Redefining F1
Progress Update NHSCT
Re-survey Results: 2020

August 2020

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Executive Summary

NIMDTA's Placement Quality (PQ) team commenced a review into the quality of Foundation Year 1 (F1) training posts in Northern Ireland in 2018. A Foundation Summit "Redefining F1" hosted jointly by QUB and NIMDTA then took place on 1 April 2019. The Summit looked specifically at the experiences of F1 doctors in NI and aimed to identify how the F1 experience could be redefined through a collaborative approach involving all of the key stakeholders. Representatives of all interested parties in the NI Foundation Programme (DoH, HSCB, PHA, HSC Trusts, GMC, BMA, and Trainee Forum) attended and participated actively in the Summit. There were 4 workshops held during the day, looking at essential F1 training outcomes and identifying priorities for action to improve the F1 training experience.

A Foundation PQ Report, which summarised the findings of the PQ Review and the actions agreed at the F1 Summit, was published in May 2019. This set out 12 Key Recommendations to be implemented across organisations to improve the F1 training experience. These included: ward-based shadowing; induction; clinical duties; protected teaching and work/rest facilities (Appendix 1). Further engagement with Trusts, through PQ visits, led to the creation of locally agreed Trust actions to address the recommendations.

A 'Redefining' F1 Follow-up meeting was held in October 2019 where all HSC Trusts presented progress that had been made in assessing, planning and implementing the 12 recommendations. A Progress Update Report published in November 2019 summarised the areas of good practice, identified solutions and local obstacles to implementing recommendations and highlighted key areas requiring further development.

Following local introduction of improvement strategies a re-survey of F1 doctors was conducted in January 2020 to ascertain what progress had been made in achieving the 12 key recommendations.

Regionally, there have been improvements in a number of areas including ward-based shadowing, induction, protected teaching, clinical supervision and the provision of rest facilities. There has however been minimal change in the amount of time that F1 trainees are spending on tasks of limited educational value and in participating in educationally beneficial clinical duties. The results vary significantly across sites and Trusts.

Section 1 of this report summarises the results of the re-survey for the Northern Health and Social Care Trust (NHSCT). The NHSCT 2018 F1 PQ survey results and the regional averages from the F1 2020 PQ re-survey are included for comparison.

Section 2 outlines the positive developments within the NHSCT and areas where further improvements are still required.

Section 3 provides F1 free text comments on different aspects of training.

Section 4 summarises the overall results of the 2020 Resurvey.

To ensure improvements are maintained and to assess the success of additional measures that have been introduced to further improve the F1 training experience, the Placement Quality Team at NIMDTA will be conducting a further survey of all F1 doctors in January 2021.

The results of the resurvey will be circulated to the Department of Health as well as all Medical Directors, DMEs and Foundation Programme Directors and will help to better inform Trusts of the additional progress that had been made in addressing the recommendations where the need for further improvement had been identified.

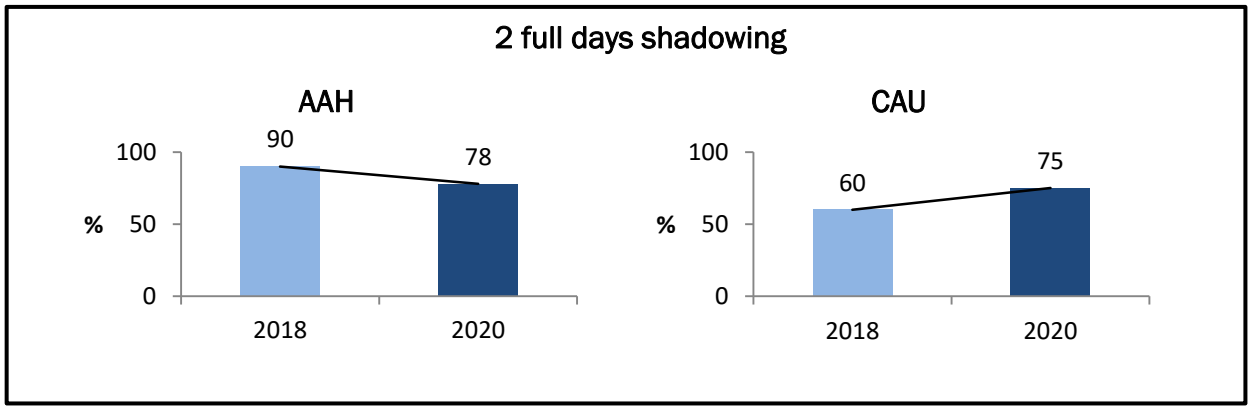
Section 1: Key Recommendations – Progress Update

In the PQ Re-survey of the NHSCT, each F1 doctor was asked about training in their FIRST four month post between 07/08/19 and 03/12/19.

The survey response rate for Antrim Area Hospital (AAH) was 36% (9 F1s of which 67 % were in a medical post and 33 % in a surgical post) and for Causeway Hospital (CAU) 31% (4 F1s of which 50 % were in a medical post and 50 % in a surgical post). The regional response rate was 54%.

Recommendation 1:

Provide all new F1 doctors with ward-based F1 **shadowing** all day for 2 full days.

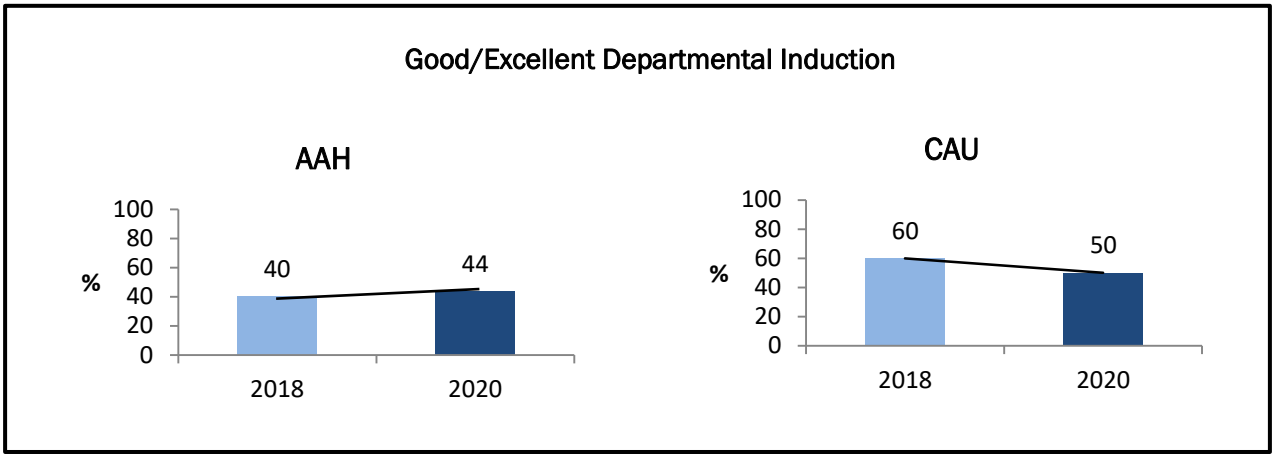


Ward-based shadowing	Northern Ireland Regional Average (2020 Re-survey)	NHSCT (%) (2020 Re-survey)	AAH		CAU	
			2018 Survey	2020 Re-survey	2018 Survey	2020 Re-survey
2 full days	79	77	90	78	60	75
<2 full days	21	23	10	22	40	25
No shadowing	0	0	0	0	0	0

Recommendation 1: NOT MET in NHSCT

Recommendation 2:

Deliver a formal **induction** for all F1 doctors to their clinical team at the start of each placement



Departmental Induction	NI Regional Average (2020 Re-survey)	NHSCT (%) (2020 Re-survey)	AAH		CAU	
			2018 Survey	2020 Re-survey	2018 Survey	2020 Re-survey
Excellent/Very Good	65	46	40	44	60	50
Satisfactory	23	15	30	11	20	25
Poor/ Unsatisfactory	12	38	30	44	20	25

Trainee Comments

"More useful things were needed like how to refer to another specialty, or where thing were." AAH F1

"Departmental induction was non-existent." AAH F1, surgery

"There was no specific induction I felt. We shadowed the wards for 2 days prior, but there was no specific induction per say, we cover all medical wards so it was just sink or swim on Day 1 I felt." CAU F1

"No specific ward induction, just shadowing." CAU F1

In the NHSCT there is no evidence in the re-survey of any improvement in the quality of departmental induction, with an increase in the number of F1 doctors reporting departmental induction as poor or unsatisfactory in **AHH** (30%→44%) and in **CAU** (20→25%).

Recommendation 1: NOT MET in NHSCT with no evidence of improvement on either site

Recommendation 3:

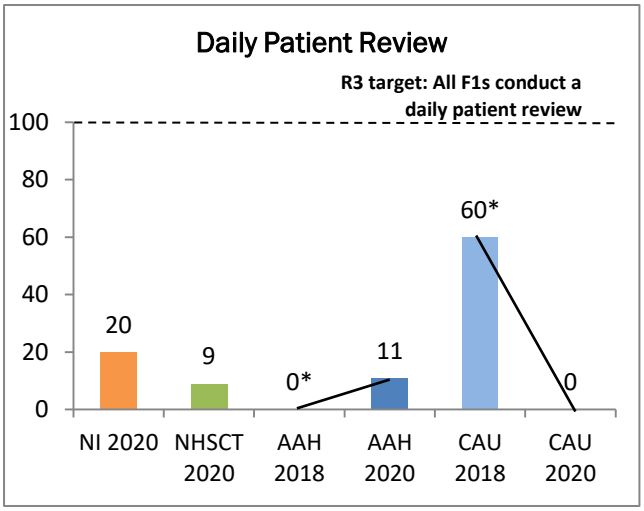
Fully involve F1 doctors in planned **patient reviews on a daily basis**

Reviewing patients on a daily basis is essential to developing the skill of managing patients with complex medical needs and progressing to more independent practice in F2 and beyond. This recommendation is an essential component of any F1 post in NI.

In **AAH** only 11% of F1s are reviewing one patient per day and a further 11 % are conducting NO daily patient reviews.

In **CAU** no F1s are conducting a daily patient review.

*Figures for 2018 not directly comparable ≈ >10/month



Recommendation 3: NOT MET in NHSCT

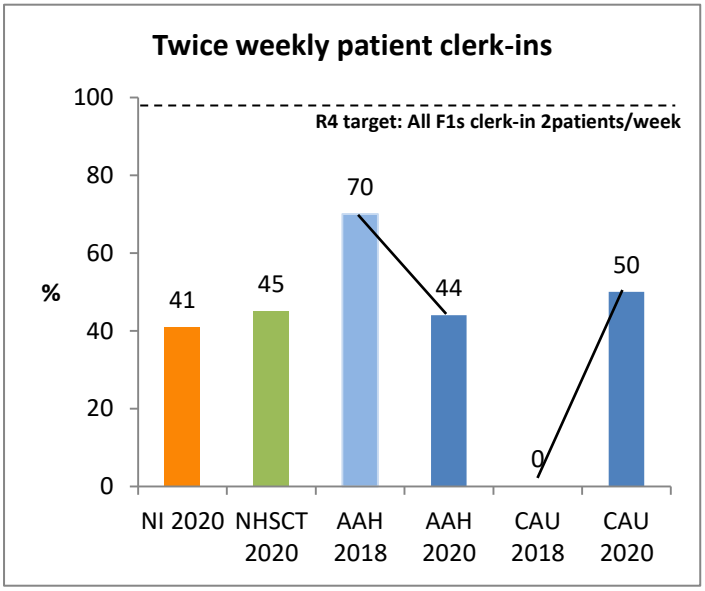
Recommendation 4:

Necessitate the participation of F1 doctors in the **clerking-in of patients** on average at least twice a week

Clerking-in patients is an essential task required at F2/CT level. Learning and developing the skills involved in this process is an important component of an F1 post.

In **AAH**, the number of F1s clerking-in 2 patients/week has fallen (70%→44%) but remains above the regional average of 41%. The number of F1s conducting NO clerk-ins has increased (0% →11%).

In **CAU** there has been a significant increase in the number of F1s clerking-in patients (0%→50%) with half of F1s now clerking in the minimum of 2 patients/week. There has been a concomitant fall in number of F1s conducting NO clerk-ins (40% → 0%).



Recommendation 4: NOT MET in NHSCT

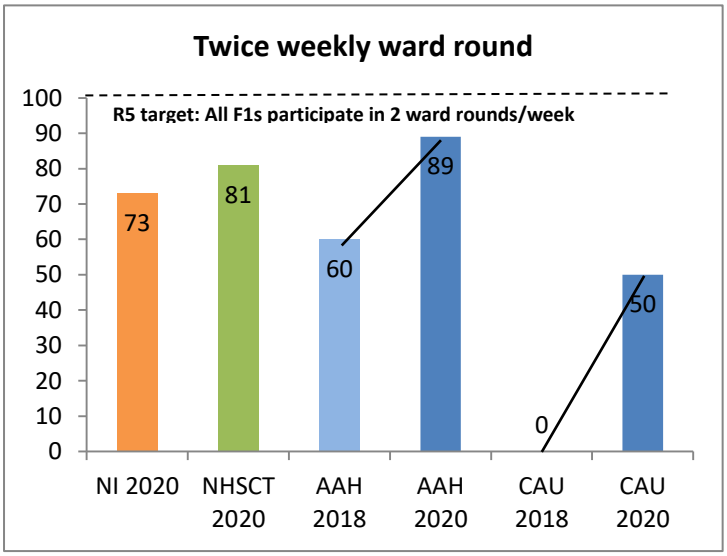
Recommendation 5:

Require the active participation of F1 doctors on **ward rounds** on average at least twice a week

Active participation in wards rounds should be an essential component of an F1 job, providing important opportunities for the development of diagnostic, management and leadership skills.

In **AAH** there has been an increase in the number of F1s attending ward rounds with 89% of F1s now participating in 2 ward rounds/week

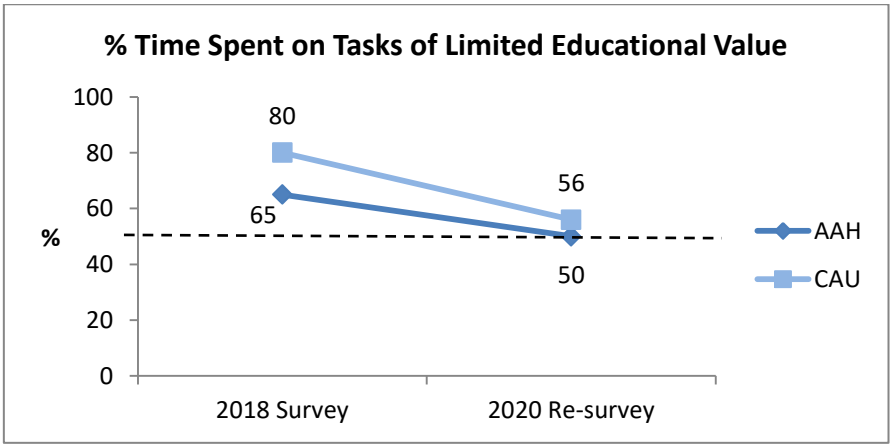
In **CAU** a significant increase is also reported in the number of F1s participating in ward rounds (0%→50%). This however remains below the regional figure of 73%.



Recommendation 5: NOT MET in NHSCT but significant improvement noted on both sites

Recommendation 6:

Limit the time spent by F1 doctors on routine **tasks of limited educational value** to no more than 50% of their time



Trainee Comments:

"Received very little medical teaching – most tasks were admin. Felt like a secretary." AAH F1."

Recommendation 6 aims to ensure that F1s do not spend more than 50% of their time on tasks of limited educational value. This includes tasks such as venepuncture, cannulation, medication kardex writing and discharge letters. While such tasks undoubtedly have an educational value in moderation, the excessive volume of these tasks, as identified by F1 doctors in the 2018 PQ survey is of little additional educational benefit and limits the time that could be used for other tasks of greater educational value such as the clinical duties highlighted in Recommendations 3-5.

Notable progress has been made in addressing Recommendation 6 across the NHSCT. AAH has achieved a significant reduction in the time spent on tasks of limited educational value (80% →56%) and has met the set target. In CAU a similar decrease has been achieved (80% →56%), nearing the set target of 50%. Both units are now below the NI regional figure of 60% (2020 Re-survey).

Continued efforts to meet Recommendation 6 are essential to redefine the F1 experience. This may involve strategies such as encouraging all levels of medical staff to contribute to these duties e.g. completing discharge letters during the ward round; addressing workforce challenges by employing more allied health care practitioners to undertake these tasks or expanding the 'Hospital at Night' role to evenings, bank holidays and weekends.

Recommendation 6: MET in AAH

Recommendation 6: Significant improvement noted on CAU site

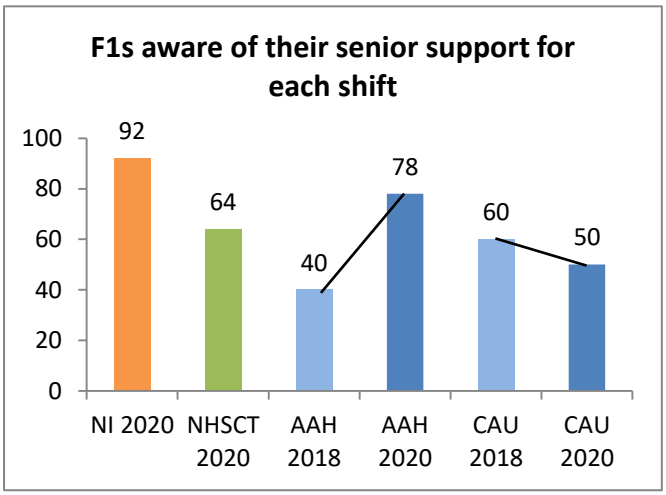
Recommendation 7:

Ensure F1 doctors are **aware of who the senior doctor is** (and how to contact them) for advice **for each shift**

In **AAH**, the number of F1 doctors reporting that they know who the senior doctor is, for advice for each shift, has increased significantly (40% → 78%).

In **CAU** however, the number has fallen (60% → 50%).

Both units rank below the regional average (92%) which has increased significantly from the 2018 survey (69%)



Recommendation 7: NOT MET in NHSCT

Recommendation 8:

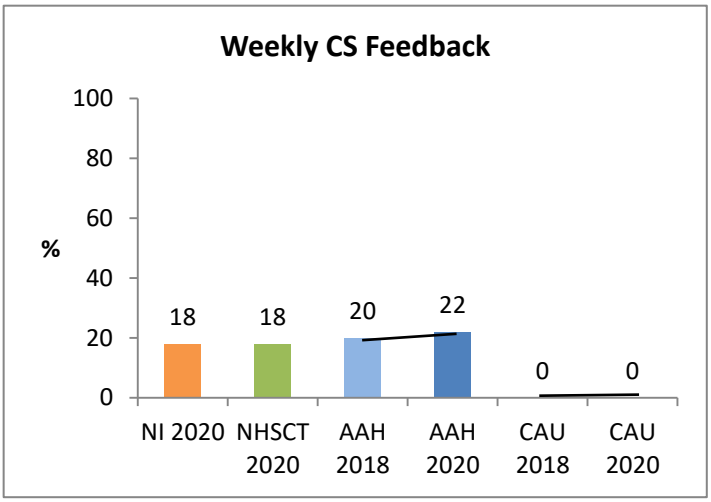
Provide **feedback** to all F1 doctors through their trained clinical supervisors on average on a **weekly** basis

Although there are now no F1s in NHSCT who never receive clinical supervisor (CS) feedback, the frequency of CS feedback remains poor with no F1s in CAU and only 22% of F1s in AAH receiving feedback weekly.

In **AAH** the overall quality of clinical supervision has improved with two thirds of F1s now reporting CS as excellent/good (30% → 66%).

In **CAU** the number of F1s reporting that the quality of clinical supervision is poor or unsatisfactory has fallen (20%→0%) and although all F1s report that CS is acceptable, no F1s report CS as excellent/good, compared to the regional figure of 65%.

Feedback is essential to developing as an F1 and contributes to feeling like a valued member of the team. More work is required to meet this recommendation.



Quality of CS	AAH		CAU	
	2018 (%)	2020 Resurvey	2018 (%)	2020 Resurvey
Excellent / Good	30	66	0	0
Acceptable	50	22	80	100
Poor/ Unsatisfactory	20	11	20	0

Frequency of CS Feedback	AAH		CAU	
	2018 Survey (%)	2020 Re-survey	2018 Survey (%)	2020 Re-survey
Daily or Once/week	20	22	0	0
< Once/week	50	77	40	100
Never	30	0	60	0

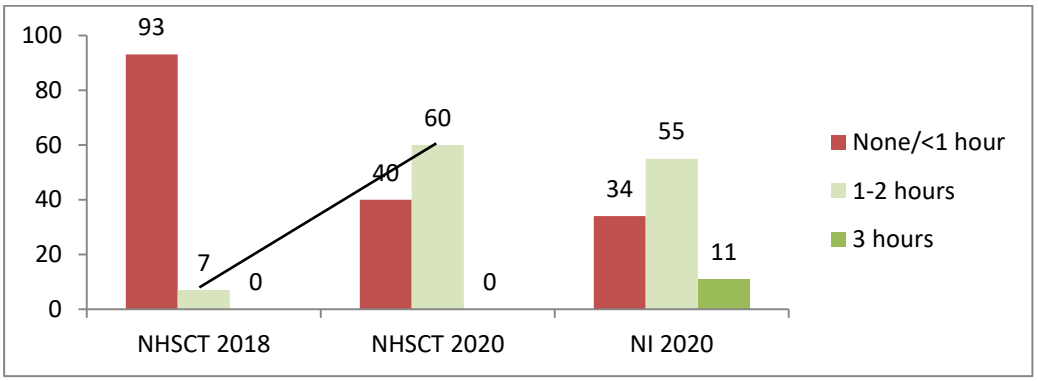
Recommendation 8: NOT MET in NHSCT

Recommendation 9:

Enable all F1 doctors to attend **3 hours of** on-site, **bleep-free, formal teaching per week**

There has been a reduction in the number of F1s receiving none or less than 1 hour/week of protected teaching across the Trust (93→40%) and a corresponding improvement in the frequency of protected on-site teaching with 60% of all NHSCT F1s now receiving at least one hour of protected teaching per week (Figure 1).

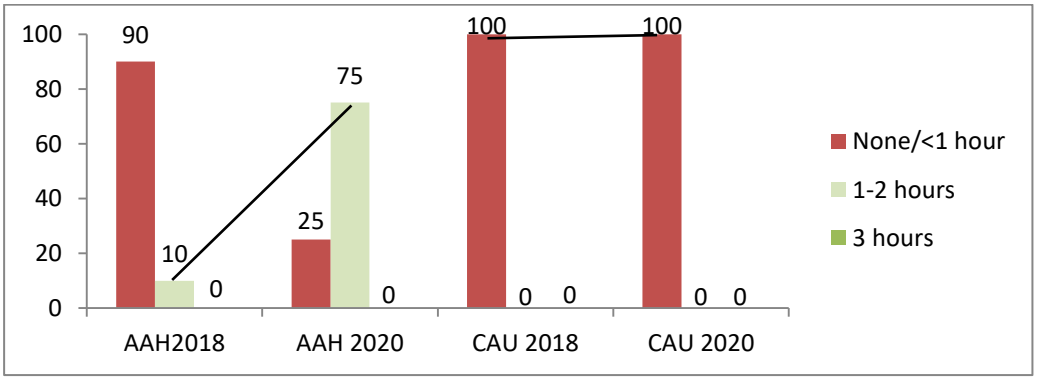
Figure 1: Weekly on-site protected teaching NHSCT 2018/20



Across all NI foundation sites, AAH has seen the greatest improvement in the delivery of protected teaching. In **AAH** the number of F1s receiving none or less than 1 hour/week of protected teaching has fallen significantly (90%→25%) with a corresponding rise (10%→75%) in the numbers of F1s receiving at least 1 hour/week of protected teaching (Figure 2). In contrast however, in CAU no F1 doctors are receiving weekly protected teaching, ranking lowest in NI for protected teaching.

In the NHSCT no F1s are receiving the NI target of 3 hours protected teaching/week.

Figure 2: Weekly on-site protected teaching AAH and CAU 2018/20



Recommendation 9: NOT MET in AAH but significant improvement noted

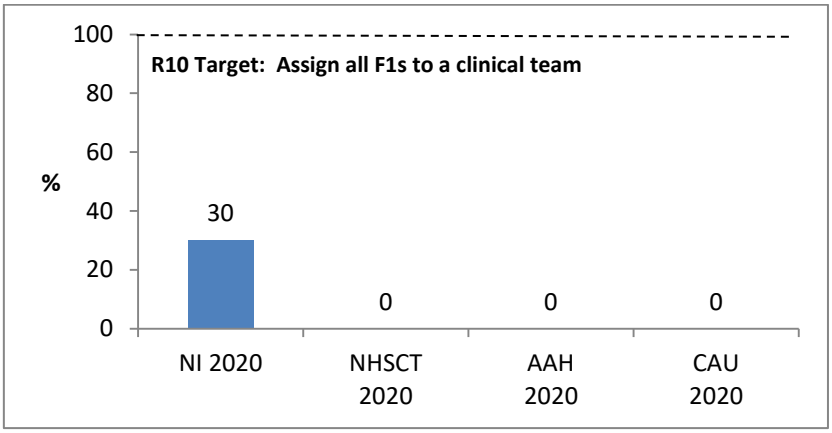
Recommendation 9: NOT MET in CAU with no evidence of improvement

Recommendation 10:

Assign F1 doctors **to a clinical team** as opposed to a clinical area

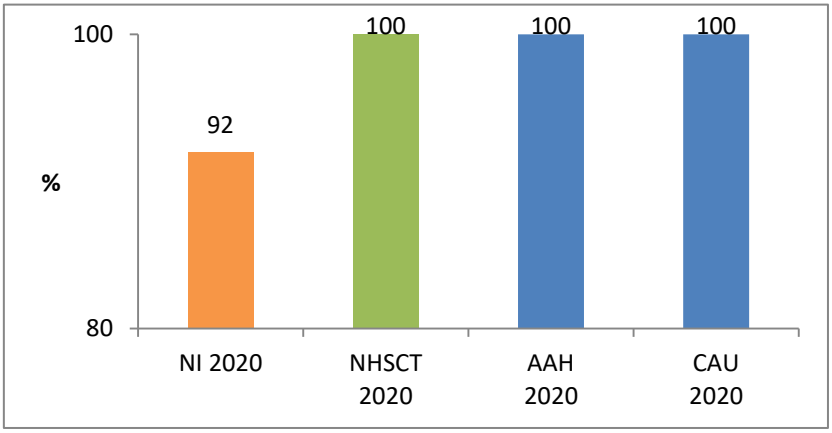
In the re-survey no F1s working in the NHSCT reported being assigned to a clinical team and instead all are ward-based or a combination of both. This was significantly below than the regional average (30%). (Figure 3)

Figure 3: Assignment to a clinical team NHSCT



Although not meeting the recommendation that all F1s should be assigned to a clinical team, 100% of F1s in the NHSCT indicated that they felt part of the multi-disciplinary team on their ward (Figure 4). This is a significant improvement from the 2018 survey (75%).

Figure 4: F1s feel part of the clinical team on the ward NHSCT



Reconfiguration of clinical teams to allow alignment of F1s should be considered in order to meet this recommendation, improve the F1 experience and promote team morale.

Recommendation 10: NOT MET in NHSCT

Recommendation 11:

Ensure that F1 doctors working **out of hours'** shifts have **access to hot food** and an **area to take rest breaks**

Recommendation 12:

Provide **rooms** where F1 doctors can **rest after a night shift before travelling home**

Measures taken to improve facilities and access to hot food out of hours boosts junior doctor morale and wellbeing, allowing F1s to care for patients to the best of their ability and consequently improves patient safety and quality of care. In addition, provision of a rest area post-nights has a positive effect in promoting the safety of F1 doctors travelling home after shifts.

The resurvey indicates that there have been some improvements in the quality of facilities provided to F1s in the NHSCT. **All** F1s in the NHSCT now report access to hot food out of hours.

In **AAH** however only 13% of F1s report having access to a rest areas OOH, below the regional figure of 46%. In contrast, availability of a rest area post-nights has improved (40 →63%).

In **CAU** <u>all</u> F1s continue to report access to a rest area OOH but access to a post-nights rest area has declined (80 →60%). (Figures 5 & 6)

Figure 5: Access to Facilities AAH

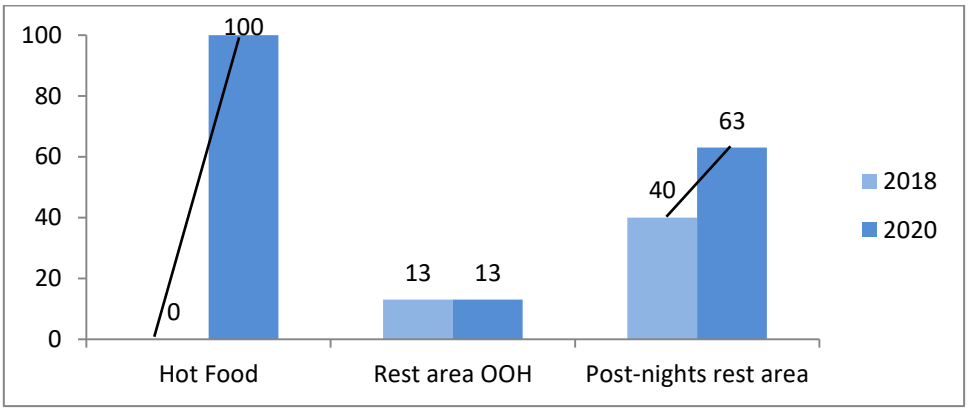
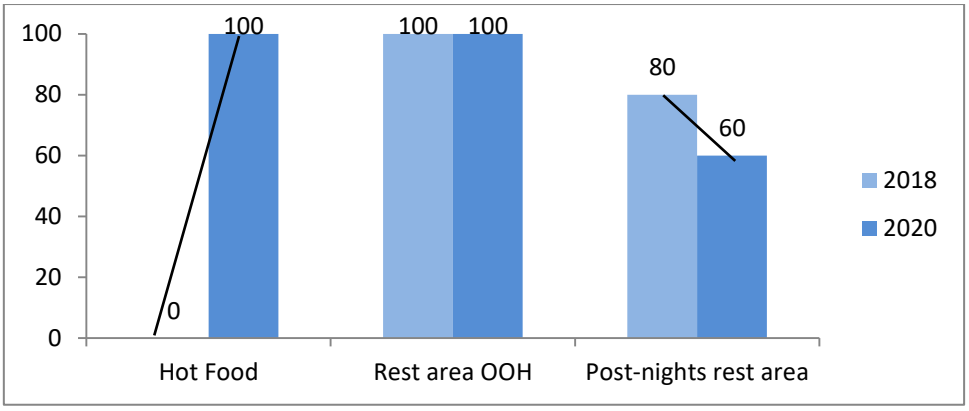


Figure 6: Access to Facilities CAU



Recommendation 11 (Hot food): MET in NHSCT

Recommendation 11 (Rest area OOH): MET in CAU

Recommendation 11 (Rest area OOH): <u>NOT</u> MET in AAH

Recommendation 12: (Rest area post-nights) <u>NOT MET</u> in NHSCT

Section 2: Practice Improvements and Development Needs

Antrim Area Hospital

Practice Improvements AAH	Development Needs
Clinical Duties: 44% of F1s conduct at least **2 patient clerk-ins** / week.	**Work based shadowing:** The number of F1s receiving 2 full days shadowing has fallen (90% → 78%)
Clinical Duties: The number of F1s actively participating in a **ward round twice a week** has significantly improved (60% → 89%) and is close to the recommended target (100%).	**Departmental Induction:** **44%** of F1s continue to report departmental induction as **poor/unsatisfactory**, significantly above the regional figure 12%.
Clinical Duties: F1s now state they spend 50% of their time on tasks of limited educational value, a significant improvement since 2018 (65%) and below the regional average (60%). RECOMMENDATION MET	**Clinical Duties:** Less than half of F1s **clerk-in 2 patients per week**, a fall since the 2018 PQ review (70% → 44%)
	Clinical Duties: **11%** of F1s conduct **no patient reviews** and just 11% review patients on a daily basis.
	Clinical Duties: **11%** of F1s still attend **no ward rounds** unchanged from the 2018 PQ review (10%).
Clinical Supervision: The overall quality of clinical supervision has improved with two thirds of F1s now reporting CS as excellent/good (30% → 66%).	**Clinical Supervisor Feedback:** There has been little change in the **frequency** of clinical supervisor feedback since the 2018 PQ review with only 1 in 5 F1s receiving weekly feedback (20%→22%). This is significantly lower than the recommended target (100%).
Senior doctor: The majority (78%) of F1s are aware of who their senior doctor is for each shift. This is an improvement from 2018 PQ review (40%) but remains below the regional average (92%).	**Clinical team:** **No** F1s are **aligned to a clinical team** as opposed to a clinical area, significantly below the regional average (30%). Despite this, all feel part of the wider clinical team on their ward.
Protected teaching: The number of F1s stating they get none or less than 1 hour/week of protected teaching has fallen significantly (90%→25%). This is mirrored by a significant increase in the number of F1s receiving at least 1 hour of protected teaching/week (10%→75%).	**Protected teaching:** **No** F1s are receiving the recommended 3 hours/week of protected teaching.
Facilities: There has been a significant increase in **access to hot food** out of hours (0%→100%). RECOMMENDATION MET	**Facilities:** Just **13%** of F1s state they have **access to a rest area out of hours**, below the regional figure of 46%.
Facilities: There has been an increase in the number of F1s reporting access to a **rest area post-nights** (40%→63%). This is above the regional figure of 45%.	

Causeway Hospital

Practice Improvements	Development Needs
Ward based shadowing: The number of F1s receiving 2 full days of shadowing has improved. (60%→75%).	**Departmental Induction:** A quarter of F1s continue to report departmental induction as **poor/unsatisfactory**, double the regional average.
Clinical Duties: There has been a significant improvement in the number of F1s participating in **at least 2 ward rounds per week** (0→50%). This however remains below the regional average (73%).	**Clinical Duties:** Although an improvement from the 2018 PQ review when all F1s did not meet the target of 2 ward rounds /week, **50%** of F1s still attend **<2 ward rounds/week.**
Clinical Duties: Half of F1s are now **clerking in** the minimum of **2 patients/week** a significant improvement from the 2018 PQ review when no F1s were meeting this target. This however remains significantly below the recommended target of 100%.	**Clinical Duties:** **No** F1s in CAU are **reviewing a patient on a daily basis**. Regional average 20% F1s conducting at least 1 patient review/day)
Clinical Duties: F1s now state they spend 56% of their time on tasks of limited educational value, a significant improvement since 2018 (80%) and below the regional average (60%).	**Clinical Duties:** **No** F1s report the quality of clinical supervision as excellent or good.
	Clinical Supervisor Feedback: Although the number of F1s receiving no clinical supervisor feedback has fallen (60%→0%), **No F1s** are receiving the recommended **weekly CS feedback**. This remains unchanged since the 2018 PQ review.
Facilities: There has been a significant increase in **access to hot food** out of hours (0%→100%). RECOMMENDATION MET	**Senior doctor:** Only **50%** of F1s report they are **aware of** who is the **senior doctor for each shift**. This is a decrease from the 2018 PQ review (60%) and is significantly below the regional average (92%).
Facilities: 100% of F1s continue to report **access to a rest area OOH**. RECOMMENDATION MET	**Clinical team:** **No** F1s are **aligned to a clinical team** as opposed to a clinical area, significantly below the regional average (30%). Despite this, all feel part of the wider clinical team on their ward.
	Protected teaching: **No F1s** in CAU are receiving **weekly protected teaching**, giving CAU the lowest ranking in NI for this recommendation. 50% of F1s state that they do get 3 hours of non-protected teaching/week but all report having to leave teaching to answer bleeps.
	Facilities: There has been a fall in the number of F1s reporting **access to a rest area post-nights** (80%→60%)

Section 3: Summary

There have been clear improvements in the quality of the F1 experience in the NHSCT since the initial review in 2018.

Antrim Area Hospital rates highly as regards the F1 training experience (Table 1). Recommendations have been met in the areas of access to hot food out of hours and time spent on tasks of limited educational value. Significant improvements have also been seen in ward round attendance, quality of clinical supervision, protected teaching and facilities (access to a rest area post-nights).
Remaining areas for improvement include: work based shadowing and departmental induction, clinical duties (daily patient reviews, clerking-in patients), frequency of clinical supervisor feedback, alignment to the clinical team, protected teaching and facilities (access to a rest area out of hours).

In **Causeway Hospital** recommendations have been met in the areas of facilities (access to hot food OOH and access to a rest area OOH). There has also been a significant reduction in the time spent on tasks of limited educational value which now scores below the regional figure and close to the recommended target. Improvements are also noted in ward round attendance and patient clerk-ins. Despite this, when asked to provide a global score for the placement as a training opportunity, no F1 rated the training as excellent or good (Table 1).
Remaining areas for improvement include: departmental induction, ward round attendance, daily patient reviews, frequency of clinical supervisor feedback, awareness of senior doctor supervision, protected teaching and facilities (access to a rest area post-nights).

Table 1: Global Score for placement as a training opportunity

Q/ Please provide a global score for this placement as a training opportunity?	AAH (%)	CAU (%)
Excellent	25	0
Very Good	50	0
Acceptable	12.5	100
Poor/ Less than satisfactory	12.5	0
Very poor, serious concerns	0	0
Overall ranking based on this question	4/11	11/11

Workload intensity remains an issue in both units with ALL F1s reporting workload as very intense or excessive at weekend on both sites (Table 2). In addition every F1 respondents in NHST felt the workload was very intense or excessive at weekends. Addressing this issue will be pivotal in achieving further progress in addressing the 12 key recommendations.

Table 2: Workload Intensity NHSCT

Q/ Please rate the workload in your F1 post? (%)	AAH			CAU		
	Daytime	At night	At weekends	Daytime	At night	At weekends
Too light	0	0	0	33	0	0
Low intensity	0	0	0	0	0	0
Just right intensity	56	78	0	33	33	0
Very intense/excessive	44	22	100	33	66	100

There has been an innovative and sustained effort to implement changes in practice following the initial PQ review in 2018, evidenced by the practice improvements reported in the re-survey and these efforts are to be commended. Development of strategies to mitigate the high workload intensity at weekends on both sites remains a key issue.

To ensure improvements are maintained and to assess the success of additional measures that have been introduced to further improve the F1 training experience, the Placement Quality Team at NIMDTA will be conducting a further survey of all F1 doctors in January 2021.

Appendices

Appendix 1

12 key recommendations for HSC Trusts to improve the F1 experience.

1. Provide all new F1 doctors with ward-based F1 **shadowing** all day for **2 full days**
2. Deliver a formal **induction** for all* F1 doctors to their clinical team **at the start of each placement**
3. Fully involve F1 doctors in planned **patient reviews on a daily basis**
4. Necessitate the participation of F1 doctors in the **clerking-in of patients** on average **at least twice a week**
5. Require the active participation of F1 doctors on **ward rounds** on average **at least twice a week**
6. Limit the time spent by F1 doctors on routine **tasks of limited educational value** to **no more than 50% of their time****
7. Ensure F1 doctors are **aware of who the senior doctor** is (and how to contact them) for advice **for each shift**
8. Provide **feedback** to all F1 doctors through their trained Clinical Supervisors on average on a **weekly** basis
9. Enable all F1 doctors to **attend 3 hours** of on-site, bleep-free, **formal teaching*** per week**
10. **Assign** F1 doctors **to a clinical team** as opposed to a clinical area
11. Ensure that F1 doctors working **out of hours'** shifts have **access to hot food** and an area to take rest breaks
12. Provide **rooms** where F1 doctors can **rest after a night shift before travelling home**

**including F1 doctors who are commencing on out of hours or who have a late start date*
*** Examples include venepuncture, IV cannulation, peripheral blood cultures, preparing and administering IV medication/injections, performing ECGs. F1 doctors should complete no more than 5 discharge letters per day*
**** 50% formal teaching should be based on the Foundation Curriculum*

Appendix 2:

Free-text trainee comments re-survey 2020

Antrim Area Hospital

Induction and Shadowing

'Too quick, unimportant topics, would rather a PDF.' [Trust Induction]

'More useful things like how to refer to another specialty, where things are.' [Departmental Induction]

'Started on nights and was told unable to shadow. F1s too busy' [Shadowing]

Workload

'Weekends are very unsupported and understaffed at AAH, putting excessive pressure on F1.'

'Had to stay overtime.'

Clinical Duties and Supervision

'At the start your allocated reg and SHO could be off on leave at the same time so there was no one to contact for questions except the consultant.' [Senior doctor awareness]

Clinical Teams

'Towards the end there were assigned teams with 3 consultants in one team with assigned Regs and SHOs. This was useful'.

'The times I worked on the team it was useful. Jobs were allocated and it reduced the need to do multiple ward rounds in one day.'

Overall opinions

'Well-staffed, obvious protocols and guidelines in place, great medical model and hierarchy of staff.'

'More senior support; Understaffing has led to less ward based clinical teaching opportunities; Clinical supervisor teaching on the ward; All consultants should be assigned to a team of 3.' [Improvements]

'Continue to expand the handbook; more F1s in this job - busy hospital.' [Improvements]

'More opportunities to attend clinics and bronchoscopies; More impromptu teaching sessions; core skills workshops for F1s.' [Improvements]

'Consultant-led ward rounds on more than 2 days of the week' [Improvements]

'Bleep protected time should be enforced. We were supposed to have no bleeps from 1-2 on wed for teaching but often the surgical F1s kept getting bleeped.' [Improvements]

'There should be a rule like there is in medicine that nurses should try cannulas and bloods at least twice before bleeping the doctor. Often they were trained but they just didn't think they would get it so they didn't try. I think they would've got it most of the time if they had attempted.' [Improvements]

Causeway Hospital

Induction

'Too hot, poor ventilation, way too much to do. Cover warfarin prescription. Ensure passwords/ID cards available at beginning.' [Trust Induction]

'No specific ward induction, just shadowing.' [Departmental Induction]

Workload

'At weekends emergency F1 bleep is constantly bleeped for high NEWS and routine tasks.'

Clinical Teams'

'Assigned to a ward. Clinical teams would come in and out. Quite chaotic'

Overall opinions

'The job role - what an F1 is expected to do' [Improvements - induction]

'More consultant teaching/ input into their patients (locum consultants who aren't very interested in what's going on.' [Improvements]

'Proper bleep free teaching.' [Improvements]