK Foundation Programme Office F2 Career Destinations Report 2019 UKFPO Team - F2 CDS Report 2019

2. General Medical Council. Promoting excellence: standards for medical education and training. July 2015 (gmc-uk.org)

3. JCST Quality Indicators for Core Surgical Training (2021) Quality Indicators - JCST

4. Intercollegiate Surgical Curriculum Programme 2021. ISCP

5. British Medical Association. Code of Practice. May 2019. (bma.org.uk)

Appendix 1 Survey Results

PQ Review CST 2023

Education Areas:	RVH (%)	BCH (%)	AAH (%)	CAU (%)	UHD (%)	ALT (%)	REGIONAL (%)
TRUST notification of on-call rota > 4 weeks (Q.9)	70	83	100	100	100	33*	63
UNIT Induction appropriate (Q.11)	38*	83	33*	100	43*	100	60
Impact of rota gaps on day to day training (Q.22) – (Increased workload)	50	0	67	33	71	67	47
Impact of rota gaps on day to day training – (Missed Training Opportunities/Difficulties getting to teaching)	75	0	100	67	71	100	47
Impact of rota gaps on day to day training – (Difficulty getting study /annual leave)	25	0	100	33	43	0	17
Told who AES was for placement: (Q.23) Before starting post/within 2 weeks of starting post	63	50*	33*	67	71	67	63
Objective setting meeting with AES: (Q.24) Within 6 weeks	83	100	33*	100	100	100	83
Mid-point review meeting with AES? (Q.27) Yes	88*	100	100	100	100	100	97
Educational Supervision - Satisfactory (Q.28) (Excellent/Above average)	75	100	67	100	71	100	93
Workload (Day-time) (Q.31) - Very Intense/Excessive	63	0	67*	33	88*	67*	55
Workload (Long Day) - Very Intense/Excessive	63	25	67	67	100*	67	64
Workload (Night) – Very Intense/Excessive	63*	0	67*	0	75*	67*	47
Workload (Weekends) – Very Intense/excessive	100*	17	67	33	75	67	65
Good support from senior trainees (when workload excessive) (Q.32)	75	67	33*	100	100	67	77
Good support from Consultant – If applicable (Q.33)	25*	67	33*	100	86	100	63
Clinical Supervision (Day time) – Acceptable (Q.34) (Excellent/Good)	75*	100	33*	100	100	100	89
Clinical Supervision (OOH) - Acceptable (Q.35) (Excellent/Good)	63*	100	33*	100	71	100	77
Feedback (formal /informal) from CS:(Q.36): At least a few times per month (Weekly/A few times a month)	38*	67	33 *	100	57	67	57
Received timetable for **Regional** online teaching within the first month of starting post (Q.38): Yes	63*	100	100	67*	100	100	87
Experienced barriers to attending Regional online teaching (Q.39)	75	83	67		100	67	77
Quality of Regional teaching (Q.43): Interesting and relevant – occurring regularly	13	33	0*	67	14	33	23
Quality of Regional teaching (Q.43): Interesting and relevant – but NOT occurring regularly	75	50	100	0	86	33	67
Received teaching for exam preparation (Q.44): Yes	38	17*	0*	100	71	33	43
Protected local teaching (Q.45): At least 2 hrs/week)	13*	40	0*	100	0*	33	24
Protected local teaching: 1 hr/week or less / None	87*	60	100	0	100*	67	76
Quality of Locally delivered teaching (Q.46): Interesting and relevant – occurring regularly	13*	20	0*	100	14	33	24
Quality of Locally delivered teaching (Q.46): Interesting and relevant – but NOT occurring regularly	13	60	67	0	29	67	35
Local Teaching: Consultant attendance (Q.48) - Always/Usually	50	80	33*	67	43*	67	55

Education Areas:	**RVH (%)**	**BCH (%)**	**AAH (%)**	**CAU (%)**	**UHD (%)**	**ALT (%)**	REGIONAL **(%)**
Encouraged to complete posters/presentations/research (Q.49) – active culture/ encouraged to participate	0*	20	33 ENT	67	14*	33	24
Able to set up **QI** and Active culture of QI (Q.50)	38	60	0*	100	14*	100	45
Able to attend 1 consultant led MDT per week: (Q58)	38	0*	0*	0*	0*	0*	11
Receiving adequate exposure to **SIM training** as part of CST (Q.51)	38	20	0*	33	14*	0*	21
Able to access sufficient **OPCs t**o meet raining needs (Q.62) -Yes	38*	100	33*	100	14*	100	54
Able to access sufficient **Operating sessions** to meet raining needs (Q.63) -Yes	50*	100	33*	100	43*	100	64
Given priority for training opportunities (over non-trainees): (Q.64) - Yes	25*	40	33	100	43	50	43
Able to attend monthly M&M meetings: (Q.60) - Yes	88	100	33*	100	57*	100	79
Culture in Department to raise concerns wrt patient safety or Q of care – Yes (Q.65)	75	100	33*	100	67*	100	78
Shown how to use Trust incident reporting system (DATIX) – Yes (Q.66)	25	0	67	100	17*	0*	30
Aware of the processes for investigation of an adverse incident – Yes (Q.67)	0	0	67	100	0	50	15
Quality of care provided to patients in this post; (Q.68) – Excellent/Good	100	100	33*	100	100	50*	89
Feel valued and part of the team in this post (Q.69)	50*	80	33*	100	83	100	70
Experienced Undermining/Bullying (Q.70)	38	20	67*	67*	0	0	30
Witnessed Undermining/Bullying (Q.71)	13	20	33*	33*	17	0	19
OVERALL Satisfaction (Q.73): Placement rated as at least Acceptable (Excellent/Good)	50*	80	33*	100	100	50*	74
OVERALL Satisfaction: Placement rated as Less than satisfactory/Poor	50*	20	67*	0	0	50*	26

ACCESS to TRAINING OPPORTUNITIES – BELFAST HSCT

Consultant led clinical sessions: BHSCT

ACCESS to Training Opportunities Consultant led clinical sessions per week	BHSCT: **RVH (%)**					
	None	1-2	3 - 4	5	>5	N/A
Theatre/DPU	0	25	63	0	13	0
Endoscopy	0	13	0	0	0	88
Outpatient Clinic	38	63	0	0	0	0
Ward Round	0	13	25	0	50	13

ACCESS to Training Opportunities Consultant led clinical sessions per week	BHSCT: **BCH (%)**					
	None	1-2	3 - 4	5	>5	N/A
Theatre/DPU	0	80	0	0	20	0
Endoscopy	60	20	0	0	0	20
Outpatient Clinic	0	100	0	0	0	0
Ward Round	0	20	40	0	0	0

ACCESS to Training Opportunities Consultant led clinical sessions per week	**REGIONAL (%)**					
	None	1-2	3 - 4	5	>5	N/A
Theatre/DPU	4	46	32	3	14	0
Endoscopy	43	18	0	0	4	36
Outpatient Clinic	25	64	7	4	0	0
Ward Round	0	18	32	14	32	4

Quality of Training Opportunities (Excellent/Good at all or most attendances)	BHSCT (RVH) **(%)**	BHSCT (BCH) **(%)**	N.I 2023 Regional **(%)**
Theatre/DPU	50	80	68
Endoscopy	13	0	18
Outpatient Clinic	25	80	50
Ward Round	38	40	50

Capabilities in Practice (CiPs): BHSCT

QUALITY of TRAINING OPPORTUNITIES: to meet Specialty-specific Capabilities in Practice (CiPs)

QUALITY of Training Opportunities to achieve CiPs (Excellent/Good at all or most attendances – where felt applicable)	BHSCT **(RVH)**	BHSCT **(BCH)**	BHSCT	N.I 2023 Regional
Specialty-specific CIPs				
Managing an OPC	25	80	52	54
Managing an unselected emergency take	50	100	76	72
Managing ward rounds and the ongoing care of patients	63	60	61	72
Managing an operating list	63	80	71	61
Managing multidisciplinary working	25	80	52	50

ACCESS to TRAINING OPPORTUNITIES – NORTHERN HSCT

Consultant led clinical sessions: NHSCT

ACCESS to Training Opportunities Consultant led clinical sessions per week	NHSCT: **AAH (%)**					
	None	1-2	3 - 4	5	>5	N/A
Theatre/DPU	0	33	67	0	0	0
Endoscopy	67	33	0	0	0	0
Outpatient Clinic	67	33	0	0	0	0
Ward Round	0	0	0	33	67	0

ACCESS to Training Opportunities Consultant led clinical sessions per week	NHSCT: **CAU (%)**					
	None	1-2	3 - 4	5	>5	N/A
Theatre/DPU	0	33	33	0	33	0
Endoscopy	0	67	0	0	33	0
Outpatient Clinic	0	33	33	33	0	0
Ward Round	0	33	0	67	0	0

ACCESS to Training Opportunities Consultant led clinical sessions per week	**REGIONAL (%)**					
	None	1-2	3 - 4	5	>5	N/A
Theatre/DPU	4	46	32	3	14	0
Endoscopy	43	18	0	0	4	36
Outpatient Clinic	25	64	7	4	0	0
Ward Round	0	18	32	14	32	4

Quality of Training Opportunities (Q.57) (Excellent/Good at all or most attendances)	**AAH (%)**	**CAU (%)**	**NHSCT (%)**	**Regional (%)**
Theatre/DPU	33% ENT	100	67	68
Endoscopy	33% ENT	33	67	18
Outpatient Clinic	33% ENT	67	50	50
Ward Round	33% ENT	100	67	50

Capabilities in Practice (CiPs): BHSCT

QUALITY of TRAINING OPPORTUNITIES: to meet Specialty-specific Capabilities in Practice (CiPs)

QUALITY of Training Opportunities to achieve CiPs (Excellent/Good at all or most attendances – where felt applicable)	BHSCT **(RVH)**	BHSCT **(BCH)**	BHSCT	N.I 2023 Regional
Specialty-specific CIPs				
Managing an OPC	25	80	52	54
Managing an unselected emergency take	50	100	76	72
Managing ward rounds and the ongoing care of patients	63	60	61	72
Managing an operating list	63	80	71	61
Managing multidisciplinary working	25	80	52	50

ACCESS to TRAINING OPPORTUNITIES - SOUTH EASTERN HSCT

Consultant led clinical sessions: SEHSCT

ACCESS to Training Opportunities Consultant led clinical sessions per week	SEHSCT: **UHD (%)**					
	None	1-2	3 - 4	5	>5	N/A
Theatre/DPU	14	43	14	14	14	0
Endoscopy	86	0	0	0	0	14
Outpatient Clinic	29	71	0	0	0	0
Ward Round	0	14	57	14	14	0

ACCESS to Training Opportunities Consultant led clinical sessions per week	**REGIONAL (%)**					
	None	1-2	3 - 4	5	>5	N/A
Theatre/DPU	4	46	32	3	14	0
Endoscopy	43	18	0	0	4	36
Outpatient Clinic	25	64	7	4	0	0
Ward Round	0	18	32	14	32	4

Quality of Training Opportunities (Excellent/Good at all or most attendances)	SEHSCT (UHD) **(%)**	Regional **(%)**
Theatre/DPU	71	68
Endoscopy	0	18
Outpatient Clinic	33	50
Ward Round	71	50

Capabilities in Practice (CiPs) SEHSCT

QUALITY of TRAINING OPPORTUNITIES: to meet Specialty-specific Capabilities in Practice (CiPs)

QUALITY of Training Opportunities to achieve CiPs (Excellent/Good at all or most attendances – where felt applicable)	SEHSCT **(UHD)** (%)	N.I 2023 Regional (%)
Specialty-specific CIPs		
Managing an OPC	43	54
Managing an unselected emergency take	71	72
Managing ward rounds and the ongoing care of patients	100	72
Managing an operating list	57	61
Managing multidisciplinary working	43	50

ACCESS to TRAINING OPPORTUNITIES – WESTERN HSCT

Consultant led clinical sessions: WHSCT

ACCESS to Training Opportunities Consultant led clinical sessions per week	WHSCT: **ALT (%)**					
	None	1-2	3 - 4	5	>5	N/A
Theatre/DPU		2				
Endoscopy	50				50	
Outpatient Clinic		50	50			
Ward Round		50	50			

ACCESS to Training Opportunities Consultant led clinical sessions per week	**REGIONAL (%)**					
	None	1-2	3 - 4	5	>5	N/A
Theatre/DPU	4	46	32	3	14	0
Endoscopy	43	18	0	0	4	36
Outpatient Clinic	25	64	7	4	0	0
Ward Round	0	18	32	14	32	4

Quality of Training Opportunities (Excellent/Good at all or most attendances)	WHSCT (ALT) **(%)**	Regional **(%)**
Theatre/DPU	100	68
Endoscopy	(100 NA)	18
Outpatient Clinic	100	50
Ward Round	0	50

Capabilities in Practice (CiPs): WHSCT

QUALITY of TRAINING OPPORTUNITIES: to meet Specialty-specific Capabilities in Practice (CiPs)

QUALITY of Training Opportunities to achieve CiPs (Excellent/Good at all or most attendances – where felt applicable)	WHSCT **(ALT)** (%)	N.I 2023 Regional (%)
Specialty-specific CIPs		
Managing an OPC	100	54
Managing an unselected emergency take	100	72
Managing ward rounds and the ongoing care of patients	50	72
Managing an operating list	100	61
Managing multidisciplinary working	100	50

Key

NI Regional & Trust Data		Trust Data
Target achieved	Below Target	Figures 10% or more outside the NI figures*

* All results better or worse than the regional figure by 10% or more are marked with an asterisk

Training Opportunities (Access & Quality)

Targets for Training Opportunities (Excellent/Good) - % of trainees			
≥50%	≥75%	<50%	≤30%

Appendix 2 Education Areas & Targets

Education Areas	Target (% trainees)
TRUST notification of on-call rota > 4 weeks (Q.9)	100%
Induction appropriate (Q.11)	100%
Told who AES was for placement (Before/within 2 weeks of starting post) (Q.23)	100%
Objective setting meeting with AES within 6 weeks of starting post (Q.24)	100%
Midpoint review meeting with AES? (Q27) - Yes	100%
Workload (Daytime) Very intense/Excessive (Q.31)	≤50%
Workload (Long Day) Very Intense/Excessive	≤50%
Workload (Night) – Very Intense/Excessive	≤50%
Workload (Weekends) – Very Intense/excessive	≤50%
Good support from senior trainees (when workload excessive) (Q.32)	≥75%
Good support from consultant (when workload excessive) (Q.33)	≥75%
Educational Supervision - Satisfactory (Q.19)	≥90%
Clinical Supervision (Day time) – at least Acceptable (Q.34).	≥90%
Clinical Supervision (OOH) – at least Acceptable (Q.35)	≥90%
Feedback (formal or informal): (Q.36) At least a few times a month	100%
Received timetable for **Regional** online teaching within the first month of starting post (Q.38): Yes	100%
Quality of Regional teaching (Q.43): Interesting and relevant – occurring regularly	100%
Received teaching for exam preparation (Q.44): Yes	100%
Protected local teaching: At least 1 hr/week (Q.45)	100%
Quality of Locally delivered teaching (Q.46): Interesting & relevant – occurring regularly	100%
Protected local teaching: At least 2 hrs/week	≥50%
Protected local teaching: Less than 1 hr/week	0%
Local Teaching: Consultant attendance - Always/Usually (Q.48)	100%
Encouraged to complete posters/presentations/research (Q.49)	100%
Able to set up a QIP/Active culture of QI (Q.50) - (yes)	100%
Receiving adequate exposure to **SIM training** as part of CST (Q.51)	≥50%
Able to attend 1 consultant led MDT per week: (Q.58)	100%
Able to attend 1 M&M meeting per month: (Q.60)	100%
Able to access sufficient OPCs to meet training needs: (Q.62)	100%
Able to access sufficient Operating lists to meet training needs: (Q.63)	100%
Given priority for training opportunities (over non-trainees): (Q.64) – Yes	100%
Culture in Department to raise concerns about patient safety or Q of care – Yes (Q.65)	100%
Shown how to use Trust incident reporting system (DATIX) – Yes (Q.66)	100%
Feel valued and part of the team in this post (Q.69)	100%
Experienced Undermining/Bullying	0%
Witnessing Undermining/Bullying/Harassment	0%
OVERALL Satisfaction: Placement rated as At least acceptable	100%
OVERALL Satisfaction: Placement rated as Less than satisfactory/Poor	0%