

Making the most of trainee doctors' insights

A discussion paper

Background

The Francis Inquiry report¹ and Professor Sir Bruce Keogh² have noted that trainee doctors are well placed to improve patient safety in their trusts but too many are not being valued or listened to. Trainee doctors also provide constructive feedback on their training, and bring enthusiasm to collaborative research. The recent junior doctors' contract dispute has also highlighted how the wider NHS needs to do much more to support junior doctors.

Sir Robert Francis noted that at Mid-Staffordshire Hospital "the system for reporting ... did not give sufficient weight to concerns raised by trainees with regard to ... patient safety", and recommended that "obtaining information directly from trainees should remain a valuable source of information". Current incident reporting systems may however foster a sense of vulnerability, discouraging trainee doctors from speaking up.³

Seeking trainee doctors' views on their own training is vital, as it can help to ensure that training is effective and translates into quality patient care. Surveys such as the annual General Medical Council (GMC) national trainee survey monitor trainee doctors' opinions on the quality of medical education and training.⁴ Survey feedback is not always acted on, hindering its potential to improve medical training.

Trainee doctors are also ideally placed to contribute to trial and audit-based research studies involving multiple organisations ('collaborative research'),⁵ as they rotate through several hospitals and are in regular contact with each other. Trainee-led collaborative research has been developed for several surgical specialties, a model now being used for other medical specialties, including anaesthetics and oncology. However, barriers such as insufficient time and recognition can discourage trainee doctors' involvement in such initiatives.

About this paper

This paper considers the barriers to trainee doctors contributing their insights and examples of best practice across three areas: quality improvement (QI), education and training, and clinical research (primarily large scale collaborative research).

It follows a roundtable discussion held at the RCS with trainee doctors, managerial representatives, and representatives from Royal Colleges, regulators, education and training bodies, and think tanks. We hope that by spreading best practice we can encourage the valuable insights of trainee doctors to be taken on board to improve the health service. This document should also feed into current debates⁶ about the skills we expect doctors to have and how they can better contribute to patient care.

Using insights from the roundtable discussion, we have identified three broad means by which we can make the most of trainee doctors' insights in the NHS:

1. Recognise and incentivise the insights of trainee doctors: Trainee doctors face high workloads and competing pressures. Incentives can encourage them to take part in the three areas covered in this paper. Doctors can be recognised through curricula and training assessments or through awards.
2. Promote a culture that supports trainee doctors: trusts need to facilitate a culture where trainee doctors feel able and confident to raise patient safety concerns and feed back on their training without fear of repercussions.
3. Establish formal mechanisms to support trainee doctors: Formal systems need to be in place to ensure that trainee doctors' views are taken on board, and their training allows them to take part in research and QI projects.

1 Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. 2013 February 6. Available from: <https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry>

2 Keogh B. Review into the quality of care and treatment provided by 14 hospital trusts in England. 2013 July 16. Available from: <http://www.nhs.uk/nhsengland/bruce-keogh-review/documents/outcomes/keogh-review-final-report.pdf>

3 Sarfo-Annin JK. Should trainees be the 'eyes and the ears' of both good and bad practice in hospitals? *Future Hosp J* 2015; 2: 11-12

4 General Medical Council. National trainee survey. http://www.gmc-uk.org/education/national_trainee_survey.asp

5 Bhangu A, Kolias AG, Pinkney T, Hall NJ, Fitzgerald JE. Surgical research collaboratives in the UK. *Lancet* 2013; 382: 1091-1092

6 For example, the Academy of Medical Royal Colleges and the GMC are currently outlining what additional skills they believe doctors should have to ensure they can deliver safe, high quality clinical care. As part of this they are recommending the importance of doctors' involvement in QI, evaluation of their education and training, and participation in research – the areas outlined by this paper. Further information is available here: <http://www.gmc-uk.org/education/23581.asp>

Sharing best practice: Barriers, actions and case studies

1. Making the most of trainee doctors' insights in quality improvement (QI)

The King's Fund has demonstrated that reform and improvement in the NHS are primarily driven by those on the front-line, rather than changes to regulation or legislation.⁷ Doctors' involvement in QI programmes and projects are therefore vital in supporting high quality care.

QI programmes involve a systematic approach to improve patient outcomes.⁸ QI starts when an area of care that requires improvement is identified. In some cases the standard of care is of decent, but not excellent, quality. However, there are also cases where patient safety is at risk, and staff have to raise concerns to initiate the QI process. There are obstacles in the way of trainee doctors both getting involved in QI projects and raising patient safety concerns.

BARRIERS

Time: There are competing pressures on training, not least helping a hospital to deliver important service commitments. This reduces the time and resources that trainee doctors are willing and able to spend on QI work. Most training curricula include QI work but it is not sufficiently recognised by all hospitals and training programmes. Involvement in QI also varies by Trust.

Perceived career risk: As recognised in the Francis Review, trainee doctors may fear that their career will be undermined if they raise concerns.¹

Hierarchy: A divide can exist between management and doctors, particularly trainee doctors, who often do not know who their medical director is. The spend on training is large at Trust level yet board meetings often involve little time engaging with trainee doctors.

Short rotations: Given the short length of rotations, trainee doctors may not see the value in committing to a QI project which they may not be able to see through, or which they think is unlikely to be continued after they leave. Often an enthusiastic trainee doctor will implement a project successfully, but when they move on to a new placement, this project will not be continued.

ACTIONS

Reduce time commitment or protect time: Instead of QI projects, conduct incremental improvement work that is a more time-efficient everyday practice. Alternatively protect or set aside time for trainee doctors to conduct QI work, and make sure that measures of productivity are not reduced when doctors take time out from service for this purpose (see case study A).

Incentives: Encourage QI work by making it a requirement of curricula, or make curricula flexible to recognise work in a doctor's area of interest, e.g. QI, leadership, research. Alternatively, QI work could be incentivised through competitions and prizes, as illustrated in case study B. Any actions need to consider:

- quality over quantity: it is better to focus on doing one QI project well, rather than a number of projects which risk being perceived as a 'chore'
- how to incentivise the most productive project, which may require teamwork, rather than focussing on individual achievements.

Culture: Promote an open culture and safe environment for trainee doctors to raise concerns on a regular basis (see case study C), or even as part of everyday practice (see case study A). This may well involve discussions with other trainee doctors, with whom they are more likely to share their concerns, rather than to those with more senior roles. Sir Robert Francis' 'Freedom to Speak Up' review recommends establishment of 'Freedom to Speak Up' Guardians in every NHS organisation.¹ There may be a role for junior Guardians to whom trainee doctors would feel more comfortable reporting concerns.

Connect with managers: Formal systems such as those in case study D can be used to connect trainee doctors and managers. These can be used as a means to ensure that QI work is supported and overseen by managers.

Team approach: Involve a large team in QI initiatives to ensure their continuation after a key contributor leaves their post (see case study A).

⁷ Ham C. Reforming the NHS from within. The King's Fund June 2014. Available from: <http://www.kingsfund.org.uk/publications/reforming-nhs-within>

⁸ Quality improvement made simple. The Health Foundation August 2013. Available from: <http://www.health.org.uk/publication/quality-improvement-made-simple>

Case study A: Virginia Mason Institute, Seattle, USA

In 2004 a medical error led to an avoidable death at Virginia Mason Hospital in Seattle, the USA. This patient safety incident triggered a transformation which led to the hospital becoming one of the safest in the world.⁹

Staff at the hospital do not see QI as an event, rather it is an everyday practice of incremental improvement work, and an integral part of their culture. There is an ongoing programme of improvement, with new priority areas selected every five years. Doctors at all levels participate in this programme, and trainee doctors are considered to add great value to QI activity. This is because of their open minds; exposure to newer approaches in healthcare; proximity to challenging clinical work; and focus on improvement 'systems'. Indeed trainee doctors are required to be involved in QI projects during their placement at Virginia Mason and can elect to do a unique (and popular) rotation involving more intense study of improvement systems and tools. The organisation considers involving trainee doctors in QI to be an investment in the doctors of the future.

Virginia Mason's emphasis on continuous learning and improvement is supported by a team approach, whereby projects are carried out by multiple clinicians. This ensures project continuity even after a key figure in the project leaves their post. In addition, improvement goals are designed to be achievable within one year, increasing the likelihood that doctors will see the project lead to concrete outcomes before the end of their placement. This gives trainee doctors a goal to work towards, making them more committed to the project. Furthermore, actions are taken to ensure that doctors' measures of productivity are not affected if they take time out from service to do QI work. This ensures that time pressures are not a barrier to doctors taking part.

With regard to patient safety, the hospital has an alert system through which all staff (including non-clinical staff such as cleaners) are encouraged to report potential safety issues, with no fear of repercussions – by contrast, they are thanked. They agree to a 'compact', a two-sided contract which sets out what the organisation can expect of staff and vice versa. Staff are expected to report patient safety concerns and incidents, and in return they can expect to be supported by the organisation during this process. They also receive feedback on what changes will be made as a consequence of the concern they have raised. This reassures staff that their concerns will be acted on, and are therefore worth raising.

Case study B: Dragons' Den, Health Education North West

A team of trainee doctors at Health Education North West run an annual Dragons' Den¹⁰ where trainee doctors pitch an idea to Board Level Executives that aims to 'transform the way we deliver our service, training and the environment we work in for the better'. Doctors with the best pitches are then given funding and mentoring to help them implement their idea. Afterwards they then have the opportunity to present their project at a regional conference. They could win a regional prize, and their idea could be expanded to other North West trusts.

Case study C: Patient safety group, East Kent Hospitals University NHS Trust

A patient safety group¹¹ of trainee doctors was set up to encourage the development of innovative ways of learning from serious patient safety incidents. The group meets monthly and is a two way interface, acting on trainee doctors' concerns and using them to feed back to colleagues.

One of the outcomes has been educational posters promoting correct prescribing practices, following the identification of errors in prescribing as a concern for the Trust.

Case study D: Quality improvement (QI) Academy

The 'F1 QI Academy training programme'¹² helps trainee doctors to run a structured, supported QI project of their choice over a year period. Each trainee doctor is joined up to a hospital manager who helps them to see their project through. Over 100 projects have been run so far on topics such as discharge summaries, common equipment trolleys, weekend handover, and reducing unnecessary blood tests. This model has been rolled out in nine acute Trusts in the South West, by Severn and Peninsula Deaneries with the support of the South West Academic Health Science Network. It has been very successful and has led to the Academy being shortlisted for the HSJ Patient Safety and Care Awards. As part of the QI Academy programme trainee doctors gain an understanding of the hospital as a system by becoming involved in core management meetings with managers. They also learn QI methods and most importantly advance their own professional development.

⁹ Virginia Mason Blog. Terrible tragedy – and powerful legacy – of preventable death. Available from: <http://virginiamasonblog.org/2014/03/26/terrible-tragedy-and-powerful-legacy-of-preventable-death/>

¹⁰ Health Education North West. North West Dragons' Den. <https://nw.hee.nhs.uk/our-work/jdat/dragons-den/north-west-junior-doctor-dragons-den>

¹¹ Health Education Kent, Surrey and Sussex. Quality Management of Specialty Training. Available from: http://www.gpkss.ac.uk/sites/kssdeanery/files/Collated-Pre-Visit-Templates-CMT_0.pdf

¹² South West Academic Health Science Network. F1 Quality Improvement Academy. <http://www.swahsn.com/documents>

2. Making the most of trainee doctors' insights in education and training

One of the best ways to assess and improve the quality of medical training programmes is to hear directly from doctors in training – there will always be aspects of training that are less popular than others. Ideally this would take place in the form of open conversations with those who have influence over training, but fear of repercussions can deter trainee doctors from feeding back in this way.

BARRIERS

Hierarchical culture: Trainee doctors can feel it is inappropriate for them to make suggestions to senior staff about how their training can be improved. They can also feel that decisions about their training take place behind closed doors.

Perceived career risk: Trainee doctors may fear that giving honest feedback on their education and training could have negative consequences for their career.

ACTIONS

Open culture: Promote a culture which encourages trainee doctors to feed back on their training without fearing repercussions. Facilitate open conversations via the College Tutor who oversees doctors' training or as part of the Annual Review of Competence Progression discussions. (For trainee surgeons, such conversations could take place with the Joint Committee on Surgical Training (JCST) Specialty Advisory Committee members, who devise the surgical trainee curriculum.) Trainee doctors' views can also be fed back via an elected representative doctor, or through focus groups and feedback sessions (see case study E).

Guarantee anonymity: In many instances, the culture is not sufficiently open for trainee doctors to feel comfortable enough to give honest feedback. An alternative is to ensure feedback is anonymous (though we recognise guaranteed anonymity is not always possible). Surveys can facilitate this. Local or small-scale surveys can be particularly effective in bringing about more tailored improvements, as demonstrated in case study F.

Case study E: Frimley Park Hospital, Frimley Health NHS Foundation Trust

Frimley Park was the first hospital to be rated as outstanding by the CQC.¹³ It therefore comes as no surprise that the culture at the Trust encourages trainee doctors to share their views. This attitude is made clear straight after trainee doctors' full day induction, when they are sent an electronic form to gain feedback on the day, which is then used to improve the next induction. As their placement progresses, doctors can go to the Trust's Postgraduate Centre to talk about any concerns they have about their training, and staff are grateful that doctors use this opportunity. In addition the Surgical Tutor holds regular lunches for all trainee doctors to attend and discuss any issues informally.

Trainee doctors' voices are heard at the highest levels. At the Junior Doctors Forum, trainee doctors are asked to share any issues they have experienced since starting their placements. The Chief Executive wants to hear of any issues so attends the session, illustrating just how valued trainee doctors' insights are. The session is relaxed and informal so, even in the presence of senior staff, trainee doctors are happy to discuss the issues they have had. This has led to new ways of working, such as nurses taking patients' blood at the weekend to free up trainee doctors' time to do other work.

Doctors with particular enthusiasm for effecting organisational change are supported by a 'Trainee Voice Programme' to become trainee doctor representatives on the Trust's Local Faculty Group. This group meets three times a year to discuss issues including training and patient safety. These discussions are then fed back to the Local Education and Training Board. At one such meeting, trainee doctors raised the point that there was not enough cover over bank holidays at Christmas. Actions were taken to change this, and at subsequent bank holidays these trainee doctor representatives were consulted on whether they felt the measures had been successful. Indeed the doctors found that the system had been made fairer and there was enough cover over these periods. Feedback from trainee doctors had translated into an improved service.

¹³ Care Quality Commission. Frimley Park Hospital NHS Foundation Trust awarded first Outstanding rating by Chief Inspector of Hospitals. 2014 September 26. Available from: <http://www.cqc.org.uk/content/frimley-park-hospital-nhs-foundation-trust-awarded-first-outstanding-rating-chief-inspector>

Case study F: Anonymous hospital department-specific survey feedback, Severn Deanery, Health Education South West

At the Severn Deanery, surveys of each training hospital have been used (in conjunction with the wider GMC trainee survey⁴ responses for each site) to get hospital department-specific feedback on training. These surveys focus on obtaining written feedback to pinpoint problems with training and facilitate constructive suggestions.

Trainee doctors fill in the survey and pass on their responses to a representative trainee doctor, who then condenses the responses into a summary, taking care to anonymise information. Anonymity is further ensured by the combination of the current year's data with that from the previous year, submitted by former trainee doctors. The condensed summary is then presented to the Quality Panel, which includes the Head of School and consultants with training responsibilities. The Panel then uses the feedback as a basis on which to initiate improvements.

Feedback through the trainee survey has led to several positive changes. After trainee doctors working in major trauma fed back that they felt excluded from the team, the system was successfully reorganised to increase their dedicated involvement in major trauma. Similarly, trainee survey feedback was used to change an unworkable rota system, which eroded the quality of training, into a system that led to increased satisfaction of the whole department. Notably in this instance, the department had already called for change, but subsequent feedback from trainee doctors in support of this was the necessary trigger to instigate change. Evidently decision makers at the Severn Deanery take trainee doctors' views seriously.

3. Making the most of trainee doctors' insights in research

In recent years a collaborative approach to trial and audit-based research has been developed, which involves conducting research studies across multiple organisations.⁵ By collaborating in this way, studies have a larger sample size of patients, take less time, and their results are more generally applicable to a range of organisations. Trainee doctors rotate through several different hospitals, conduct research as part of their training, and often show great enthusiasm – all of which places them in an ideal position to lead collaborative research projects. Indeed trainee-led collaborative research is becoming increasingly common in a number of medical specialties. However, various barriers can discourage trainee doctors' involvement in such initiatives.

BARRIERS

Lack of awareness: Many medical students and trainee doctors are eager to participate in collaborative research, but are not always aware of how to do so.

Time: Clinical training programmes are quite inflexible, restricting time available for participation in multicentre research projects.

Lack of recognition of participation in collaborative research: The ability to critically analyse research and understand methodology is more important for doctors' care of patients than simply having their name on a research paper. The NIHR has now made it more credible to be part of a large research project. Nevertheless, there is still little recognition of this collaborative work within the training curriculum, which favours first authorship on a small-scale audit.

ACTIONS

Collaborative programmes: Develop and publicise large collaborative programmes to harness doctors and medical students' interest in conducting national research (see case study G).

Flexibility in training: It is important for clinical training to be structured in a way that enables participation in collaborative research. This could be facilitated by offering trainee doctors a flexible 'menu' of academic projects to engage in.

Curricular recognition: Curricula, the Annual Review of Competence Progression panel, and Foundation Programme Application Service should be adjusted to take into account the contribution of medical students and trainee doctors towards collaborative research projects.

Case study G: STARSurg

STARSurg (Student Audit and Research in Surgery)¹⁴ is a student-led initiative which connects a network of medical students and trainee doctors for the purpose of surgical audit and research. It was founded on the basis that many medical students and trainee doctors are eager to participate in research, but are not aware of how to go about it. The development stages are as follows: develop a clinical question; establish a study protocol; publicise the study nationally; conduct a national study; evaluate it; and feed back locally and via academic publication.

Participants are organised into mini-teams of three medical students, a trainee doctor and a supervising consultant. All participants are recognised on the authorship of the resulting paper, which is published under the STARSurg group name.

The STARSurg initiative has been very successful. It was founded in 2013 and its first study (published in 2014) involved 258 students from 31 UK medical schools, who collected outcomes data on a cohort of 1500 patients across 109 UK hospitals. The second study involved over 1000 medical students and trainee doctors, with data collected on over 9000 patients. The initiative has fostered medical students' understanding of research methodology and engagement in group projects.

¹⁴ STARSurg (Student Audit and Research in Surgery) <http://www.starsurg.org/>

Acknowledgements

Many thanks to the attendees of the roundtable:

Professor Iain Cameron, Chair, Medical Schools Council

Miss Roisin Finn, trainee surgeon and Clinical Fellow to the National Medical Director, NHS England

Mr Edward Fitzgerald, trainee surgeon and STARSurg steer

Dr Phil Hammond, doctor and journalist with the Private Eye

Miss Rhiannon Harries, trainee surgeon and President, Association of Surgeons in Training

Dr Olivia Jagger, trainee doctor and Fellow of the Faculty of Medical Leadership and Management

Dr Giles Major, Chair, Royal College of Physicians Trainees Committee

Dr Clifford Mann, President, Royal College of Emergency Medicine

Miss Clare Marx, President, Royal College of Surgeons (Chair)

Bill McMillan, Assistant Director, NHS Employers

Vijaya Nath, Director of Leadership Development, the King's Fund

Dr Vicky Osgood, Director of Education and Standards, General Medical Council

Dr Gethin Pugh, Chair, Academy of Medical Royal Colleges Trainee Doctors' Group

James Quinn, Associate Medical Director for the South Region, NHS Trust Development Authority

Professor Wendy Reid, Director of Education and Quality, Health Education England

Dr Toby Reynolds, trainee doctor and Clinical Fellow, General Medical Council

Professor Sir Mike Richards, Chief Inspector of Hospitals, Care Quality Commission

We would also like to thank those who kindly gave up their time to provide information for the case studies, in particular:

Tracey Franklin, Medical Education Manager, Frimley Health NHS Foundation Trust

Lynn Moran, Quality and Business Manager, Frimley Health NHS Foundation Trust

Diana Moses and colleagues, Client Experience Team, Virginia Mason Institute, Seattle, USA

Mrs Lisa Munro-Davies, Head of Severn School of Emergency Medicine, Health Education South West

Mr Humphrey Scott, Head of School of Surgery and Associate Dean, Health Education Kent, Surrey and Sussex

For further information please contact:

Grace Gottlieb, RCS Policy Officer, at ggottlieb@rcseng.ac.uk or on 020 7869 6049.

