


General Medical Council

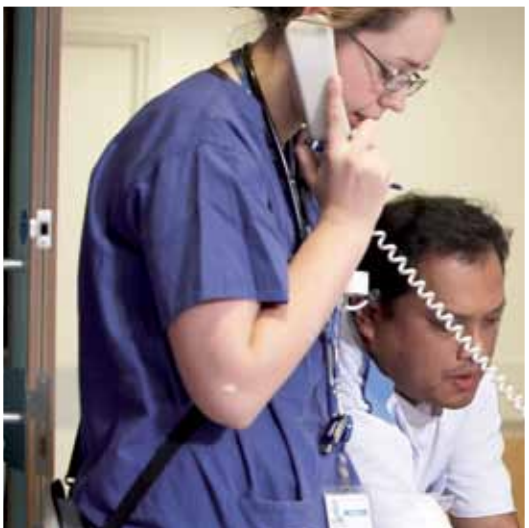
Regulating doctors
Ensuring good medical practice








National Training Surveys 2010 Key findings


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Foreword

On behalf of the GMC, I am delighted to present this report of the key findings of the 2010 national surveys of trainee doctors and their trainers. This year marks the fourth year of the trainee survey and the third year of the trainer survey, although it is the first year that the GMC has run them; the surveys were previously the remit of the Postgraduate Medical Education and Training Board (PMETB) and the Conference of Postgraduate Medical Deans (COPMeD). The 2010 surveys were launched on 1 April 2010 – the date of the merger of PMETB with the GMC – and for the first time they ran concurrently, allowing stakeholders to access data from trainers and trainees at the same time.

This report shows that the response rate in 2010 was the highest so far achieved, building on the already high response rates from previous years. The surveys continue to develop and each year the survey group works with a wide range of stakeholders to ensure that they remain relevant at a time of change in medical education and service delivery. Particular thanks go to COPMeD for its role in developing the surveys, to deaneries and to local education providers for delivering the surveys and helping to achieve the high response rate, and of course to those who answered the surveys. There are many others who have played an important part in the delivery of the surveys and full acknowledgements are provided at the end of this report.

The surveys are an important part of the evidence base that informs a range of the GMC's quality assurance activities including the monitoring of standards compliance, visits, and reporting. They help the GMC to build an overall picture of the management and delivery of postgraduate medical education and training by deaneries, local education providers and the medical Royal Colleges. They provide the basis for further analysis and action both by the regulator and those on the frontline of education delivery.

It is important, therefore, that stakeholders have access to the data from these surveys. This year, the GMC has made improvements to the online reporting tool, a key resource for deaneries and local education providers.

The national findings presented here give room for encouragement. They show, for example, that satisfaction with training remains high and is increasing, trainers remain committed to training and that local education providers have made much progress towards implementing the GMC's standards. It also highlights some areas that require closer investigation, for example around preparedness of doctors, and I urge you to read this report in full and contribute to the debate that it will generate.

Next year will be the fifth year for the trainee survey and we propose to provide a longitudinal analysis in the national report.

John Smith
Chair of the GMC Surveys Working Group

"The surveys are an important part of the evidence base that informs a range of the GMC's quality assurance activities including the monitoring of standards compliance, visits, and reporting."

Introduction and scope of the report

Every year for the last four years, the Postgraduate Medical Education and Training Board (PMETB) – now merged with the General Medical Council (GMC) – and Conference of Postgraduate Medical Deans (COPMeD) have undertaken a national survey of trainee doctors covering the four UK nations. For the past three years there has also been a survey of their trainers. This report draws out some of the key findings and provides a commentary on the 2010 surveys.

The surveys are important components of the Quality Framework, which helps those involved with training to ensure it is delivered to the national standards required. Results from the surveys inform visits, reporting and the gathering of evidence. This ensures that the quality of training led by deaneries, local education providers and Royal Colleges is of the standard that trainees, the health services and patients require. By providing a picture of what trainers and trainees think about training and how it could be improved, the surveys will help the GMC improve the quality, now and in the future, of postgraduate medical education and training in the UK.

In 2010, the national training surveys addressed:

- patient safety
- quality assurance, review and evaluation
- delivery of curricula including assessments
- support and development of trainees, trainers and local faculty
- educational resources and capacity.

The national survey of trainers is an opportunity for trainers to tell the regulator about their experiences and the data collected help to inform the GMC how support for trainers can be improved. The GMC's *Generic standards for specialty including GP training*, which apply to all doctors who have completed their training and act as supervisors and those who are formal educational supervisors, were expected to have been fully implemented at the time of the survey.

The 2010 national survey of trainers addressed three key issues:

- how effectively trainers feel they perform their duties
- how these duties are recognised in their job plans and training
- the level of support trainers feel they receive.

This report draws out some of the key findings from these data[1], looking at some of the trends over time and examining how survey items are linked. The GMC hopes it is useful to education providers, employers and policymakers.

87.5%

was the response rate in the trainee survey

[1] **Please note:** figures have been rounded to one decimal place.



Who was surveyed?

Trainees

Trainees were asked to answer the trainee survey with reference to the post they held on 31 March 2010 (31 January 2010 for Northern Ireland, which participated in the surveys process pilot). All respondents answered some general questions about their posts. Additional questions were aimed at trainees in specific posts, such as foundation trainees, or related to their specialty training where relevant.

The **trainee population** was defined as all trainees in posts within the GMC approved programmes including Academic Clinical Fellowship (ACF)/ Clinical Lecturer (CL) and foundation programmes on the census date:

- foundation trainees (FY1 and FY2 trainees on the foundation programme)
- core trainees
- higher specialty trainees including SpRs and GP trainees regardless of their setting
- trainees in Fixed Term Specialty Training Appointment (FTSTA) posts
- trainees in Locum Appointment for Training (LAT) posts
- military trainees – all military trainees working in NHS organisations and within the services
- trainees in ACF and CL posts approved by the GMC
- trainees working for non-NHS organisations, for instance occupational medicine, pharmaceutical medicine and palliative medicine.

Excluded:

- Trainees on maternity leave at the time of the census
- Trainees on Out of Programme Training (OOPT) or Out of Programme Research (OOPR) at the time of the census
- Public health practitioner trainees who are not medically qualified
- Doctors who have been awarded their CCT but are awaiting a consultant post

Trainers

The trainer survey took place between 1 April 2010 and 30 June 2010 (pilot surveys in Northern Ireland took place between 1 March 2010 and 31 May 2010) and included:

- all clinical and educational supervisors as identified by deaneries. For ease of reading, this group is referred to in the subsequent text as 'consultants' although a minority of respondents will have been associate specialists
- all approved GP trainers
- all GPs with foundation trainees.

The survey was not mandatory for trainers but participation was strongly encouraged by deaneries.

Each year the surveys are reviewed with researchers, trainees, trainers and other stakeholders to ensure they stay relevant and fresh while still allowing us to make comparisons over time.

The full results for both surveys can be accessed via the GMC reporting tool, **http://reports.pmetbtrainingsurveys.org**, which allows results to be viewed by local education provider, specialty and deanery. These results are part of the shared evidence base used across the postgraduate medical education community to assess the quality of training.

Free text comment analysis

The surveys were largely quantitative but there was space at the end for free text comments (no limit on the size). In total 7,662 trainees used this facility (the question was not mandatory). All these comments have been read and some of them are used here to illustrate the findings in this summary report. The comments were grouped into themes:

- college, curriculum, specialty examination
- deanery management (including ARCP)
- training programme
- post/local education provider
- GMC
- assessments (for example Workplace Based Assessment)
- EWTR/Rotas
- undermining/discrimination
- patient safety concern
- survey related.

The comments were also classified as positive, negative or neutral.

Among trainers, 3,435 used the free text comment box. All the comments have been read and grouped into themes for further analysis:

- college, curriculum, specialty examination
- deanery management (including ARCP)
- training programme
- post/local education provider
- GMC
- assessments (for example Workplace Based Assessment)
- EWTR/Rotas
- patient safety concern
- survey related.

Trainer comments were also classified as positive, negative or neutral.

In both cases, the comments used in this report were selected purely to illustrate the findings of the main analysis. The responses chosen were not selected using any scientific method and it cannot be determined precisely how representative they are of the general views expressed in the comments section.

National survey of trainee doctors

The national survey of trainees has the support of employers and junior doctor representatives from the BMA's Junior Doctors Committee and the Academy of Medical Royal Colleges Trainee Doctors' Group (ATDG). All trainees are required to take part.

This year 46,774 doctors in training out of 53,448 for whom the GMC had a valid record in the surveys database answered the survey giving a response rate of 87.5% (see table 0.1 below) compared with 85% in 2009. The response rate by deanery varied from 97.6% from Severn Deanery to 78.2% from the NHS West Midlands Worksforce Deanery.

Table 0.1 Trainee response rates by deanery (source of trainee details)

Deanery	Number responding	Number targeted	Response rate
NHS Education South West – Severn Deanery	1,926	1,973	97.6%
Northern Ireland Medical & Dental Training Agency	1,592	1,641	97.0%
Wales	2,317	2,412	96.1%
Kent, Surrey & Sussex Deanery	2,616	2,771	94.4%
NHS Education for Scotland (North)	711	775	91.7%
East Midlands Healthcare Workforce Deanery	2,742	3,001	91.4%
London Deanery	9,535	10,566	90.2%
East of England Deanery	2,662	2,987	89.1%
NHS Education for Scotland (East)	498	569	87.5%
NHS Education for Scotland (West)	2,264	2,593	87.3%
NHS Education for Scotland (South East)	1,124	1,297	86.7%
Yorkshire and the Humber Postgraduate Deanery	4,102	4,754	86.3%
Mersey Deanery	1,851	2,207	83.9%
NHS Education South West – Peninsula Deanery	1,103	1,334	82.7%
Northern Deanery	2,137	2,589	82.5%
Defence Postgraduate Medical Deanery	61	74	82.4%
North Western Deanery	2,995	3,646	82.1%
NHS Education South Central – Wessex	1,654	2,049	80.7%
NHS Education South Central – Oxford	1,297	1,625	79.8%
Faculty of Pharmaceutical Medicine	123	156	78.9%
NHS West Midlands Workforce Deanery	3,464	4,429	78.2%
Total	46,774	53,448	87.5%



"This year, 17,264 trainers responded out of 35,628 targeted, giving a response rate of 48.5%."

National survey of trainers

In 2010 the survey targeted clinical and educational supervisors, most of whom are likely to be consultants (referred to hereafter as 'consultants'), as well as all GP trainers and GPs with foundation trainees (referred to hereafter as 'GP trainers'). This is a change from 2009 when the target population was all consultants, GP trainers and GPs with foundation trainees. This year, 17,264 trainers responded out of 35,628 targeted, giving a response rate of 48.5%. This is a marked improvement on 2009 when the response rate was 25.6% (n=30,342). There was a marked difference in response rate by deanery (see table 0.2 below), ranging between 33% and 78%.

The overall response rate from consultants was 47.7% (n=30,596), (see table 0.3 for breakdown by deanery).

The response rates for GP trainers were higher at 53% (n=2,673) compared with 49% (n=2,751) in 2009. (See table 0.4 for breakdown by deanery.)



Table 0.2 Trainer response rates by deanery

Deanery	Number responding	Number targeted	Response rate
Northern Deanery	1,577	2,281	69.1%
NHS Education South West – Severn Deanery	952	1,387	68.6%
Kent, Surrey & Sussex Deanery	1,085	1,736	62.5%
East of England Deanery	1,561	2,724	57.3%
Mersey Deanery	897	1,610	55.7%
Wales	950	1,788	53.1%
NHS Education for Scotland (North)	414	787	52.6%
NHS Education South West – Peninsula Deanery	511	990	51.6%
NHS Education for Scotland (West)	888	1,721	51.6%
NHS Education for Scotland (East)	243	483	50.3%
Yorkshire and the Humber Postgraduate Deanery	975	1,979	49.3%
Northern Ireland Medical & Dental Training Agency	590	1,234	47.8%
NHS Education for Scotland (South East)	544	1,190	45.7%
East Midlands Healthcare Workforce Deanery	783	1,795	43.6%
Defence Postgraduate Medical Deanery	29	69	42.0%
North Western Deanery	1,214	3,037	40.0%
London Deanery	2,105	5,540	38.0%
NHS West Midlands Workforce Deanery	1,156	3,089	37.4%
Faculty of Pharmaceutical Medicine	36	99	36.4%
NHS Education South Central – Wessex	438	1,205	36.4%
NHS Education South Central – Oxford	316	884	35.8%
Total	**17,264**	**35,628**	**48.5%**

Table 0.3 Consultant trainer response rates by deanery

Deanery	Number responding	Number targeted	Response rate
Northern Deanery	1,371	2,020	67.9%
NHS Education South West – Severn Deanery	783	1,165	67.2%
Kent, Surrey & Sussex Deanery	672	1,093	61.5%
East of England Deanery	1,320	2,168	60.9%
Mersey Deanery	815	1,462	55.8%
Defence Postgraduate Medical Deanery	19	35	54.3%
NHS Education for Scotland (North)	364	692	52.6%
NHS Education for Scotland (West)	739	1,428	51.8%
Wales	800	1,552	51.6%
NHS Education South West – Peninsula Deanery	448	879	51.0%
Yorkshire and the Humber Postgraduate Deanery	843	1,705	49.4%
NHS Education for Scotland (East)	202	421	48.0%
Northern Ireland Medical & Dental Training Agency	486	1,074	45.3%
NHS Education for Scotland (South East)	443	1,008	44.0%
East Midlands Healthcare Workforce Deanery	620	1,502	41.3%
North Western Deanery	1,105	2,795	39.5%
NHS West Midlands Workforce Deanery	1,028	2,690	38.2%
London Deanery	1,905	5,054	37.7%
Faculty of Pharmaceutical Medicine	36	99	36.4%
NHS Education South Central – Wessex	333	973	34.2%
NHS Education South Central – Oxford	260	777	33.5%
Total	**14,592**	**30,592**	**47.7%**

Table 0.4 GP response rates by deanery

Deanery	Number responding	Number targeted	Response rate
Northern Deanery	206	261	78.9%
NHS Education South West – Severn Deanery	169	222	76.1%
NHS Education for Scotland (East)	41	62	66.1%
Northern Ireland Medical & Dental Training Agency	104	160	65.0%
Kent, Surrey & Sussex Deanery	413	643	64.2%
Wales	150	236	63.6%
NHS Education South West – Peninsula Deanery	63	111	56.8%
East Midlands Healthcare Workforce Deanery	163	293	55.6%
NHS Education for Scotland (South East)	101	182	55.5%
Mersey Deanery	82	148	55.4%
NHS Education for Scotland (North)	50	95	52.6%
NHS Education South Central – Oxford	56	107	52.3%
NHS Education for Scotland (West)	149	293	50.9%
Yorkshire and the Humber Postgraduate Deanery	132	274	48.2%
NHS Education South Central – Wessex	105	232	45.3%
North Western Deanery	109	242	45.0%
East of England Deanery	241	556	43.3%
London Deanery	200	486	41.2%
NHS West Midlands Workforce Deanery	128	399	32.1%
Defence Postgraduate Medical Deanery	10	34	29.4%
Total	**2,672**	**5,036**	**53.1%**

Summary of chapters

Chapter 1: Survey overview and satisfaction with training

This chapter reports on response rates to the surveys and presents data on age, gender, disability and ethnicity for trainees. It also examines trainees' overall satisfaction with their training.

Key findings

- Response rate remains high and has increased compared with 2009.
- Satisfaction with training remains high and has increased compared with 2009.

Chapter 2: Supervision

This chapter examines what the survey data tell us about supervision from the perspective of trainers and trainees and ask whether local education providers, trainees and trainers are meeting the expectations of the GMC, highlighting any areas of concern.

Key findings

- Local education providers are making progress in meeting GMC standards.
- Trainees rate the quality of the supervision they receive highly.
- Trainers are working beyond their contracted hours to provide supervision.

Chapter 3: Workplace based assessment

This chapter examines trainers' responses to the survey questions about workplace based assessment (WPBA).

Key findings

- The majority of trainers have received training for this role.
- The biggest impediment to them carrying out WPBA is lack of time.
- Some trainers report documenting WPBA retrospectively.

Chapter 4: Foundation doctors

This chapter examines what the survey data tell us about the experiences of foundation doctors.

Key findings

- The majority of foundation trainees felt prepared for their first job although a minority indicated that they did not.
- The majority were clear about the competences they needed to be signed off from the Foundation Programme.
- The majority had received informal feedback from consultants.

Chapter 5: European Working Time Regulations

This chapter explores the impact of the European Working Time Regulations (EWTR) on training as reported by trainees and trainers.

Key findings

- Most trainees report that their rotas are EWTR-compliant, but many are working longer hours.
- Some trainers are adapting their teaching in response to the 48 hour week.
- Overall, the impact of the EWTR on training is inconsistent. There has been some significant progress but both trainees and trainers report serious problems in some areas.

Chapter 6: Preparedness

This chapter examines what the survey data tell us about how well prepared trainees are to move to the next stage of their training or to becoming a consultant or GP. It goes on to look at factors around career choice.

Key findings

- The majority of trainers feel their trainees are signed off a stage of training only when they have reached the appropriate standard, but a minority do not.
- Most trainees rate their practical experience highly.
- Most trainees are confident of acquiring the required competences in their current post.

Chapter 7: How is the survey data used?

This chapter provides a general overview of how some deaneries have used the surveys to support their quality control functions.

Key findings

- The survey data are used to support the deanery Quality Management process and ultimately improve the quality of medical education and training.

"In 2010 the survey targeted clinical and educational supervisors, most of whom are likely to be consultants, as well as all GP trainers and GPs with foundation trainees."





Chapter 1: Survey overview and satisfaction with training

This chapter reports on response rates to the surveys and presents data on age, gender, disability and ethnicity for trainees.

It uses survey data to answer the following questions about trainers.

- Do trainers have clarity about their roles?
- Given the choice, would they choose to have trainees?
- Do they feel that their employers, departments, Primary Care Trusts (PCTs) and colleagues support training?
- Have they been appraised for their educational roles in the last 12 months?

Finally, it examines trainees' overall satisfaction with their training.

Trainers

Who answered this survey?

This year 17,264 trainers took part out of 35,628 sent the questionnaire, a response rate of 48.5%. This included:

- 14,556 consultants[2]
- 2,672 GP trainers
- 36 pharmaceutical medicine trainers.[3]

The respondents undertook a variety of roles and some of them had multiple roles:

- 68% of the total (n=17,263) were clinical supervisors
- 59% (n=17,263) were educational supervisors
- 7% (n=17,263) were training programme directors in hospitals
- 14% (n=17,263) were GP trainers
- 1% (n=17,263) were GP foundation tutors
- 1% (n=17,263) were GP training programme directors.

There were 739 (4%, n=17,263) hospital consultants and one pharmaceutical medicine consultant who reported that they had no designated title for their educational role.

How clear are trainers about their roles and responsibilities?

The survey asked trainers how clear they were about their training role responsibilities and found a high degree of clarity:

- 91% (n=14,592) of consultants were mostly or very clear about their training role
- 96% (n=2,672) of GP trainers were mostly clear or very clear about their training roles and responsibilities.

This left nearly one in ten consultants (9%, n=14,592) and 4% (n=2,672) of GP trainers either very unclear or mostly unclear about their training roles.

68%

of respondents were clinical supervisors

[2] This figure does include some associate specialists but for ease of reading, this group will be referred to as consultants in subsequent text.

[3] Please note one consultant record has been excluded from the analysis.

Would trainers choose to have trainees?

The survey asked if, given the choice, trainers would opt to have trainees. The overwhelming majority of consultants were keen on having trainees, but more than half of GP trainers would opt not to have trainees:

- 93% (n=14,592) of consultants would choose to have trainees
- 46% (n=2,672) of GPs would choose to have trainees
- 89% (n=36) of pharmaceutical medicine trainers would choose to have trainees.

How supportive are departments, employers and Primary Care Trusts (PCT) of training?

How supportive are colleagues?

The survey asked trainers about whether their employing organisation, PCT or department was supportive of training and whether colleagues supported training.

There was a wide discrepancy between the views of consultants and those of GP trainers when it came to the supportiveness of their employers with 67% (n=14,522) of consultants agreeing or strongly agreeing that their employers were supportive of training, compared to 47% (n=2,622) of GP trainers.

Consultants felt their departments were more supportive of training than their employing organisations:

- 88% (n=14,526) of consultants agreed or strongly agreed that they worked in a department that was supportive of training
- 67% (n=14,522) agreed or strongly agreed that their employing organisation was supportive of training, and 13% neither agreed nor disagreed.

There was a mixed picture on support from colleagues:

- 90% (n=1,322) of training programme directors said that they received help from colleagues when they asked
- 62% (n=13,233) of consultants said they always received all the information they needed from the person responsible for education in their department.

Have trainers been appraised for their educational roles?

The survey asked trainers whether they had been appraised for their educational roles in the last 12 months:

- 47% (n=14,555) of consultants had been appraised
- 72% (n=2,672) of GP trainers had been appraised
- 20% (n=36) of pharmaceutical medicine consultants had been appraised.

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93%

of consultants would choose to have trainees

Trainees

Who answered this survey?

This year 46,774 trainees responded to the survey, giving an 87.5% response rate, compared with 85% in 2009.

Demographics of trainees

Gender

In this survey, just over half the respondents (50.7%, n=46,774) were female and just under half (46.1%, n=46,774) were male. The remaining 3.1% chose not to answer this question.

Disability

Of the total number responding, 1,026 (2.2%, n=46,774) reported they had a disability. Most said that either they needed no adjustments or that reasonable adjustments had been made to enable them to work but 160 (0.3%, n=46,774) said reasonable adjustments had not been made.

Age

Most of the trainees were aged 35 or less, with 82.6% (n=46,774) falling in this age group. There were 1,555 respondents over the age of 40 (3.3%, n=46,774) and a similar number did not wish to give information about their age.

Ethnicity

There was a wide range of ethnicity among respondents. The largest groups were people who defined themselves as 'White British' (45.3%, n=46,774) and 'Asian or Asian British – Indian' (17.5%, n=46,774). More detail can be found in the Annex.

82%

of the trainees who answered this survey were aged 35 or less



79%

rated the quality of experience in their current post as good or excellent

How satisfied are trainees with their training?

The annual trainee surveys have measured trainee satisfaction for the past four years, asking them how they rate the quality of teaching, experience and supervision, how useful the post will be for their future career and whether they would recommend the post to a friend. These five items make up the overall satisfaction score, which can be considered a proxy measure of the quality of training.[4]

Over the years, the trainee surveys have shown consistently high levels of satisfaction with most trainees rating the quality of teaching and supervision in their current posts as good or excellent.

In 2010, trainees scored highly on the overall satisfaction score, with 25% scoring 92 or more out of a possible 100, up from 88 in 2009. This means that trainees are generally giving ratings of 'good' or 'excellent' to the individual items that make up the score. In total, 50% of trainees scored 79 or more and 75% scored 70 or more (compared with 79 and 67 in 2009).

The five items that comprise the overall satisfaction score highlight the different aspects that contribute to the high satisfaction reported by trainees.

The scores

- 79% rated the quality of experience in their current post as good or excellent, compared with 77% in 2009.
- 77% said their current post would be useful for their future career, compared with 76% in 2009.
- 75% rated the quality of supervision in their current post as good or excellent, unchanged from 2009.
- 72% would describe the post as good or excellent to a friend who was thinking of applying for it, compared with 71% in 2009.
- 65% rated the quality of teaching (informal and formal) as good or excellent, compared with 63% in 2009.

Across all five items, 2.3% (n=46,774) or fewer gave these items the poorest ratings.

Discussion

By January 2010, all medical education providers were expected to have implemented the PMETB's *Generic Standards for Trainers*, now incorporated into the *GMC's Generic standards for specialty including GP training*. These stipulate:[5]

- trainers must provide a level of supervision appropriate to the competence and experience of the trainee
- trainers must be involved in, and contribute to, the learning culture in which patient care occurs
- trainers must be supported in their role by a postgraduate medical education team and have a suitable job plan with an appropriate workload and time to develop trainees
- trainers must understand the structure and purpose of, and their role in, the training programme of their designated trainees.

The first two of these standards will be scrutinised in chapter 2.

On the whole, trainers in this survey were clear about their roles. By and large they work in departments and employing organisations that are supportive and with colleagues who also support training. There is no room for complacency, however.

[4] *National Training Surveys 2008-2009 Key Findings*. PMETB 2009.

[5] *Generic standards for specialty including GP training*. GMC, revised April 2010.

One in ten hospital consultants was not clear about their role and over one third did not always receive the information they needed from the person in charge of education in their department.

The degree to which GP trainers felt supported by PCTs must also be an area of concern; the GMC requires employing organisations to support training. The survey did not ask what support GP trainers felt was lacking and this may bear further investigation, particularly in the light of the Coalition Government's White Paper, *Equity and Excellence: Liberating the NHS*, which proposes to abolish PCTs by 2014. At the time of writing it was unclear where this responsibility will lie in future although early indications are that GP consortia will have a greater role to play.

The picture is more mixed when it comes to appraisals for an educational role with more than half of consultants and more than a quarter of GP trainers reporting that they had not been appraised for their educational role in the past 12 months. There is no formal requirement for annual appraisal in this respect and indeed the data should be treated with caution. Deaneries have introduced mandatory training programmes for clinical and educational supervisors that do include review and appraisal, although not on an annual basis. Certainly, there is a thirst for high quality training among consultants taking on training roles, as this comment shows:

'Please, please provide simple instructions and an accessible single course for educational supervisors so we know what is expected of us and we don't have to go on five courses to get the skills and knowledge.'

The data on overall satisfaction are particularly encouraging as they show a marginal increase on the already consistently high levels. The trainee survey respondents' free text comments give a flavour of the varying experiences that lie behind the quantitative data. There were words of praise:

'This post provided good clinical experience. Consultants and senior trainees were easily accessible and provided great teaching.'

'This is an excellent training post.'

'My training is superb, couldn't fault it.'

'Really enjoyed this placement, which I feel was useful to my training, and a busy but supportive and enjoyable environment to work in.'

'Have gained excellent experience, training and confidence in my current post.'

'I really enjoyed my F1 placements. Excellent deanery and very good teaching… the support from my supervisors has been immensely helpful.'



Others commented on the difficulty of balancing training with service requirements:

'This post has been predominantly a service post; I feel that the educational needs of the trainees have been put second to the trust managing to keep the service running…There are specific consultants who make the effort to make the job educationally productive, but the system is not designed that way.'



'I am happy with the training and support provided in the post. The only concern is that all the trainees are required to work more than the expected number of night shifts and weekends due to lack of staffing.'

But some comments highlighted negative experiences:

'There is no incentive for trusts to provide training opportunities and no punishment if they fail to deliver.'

'The survey has only asked me about this six-month post. The previous six months I was working in A&E, and my answers to the questions would have been VERY different. During this placement, we had NO teaching at all, we were completely unable to take study leave, and the rotas were not EWTD compliant.'

'No time for educational opportunities due to rota gaps.'

Trainers also gave useful free text feedback about their overall experience and impressions. Many were from highly committed trainers:

'Our trainees are highly committed individuals. As trainers we do our best to ensure that they are trained to the highest standard.'

'I enjoy being a trainer and feel that [the deanery] have been very supportive in helping me fulfil my role as a trainer.'

'Training has been the most consistently satisfying part of my medical career. I am now approaching retirement and will miss training, especially in my final run up to the end!'

Some were concerned about their own performance as trainers and whether they could balance service needs with providing high quality training:

'I just hope I am doing ok. I don't have any feedback apart from what my trainees tell me. I just don't have the time to devote to make sure I am meeting all the requirements but do the best I can. If the process is made too complicated people will be less inclined to take this role on, it is unrealistic with current service pressures to expect more time to be made available to carry out this role.'

'I, like many of my colleagues, have not had the time through work pressures to attend training and keep up to date with training developments. There is no balance between training needs and service needs.'

'I think in general everyone is very keen on teaching. However, in some departments work pressures and inadequate junior cover on ward (due to changes in hours, sick leave etc) increases workload on consultant and minimises time for teaching.'

'I really enjoy my college/training role, but find it increasingly difficult to get good attendance at events due to days off/post nights etc. We are a rural hospital, and would love to hear how other units have overcome this problem.'

"I am happy with the training and support provided in the post. The only concern is that all the trainees are required to work more than the expected number of night shifts and weekends due to lack of staffing."

Others had broad concerns about the direction of medical education and training, some of which will be explored in later chapters:

'I am concerned that there is a reductionist approach to training. By defining what a trainee must know there is a likelihood that that is what they will know, and no more. By making them "trainees" rather than "junior doctors" you make them passive, being trained by trainers rather than young professionals who are trying to improve their knowledge and skills to improve their clinical abilities. The continual checking of the educational framework, the time keeping, formal teaching and related issues [mean that] the core educational apprenticeship of working closely within a team is somewhat demeaned and the most valuable element of education may be lost.'

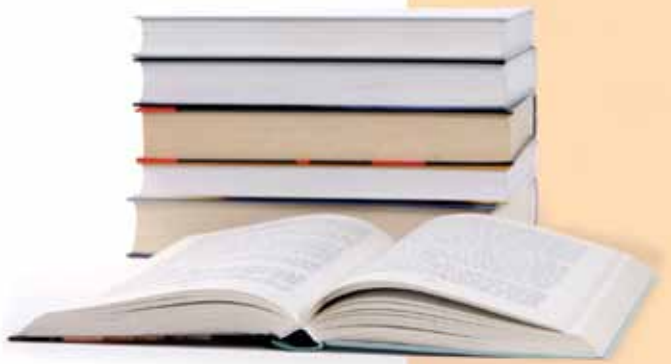
'I'm appalled at training. We have reduced doctors hours without any regard to the impact on training, introduced lots of meaningless documentation driven by educationalists who appear clueless.'

'I don't think this survey even scratches the surface of the level of discontent amongst trainers. We are expected to do more and more paperwork aiming to achieve a level of mediocrity amongst our trainees. We have to take on more clinical work to cover for gaps left by our trainees and we see them less and less. The training system appears to be run by mindless bureaucrats in their ivory towers who need to get onto the shop floor to experience the reality of good training.'

'Main problems in implementing training properly are too many changes, too often without giving bulk of trainers, especially clinical supervisors, time to take implications on board. The increased burden of training foundation doctors and students adds to the difficulties despite the great willingness shown by my anaesthetic colleagues and me.'

Overall, the survey data would not seem to support these very negative expressed views.

> ***"Training has been the most consistently satisfying part of my medical career. I am now approaching retirement and will miss training, especially in my final run up to the end!"***




00:00

Chapter 2: Supervision

This chapter examines what the survey data tell us about supervision from the perspective of trainers and trainees and asks whether local education providers, trainees and trainers are meeting the expectations of the GMC, highlighting any areas of concern.

This chapter uses survey data to answer the following questions for trainers.

- How many trainees do trainers supervise?
- How many hours are they contracted to provide educational activity and how many do they actually spend?
- Does their workload allow them to provide appropriate clinical supervision for their trainee(s)?

For trainees, it uses survey data to answer the following questions.

- Do trainees always know who is providing their clinical supervision?
- Who supervises them?
- How often did they feel forced to cope with clinical problems beyond their competence or experience?
- How often have they been expected to obtain consent for procedures where they felt they did not understand the proposed intervention and its risks?
- How do trainees view the competence of their supervisors?
- How do they rate the quality of supervision?
- How do these factors interrelate?

Trainers

How many trainees do trainers supervise?

The survey asked trainers how many trainees they had been responsible for in the last four full working weeks before the survey. The range of answers was very wide, reflecting trainers' different – and often overlapping – roles and the difficulty they had in defining the number of trainees in each of these.

In summary:

- Clinical supervisors averaged just over four trainees each.
- Educational supervisors averaged just under three trainees each.

Table 2.1 Number of trainees for whom consultants had responsibility in the last four full working weeks before the survey

	Clinical supervisor	Educational supervisor	Training programme director	Director of medical education
Number of trainers in role	11,657	10,131	1,164	191
Average number of trainees	4.2	2.7	34.7	178.6
Median	3.0	2.0	22.0	120.0



"GP trainers were contracted to spend on average just less than four and a half hours a week on educational activity but were spending nearly six hours."

How many hours are trainers contracted to spend on education and how many do they actually spend?

The survey asked trainers how many hours they were contracted in their job plans to spend each week in educational activity and how much they actually spent. Trainers in all roles were, on average, spending more time on educational activities than they were contracted for, in some cases nearly double. The widest discrepancy between contracted and actual hours was for clinical supervisors.

In summary:

- Clinical supervisors were contracted to spend on average less than two hours a week on educational activity but actually spent nearly three and a half hours.
- Educational supervisors were contracted to spend on average less than an hour and a half on educational activity but actually spent nearly three hours.
- Training programme directors, directors of medical education and tutors also spent more time on average than contracted on educational activities. For training directors, this was three hours contracted versus four hours actual; for directors of medical education it was eight hours contracted versus 10 hours 45 minutes actual; and for tutors it was two and three quarter hours contracted versus nearly four hours actual.
- GP trainers were contracted to spend on average less than four and a half hours a week on educational activity but were spending nearly six hours.
- GP foundation tutors were contracted to spend less than three hours but were spending nearly four hours.

Does trainers' workload allow them to provide appropriate support for their trainees?

The survey asked trainers to agree or disagree with the following statement:

'My workload allows me to provide appropriate clinical supervision for my trainee(s)?'

Overall, GP trainers were more likely to report having enough time to provide appropriate clinical supervision and less likely to report having insufficient time:

- 49% (n=14,555) of consultants agreed or strongly agreed
- 32% (n=14,555) of consultants disagreed or strongly disagreed
- 68% (n=2,672) of GP trainers agreed or strongly agreed
- 17% (n=2,672) of GP trainers disagreed or strongly disagreed.

Table 2.2 The number of hours hospital trainers are contracted to spend on educational activities a week and the number actually spent

	Clinical supervisor	Educational supervisor	Training programme director	Other role	Director of medical education	Tutor
Number in role	11,657	10,131	1,164	844	191	1,434
Average number of contracted hours a week	1.7	1.5	3.0	3.2	8.0	2.3
Median	1.0	1.0	3.0	1.0	8.0	2.0
Average number of actual hours a week	3.4	2.5	5.3	5.4	10.8	4.0
Median	2.0	2.0	4.0	3.0	8.0	3.0

Table 2.3 Number of hours GP trainers were contracted to spend on education each week and the number actually spent

		Foundation tutor	GP trainer	Training programme director	Other role
Number of trainers in the role		186	2,480	225	192
Number of hours contracted a week	Mean	2.8	4.4	8.0	4.4
	Median	1.0	3.0	8.0	2.0
Number of hours actually worked a week	Mean	3.8	5.6	11.0	7.2
	Median	3.0	5.0	10.0	4.0

82%

said they always knew and their supervisor was easily accessible

Trainees

Do trainees always know who is providing their clinical supervision?

The survey asked trainees if they always knew who was providing their clinical supervision:

- 82% (n=46,447) said they always knew and their supervisor was easily accessible
- 9% (n=46,447) said no, but there was usually someone they could contact
- 8% (n=46,447) said they knew who was supervising them but they were not easily accessible
- Less than 1% (n=46,447) said no, there was no one they could contact.

Who provides supervision for trainees?

The survey asked trainees who provided their clinical supervision. The most frequent answer was consultants or GP trainers, with four out of ten trainees receiving supervision at this level:

- 9% (n=46,650) were supervised by trainees of a higher grade
- 20% (n=46,650) were supervised by trainees and staff and associate specialist grade doctors with occasional input from consultants or GP trainers
- 27% (n=46,650) were usually supervised by consultants or GP trainers and occasionally by trainees at a higher grade or by staff and associate specialist grade doctors
- 41% (n=46,650) were supervised by consultants or GP trainers
- 3% (n=46,650) were supervised by specialty or associate grade doctors.

The data show that foundation doctors are supervised at a lower grade, with only 16.6% (n=12,694) being supervised by a GP or consultant and 37% (n=12,694) usually receiving their supervision from other trainees and career grade doctors.

How often did trainees feel forced to cope with problems beyond their clinical competence or experience?

The survey asked trainees to answer this question never, rarely, monthly, weekly or daily:

- 74% (n=46,650) said never or rarely
- 56% (n=12,694) of foundation stage doctors said rarely or never. (This is looked at in more detail in Chapter 4.)

How often have trainees been expected to obtain consent for procedures where they did not understand the proposed intervention and its risk?

The survey asked trainees to answer this question never, rarely, monthly, weekly or daily:

- 95% (n=40,211) said never or rarely
- 90% (n=11,406) of foundation doctors said rarely or never.

How do trainees view the competence of their supervisors?

The survey asked trainees if they ever felt supervised by someone not competent to do so, again asking them to answer this question never, rarely, monthly, weekly or daily:

- 92% (n=46,774) said never or rarely
- 87% (n=12,694) of foundation doctors said never or rarely.

How do trainees rate the quality of supervision?

The survey asked trainees to rate the quality of supervision on a scale from very poor to excellent:

- 75% (n=46,774) rated it excellent or good
- 65% (n=12,694) of foundation doctors rated it excellent or good.

Table 2.4 How would you rate the quality of supervision for this post? All trainee grades

	Frequency	%
Very poor	615	1.3%
Poor	2,229	4.8%
Fair	8,690	18.6%
Good	19,966	42.7%
Excellent	15,274	32.7%
Total	**46,774**	**100%**

How do these factors interrelate?

Table 2.5 looks at the relationship between knowing who provides a trainees' clinical supervision and the trainees' views of their supervisors' competence.

In summary:

- Trainees who knew who provided their supervision and found them easily accessible were the least likely to report receiving supervision from someone not competent. So, 89% of the 31,176 trainees who said they knew their supervisor and that he/she was easy to contact also reported that they were never supervised by someone who was not competent.
- Trainees who either did not know who provided their supervision, or knew but found their supervisor difficult to access, were more likely to report receiving supervision from someone not competent. So, 27% of the 1,296 trainees who said their supervisor was not easy to contact also reported being supervised weekly by someone they perceived was not competent.

Table 2.5 What is the relationship between trainees knowing their supervisor and receiving supervision from someone not competent?

			Did you always know who provided your clinical supervision?			
		Number of trainees	Yes and were they accessible	Yes, but they were not easy to contact	No, but there was usually someone I could contact	No, there was no one I could contact
How often were trainees supervised by someone they felt was not competent?	Never	31,176	88.5%	5.0%	6.4%	0.2%
	Rarely	11,633	72.9%	12.7%	14.0%	0.4%
	Monthly	1,692	60.1%	20.3%	18.5%	1.1%
	Weekly	1,296	50.8%	25.9%	21.3%	2.0%
	Daily	476	61.1%	19.9%	15.6%	3.4%

Table 2.6[6] looks at the relationship between who provided the supervision and trainees' perceptions of supervisory competence.

In summary:

- Those who were supervised by consultants/GPs were the least likely to report never or rarely receiving supervision from someone they perceived was not competent.
- Those who were usually supervised by higher grade trainees or career doctors were the most likely to report receiving supervision from someone they perceived was not competent.

Table 2.6 What is the relationship between the grade of supervisor and trainees receiving supervision from someone not competent?

			Who provided your clinical supervision?				
		Number of trainees	Other trainees at higher grade	Usually other trainees, sometimes consultants/GPs	Usually consultants/ GPs, sometimes higher grade trainees	Consultants/ GPs	Specialty grade or associate grade doctors
How often were trainees supervised by someone they felt was not competent?	Never	31,370	6.3%	15.8%	27.7%	47.8%	2.4%
	Rarely	11,734	12.2%	26.6%	27.6%	29.5%	4.0%
	Monthly	1,722	15.7%	34.0%	23.0%	20.3%	7.0%
	Weekly	1,330	19.0%	32.2%	17.4%	22.8%	8.6%
	Daily	494	21.5%	22.9%	16.8%	26.3%	12.6%

Table 2.7 looks at the relationship between trainees reporting that they receive supervision from someone they perceived as not competent and the way in which critical events are reported in their department.

Trainees were asked to indicate their perception of the way in which critical events and near misses were reported in their department, choosing between:

- staff were reluctant to report due to a culture of blame ('reluctant' in table 2.7)
- reporting was haphazard and not followed up ('haphazard' in table 2.7)
- reporting was encouraged and followed up ('encouraged' in table 2.7).

In summary:

- Trainees who feel they are never or rarely supervised by someone not competent are more likely to report working in a department where reporting of near misses and critical events is encouraged and followed up.
- Trainees who feel they are supervised regularly by someone they think is not competent are most likely to work in departments where they perceive that reporting of near misses and critical incidents is haphazard or reluctant.

[6] Note: not applicable answers excluded from tables 2.8 to 2.10.

Table 2.7 What is the relationship between the reporting culture of near misses and critical incidents and trainees' perceptions of the competence of their supervisors?

			Perceived reporting culture		
		Number of trainees	Reluctant	Haphazard	Encouraged
How often were trainees supervised by someone they felt was not competent?	Never	31,370	2.2%	12.3%	85.5%
	Rarely	11,734	4.8%	24.9%	70.3%
	Monthly	1,722	9.0%	35.9%	55.1%
	Weekly	1,330	13.5%	38.8%	47.7%
	Daily	494	13.8%	30.0%	56.3%

Discussion

As discussed in Chapter 1, by January 2010, all local education providers were expected to have implemented the GMC's *Standards for Trainers*, incorporated into the GMC's *Generic standards for specialty including GP training*. These stipulate:[7]

- trainers must provide a level of supervision appropriate to the competence and experience of the trainee
- trainers must be involved in, and contribute to, the learning culture in which patient care occurs
- trainers must be supported in their role by a postgraduate medical education team and have a suitable job plan with an appropriate workload and time to develop trainees
- trainers must understand the structure and purpose of, and their role in, the training programme of their designated trainees.

The data presented here again give some encouraging results on the first two of these benchmarks but also show that some longstanding problems have not been resolved.

On the positive side, three quarters of trainees rate the quality of their supervision highly. Most trainees know who is providing their supervision and can access their supervisor easily. A notable minority receive supervision from consultants or GP trainers, with foundation stage doctors more likely to receive supervision from higher grades of trainee. This finding is in line with the revised Foundation Programme curriculum, which states that 'most assessors should be supervising consultants, GP principals and doctors in training who are more senior than the foundation doctor, experienced nurses or allied health professional colleagues'. Very few trainees were regularly asked to undertake tasks or procedures beyond

[7] *Generic standards for specialty including GP training*. GMC, revised April 2010.



their capability or to obtain consent for procedures for which they were unsure about the interventions or risks, with foundation doctors scoring slightly higher.

Trainers are alive to the benefits of high quality supervision at all stages of training, as exemplified by this comment:

'Rural General Hospitals in Scotland can provide a valuable educational experience for trainees at an early stage of their career pathway. In particular we can provide close supervision in a protected environment designed to deliver holistic care. The general nature of our clinical workload is ideal for the generic training required of the Foundation Programme. The close one-to-one consultant-to-trainee contact for our ST1/2 trainee in surgery is recognised as being important in the process of acquiring basic operative and decision making skills.'

The degree of commitment required from trainers to provide this high quality supervision was clearly appreciated by this trainee:

'I currently am in an excellent post [where a] high standard of patient care is provided for [my consultant's] patients and it is a pleasure to be part of its delivery. My trainer cares about my training and closely supervises my progress.'

The analysis of interrelating factors shows what matters to trainees in supervision: seniority and accessibility. The more senior and the more accessible the trainer, the more likely the trainee is to report never being supervised by someone they felt was not competent. This is perhaps what might be expected. More important is the analysis of how near misses and critical incidents are reported: supervision by senior and accessible trainers is linked with a culture in which reporting of incidents is encouraged and followed up.

The importance of these findings should not be overplayed; the data relate to trainees' perceptions about one post given at one point in time. However they agree with the literature on supervision. As Kilminster and Jolly[8] noted in their 2000 literature review of clinical supervision:

'The environment in which learning takes place profoundly affects what is learnt and the learners' responses; clinical settings which are considered to have a positive orientation to teaching are also usually seen to provide high quality supervision, good social support, appropriate levels of autonomy, variety and workload.'

The review also showed a clear link between high quality supervision and patient safety, noting:

'There is quantitative evidence that supervision can have an effect on patient outcome. Review evidence suggests that increased deaths are associated with less supervision of junior doctors in surgery, anaesthesia, trauma and emergencies, obstetrics and paediatrics. Therefore patient care suffers when trainees are unsupervised even though some trainees claim to benefit from the experience that lack of supervision gives them. Furthermore,

[8] Kilminster S M and Jolly B C. *Effective supervision in clinical practice settings. Medical Education 2000*;34:827 Downloaded July 2010. http://faculty.ksu.edu.sa/hisham/Documents/Medical%20Education/English/Medical%20Education/237.pdf

unsupervised experience can lead to the acceptance of lower standards of care because the trainee may not learn correct practice without appropriate supervision.'

The survey results support this statement.

The survey data show that supervisors routinely work well beyond their contracted hours to provide this high quality supervision. The number of them who feel their workload does not allow them to provide adequate supervision must be a cause for concern. This is, however, a longstanding issue. As Kilminster and Jolly noted a decade ago: 'Finding time for supervision can be a problem.' Certainly this was a problem for trainers in this survey, who commented:

'I think consultants interested in medical education should be recognised, supported and trained and given boundaried time in their job plans to do this role to a high quality.'

'Still not enough formal time in contracts to supervise appropriately as an educational supervisor.'

'I enjoy training. There is an issue with time and we all have to make time outside our normal clinical commitments.'

'I strongly believe that educational commitments must be explicitly identified in consultant job plans to enable effective clinical and educational supervision in all specialties.'

This is an issue to which the GMC and others are alert. In November 2009, the GMC, PMETB, COPMeD, NHS Employers and the Academy of Medical Royal Colleges reiterated their support for supervisors.[9] Their statement acknowledged that clinical and educational supervisors are a 'vital and essential part of the success of postgraduate medical education and training' and said:

'Please be assured that we recognise and value the ongoing commitment of all trainers to patients, trainees, the health services and the medial profession. We also need the support of all trainers in our ongoing work towards ensuring that their commitment has the appropriate support, resources and recognition.'

The results presented here underscore the importance of all stakeholders acting on this statement.

"I think consultants interested in medical education should be recognised, supported and trained and given boundaried time in their job plans to do this role to a high quality."

[9] Joint statement from PMETB, AOMRC, GMC, COPMED and NHS Employers and the Acadamy of Medical Royal Colleges in relation to the role and recognition of supervisors of postgraduate medical education and training, 17 November 2009. http://www.gmc-uk.org/Joint_support_for_trainers__statement_17_Nov_2009.pdf_30373174.pdf


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Chapter 3: Workplace based assessments

This chapter examines trainers' responses to the survey questions about workplace based assessment (WPBA) in which trainees are assessed for the work they do in the workplace.

This chapter uses survey data to examine the following questions.

- How well are trainers trained for different aspects of their roles?
- How long do trainers spend on assessment and feedback to trainees?
- Have trainers turned down requests for WPBA because of work pressure?
- How frequently do trainers score assessments retrospectively?
- How well are trainers trained to deliver WPBA?
- What impedes their use of WPBA?

How well are trainers trained?

The survey asked trainers when, if ever, they had received formal training in how to:

- support trainees' learning
- conduct WPBA
- give feedback to trainees
- practise equality and diversity.

In summary, nearly three quarters of consultant trainers and over 90% of GP trainers had received formal training in all these aspects of their role in the last three years. Tables 3.1 to 3.4 give more detail.

Table 3.1 When, if ever, did you last receive formal training in how to support trainees' learning?

	Number of consultants	%	Number of GP trainers	%
Never	2,035	14.0%	33	1.2%
Yes – in the last three years	10,215	70.2%	2,491	93.2%
Yes – over three years ago	2,305	15.8%	148	5.5%
Total	**14,555**	**100%**	**2,672**	**100%**

92%

of GPs said they had never had to turn down trainees who had requested input to WPBA because of the pressure of work

Table 3.2 When, if ever, did you last receive formal training in WPBA?

	Number of consultants	%	Number of GP trainers	%
Never	2,329	16.0%	78	2.9%
Yes – in the last three years	10,392	71.4%	2,523	94.4%
Yes – over three years ago	1,834	12.6%	71	2.6%
Total	**14,555**	**100%**	**2,672**	**100%**

Table 3.3 When, if ever, did you last receive formal training in how to give feedback to trainees?

	Number of consultants	%	Number of GP trainers	%
Never	1,906	13.1%	25	0.9%
Yes – in the last three years	10,375	71.3%	2,453	91.8%
Yes – over three years ago	2,274	15.6%	194	7.3%
Total	**14,555**	**100%**	**2,672**	**100%**

Table 3.4 When, if ever, did you last receive formal training in equality and diversity?

	Number of consultants	%	Number of GP trainers	%
Never	1,715	11.8%	231	8.6%
Yes – in the last three years	11,021	75.7%	2,235	83.6%
Yes – over three years ago	1,819	12.5%	206	7.7%
Total	**14,555**	**100%**	**2,672**	**100%**

How long do trainers spend on assessment and feedback to trainees?

The survey asked trainers how long, roughly, they had spent carrying out WPBAs in the last four full working weeks.

Time spent on WPBAs

There was a wide range of answers.

In summary:

- 16% of consultants (n=12,887) and 16% of GP trainers (n=2,672) said they spent zero hours
- 62% of consultants (n=12,887) and 35% of GP trainers (n=2,672) said they spent between one and two hours
- the average amount of time consultants spent on WPBAs in the last four full working weeks was just over two hours
- the average amount of time GP trainers spent on WPBAs in the last four full working weeks was three hours and 45 minutes.

Time spent on giving feedback

Again, there was a wide range of answers.

In summary:

- Consultants spent on average one hour and 45 minutes giving feedback.
- GP trainers spent just over three hours giving feedback.

Have trainers turned down requests for WPBA because of work pressure?

The survey asked trainers how often they had had to turn down trainees who had requested input to WPBA because of the pressure of work:

- 78% of consultants (n=12,887) said never
- 92% of GP trainers (n=2,672) said never
- 10% of consultants (n=12,887) said once and 7% said twice
- 4% of GP trainers (n=2,672) said once and 3% said twice.

How frequently do trainers score assessments retrospectively?

The survey asked trainers how frequently they scored assessments a day or more after they had taken place. More detail is given in table 3.5.

In summary:

- 20% of consultants (n=12,887) said they never scored retrospectively.
- 46% of GP trainers (n=2,672) said they never scored retrospectively.
- The remainder do score retrospectively, 13% of consultants and 4% of GP trainers as much as 75% of the time.

Table 3.5 In general how frequently do you score assessments retrospectively (ie the following day or later)?

	Number of consultants	%	Number of GP trainers	%
Never	2,626	20.4%	1,231	46.1%
Less than 25% of the time	4,136	32.1%	912	34.1%
26% to 50% of the time	2,476	19.2%	270	10.1%
51% to 75% of the time	2,013	15.6%	156	5.8%
Over 75% of the time	1,636	12.7%	103	3.9%
Total	**12,887**	**100%**	**2,672**	**100%**

77%

of consultants said they had received adequate training to give useful feedback



How well are trainers trained to deliver WPBA?

The survey asked trainers if they felt they had received adequate training in WPBA to reliably assess trainees' competence and give useful feedback.

In summary:

- 78% of consultants (n=12,887) and 87% of GP trainers (n=2,672) said they had received adequate training to reliably assess trainees' competence.
- 77% of consultants (n=12,887) and 88% of GP trainers (n=2,672) said they had received adequate training to give useful feedback.

What impedes trainers' use of WPBA?

The survey asked trainers what impediments to the use of WPBA they experienced and gave them a range of answers with the option to tick more than one. The most common answer – from around half the consultants and GP trainers – was lack of time. More detail is shown in tables 3.6 (consultants) and 3.7 (GP trainers) opposite.

Table 3.6 Which of the following, if any, impede the use of WPBA in your department? (Check all that apply.)

	Number of consultants	%
Lack of time during the working day to carry out WPBA	9,451	54.7%
Difficulties in recording (e.g. e-portfolio)	3,205	18.6%
Trainee disengagement from WPBA	3,180	18.4%
No impediments	2,718	15.7%
Lack of facilities (room, etc) to carry out WPBA	2,360	13.7%
Senior clinician disengagement from WPBA	1847	10.7%
Lack of suitable training opportunities to use for assessment	1018	5.9%
Other impediments	976	5.7%

Table 3.7 Which of the following, if any, impede the use of WPBA in your department? (Check all that apply.)

	Number of GP trainers	%
Lack of time during the working day to carry out WPBA	1312	49.1%
No impediments	966	36.2%
Trainee disengagement from WPBA	518	19.4%
Difficulties in recording (eg e-portfolio)	308	11.5%
Other impediments	133	5.0%
Lack of facilities (room, etc) to carry out WPBA	126	4.7%
Lack of suitable training opportunities to use for assessment	107	4.0%
Senior clinician disengagement from WPBA	92	3.4%

49%

of GP trainers said they lacked time during the working day to carry out WPBA



Discussion

Trainees' WPBA informs both their educational appraisal and their performance review. It is an essential part of the approved assessment system, alongside national professional examinations, and there is a range of tools designed to assess for learning. WPBA is designed not only to provide an ongoing record of progress that encourages reflection and fosters a learning culture but also a means of identifying those trainees that need additional support at an early stage.[10] It is not designed as an assessment of learning and it not summative in nature. It is a required part of the programme that trainees must demonstrate and the GMC has standards and requirements of the trainers who carry it out. Trainers must be trained for this role including equality and diversity training. Educational and clinical supervisors should demonstrate their competence in educational appraisal and feedback and in assessment methods. All supervisors should be appropriately trained to teach, undertake assessments and provide feedback to trainees.

GP trainers have a long and positive history; their role is recognised and rewarded. The position for trainers in secondary care has been quite different and there have been significant advances since the standards for all trainers were introduced in 2007. The analysis presented here gives room for encouragement. The vast majority of trainers, and GP trainers in particular, reported receiving recent (ie within the last three years) training in how to support training needs, WPBA, giving feedback and equality and diversity issues. This has improved year on year since 2008. Only a tiny fraction of the trainers who responded had not received any training; the data analysis shows that some GP trainers and consultants who answered this survey did not, in fact, have responsibility for trainees at the time of responding. Over three quarters of GP trainers and consultants felt they had adequate training to carry out WPBAs. This is consistent with the figures from 2009 but shows no increase.

The importance of training was recognised by consultants who responded to this survey, as shown in these comments:

'I am only aware of the WPBAs in detail as I have recently undertaken a certificate in medical education. This has not been taught to me in my everyday practice and until undertaking the medical education course I was unaware of the evidence for WPBAs and how to undertake them and feedback.'

'I have been a consultant in surgery since August 2009 and have not had an appraisal in this new job. I have not received any formal training for WPBA but have gained information about this from the Intercollegiate Surgical

[10] *Workplace based assessment: a guide for implementation*. PMETB May 2009.

Curriculum Programme (ISCP) site and been conducting these assessments for a few years.'

'I am an associate specialist, I am asked to provide supervision training and WPBA but have had no specific training regarding assessment tools.'

As in previous years, the 2010 data show that lack of time remains the biggest impediment to using WPBA, cited by half of GP trainers (49.1%) and just over half of consultants (54.7%) in 2010. In both cases, this is a drop compared with 2009, when 56% of GP trainers and nearly 70% of consultants cited lack of time as the biggest impediment. There was no change in the number of consultants turning down trainees' requests for WPBAs because of work pressure in 2010 compared with 2009, and a drop from 10% in 2009 for GP trainers to 8% in 2010. GP trainers reported spending nearly twice as long as consultants in carrying out WPBAs and giving feedback to trainees. As PMETB noted in May 2009:[11]

'WPBA is time consuming. Resources for educational supervision and feedback have not been clearly identified. The PMETB trainers' survey report 2007 (PMETB 2008) identifies very significant pressures on educational supervisors who lack time within their clinical work plans to supervise and give feedback to trainees.'

> ***"WPBA takes significantly more time than previous systems. I am not yet convinced it improves assessment other than having a record that a trainee was trained. Educational supervision takes a huge amount of time and as programme directors we have picked up the bulk of this. The situation for programme directors and trainers as currently stands is not sustainable in the long term."***

The concern among trainers at the demands made of them in undertaking WPBAs came across in this comment:

'WPBA takes significantly more time than previous systems. I am not yet convinced it improves assessment other than having a record that a trainee was trained. Educational supervision takes a huge amount of time and as programme directors we have picked up the bulk of this. The situation for programme directors and trainers as currently stands is not sustainable in the long term.'

The number of trainers scoring WPBAs retrospectively must raise some questions. The expectation is that these will be recorded at the time they are undertaken but the data here show that this is often not the case. There will always be some delay at some times in order to prioritise patient care.

However this confirms other findings by the GMC[12] in the Annual Review of Competence Progression (ARCP) process. One trainer shed some light on one reason for this, commenting:

'The college website is not always available for WPBA recording, hence often submitting after the event.'

Further examination is required to find out why trainers are scoring retrospectively and how this can be rectified.

Other trainers' comments raised concerns about the forms, the bureaucracy involved in WPBA and the calibration of assessments rather than disengagement. This trainer remarked on the quality of forms used in different specialties:

'The suitability and usefulness of WPBA is variable, for example the emergency medicine forms [are] clearer and more useful than GP forms.'

11 *Workplace based assessment: a guide for implementation*. PMETB May 2009.
12 *Workplace based assessment: a guide for implementation*. PMETB May 2009.



> *"I believe that WPBAs can be useful for learning if applied properly, though often the trainee and/or trainer do not appreciate this. I have trialled clinical reflective writing this year and found it very useful."*

'The introduction of WPBAs provides an example of change being initiated without any attempt to change culture first. Consultants are not educationalists by background and the current cohort has not grown up with an ethos of self reflective practice. To then expect commitment and adherence to an alien philosophy inserted into a non-educational environment by the provision of training in how to complete a form seems unrealistic. Nevertheless, as more of us play catch up in taking up as much training in education as we can, things will improve to a degree but perhaps expectations should be downsized and changes introduced in a strategic fashion over a longer period of time rather than in a reactive and piecemeal fashion.'

'Regarding WPBAs – the forms aren't the useful part – it's the interaction with assessor that occurs that is useful – this isn't always clear on the submitted document when assessed by others. This means the quality of the assessor is also important and there is little way to judge this.'

'I believe that WPBAs can be useful for learning if applied properly, though often the trainee and/or trainer do not appreciate this. I have trialled clinical reflective writing this year and found it very useful.'

But some were clearly disengaged, such as these trainers:

'I feel the bureaucracy of WPBA is overwhelming and interferes with training registrars properly.'

'I strongly believe that the WPBAs are insufficient on their own to assess trainees. They only give a snapshot picture rather than a broader picture of clinical, orgnisational, interpersonal skills. We still rely heavily on all consultants in the department assessing trainees on a tickbox sheet, covering all areas of performance including interpersonal and orgnisational skills, in addition to WPBAs.'

'I feel that the emphasis on "ticking boxes" ie being marked on a few – and so few – cases is very reductionist and does not encourage trainees to take an interest in every patient for their sake, or psychiatry as a whole. A trainee can just about pass on each WPBA but would in fact not be the doctor you would hope would meet you or your family in the middle of the night.'

On the trainee side, comments fell into two categories: those who complained of WPBA being a 'tickbox exercise' and those who complained that they had trouble persuading their consultants to carry them out:

'WPBA and the current method of



competency based assessment fosters a culture of time consuming and very unchallenging end points that bear little reflection on clinical skill or competence.'

'I have received a very high standard of training with excellent trainers and clinical supervision. However the present structure of our training with stupid tick-box forms (WPBAs) is flawed and rewards trainees who focus on audits, CPD and not gaining clinical experience. This will not produce better consultants.'

'The willingness of consultants to complete WPBAs has been woefully inadequate.'

'Due to the nature of WPBA, tutorial time is often taken over with assessments.'

'Registrars can only get their WPBAs done by consultants but with the A&E department being busy with less cover, it proves very difficult to get the consultant to observe and then sign off one's competence assessment.'

This ambivalence about WPBA is a longstanding issue and one that has been recognised. As PMETB noted in 2009:[13]

'In order for WPBAs to be valid and useful, trainees and assessors need to understand and value their role in the educational process. The assessment tools and findings from WPBAs must be used formatively and constructively. Without this understanding, WPBA tools will potentially become no more than a series of external requirements and hoops to be jumped through, and the educational validity of the process will be lost.'

> ***"I have received a very high standard of training with excellent trainers and clinical supervision. However the present structure of our training with stupid tick-box forms (WPBAs) is flawed and rewards trainees who focus on audits, CPD and not gaining clinical experience. This will not produce better consultants."***

[13] *Workplace based assessment: a guide for implementation*. PMETB May 2009.



Chapter 4: Foundation doctors

This chapter examines what the survey data tell us about the experiences of foundation doctors. The survey included a number of questions that were specific to this group and these are scrutinised here. Data about more general aspects of foundation doctors' experiences can be found elsewhere in the report.

In total 12,692 foundation doctors answered this survey, of which 6,392 were in the first year (F1) and 6,300 in the second year (F2).[14] This chapter will explore the following questions.

- Did foundation doctors feel they were adequately prepared for their first foundation post?
- Did they feel forced to cope with clinical problems beyond their competence or experience?
- Has using a learning portfolio helped them with their needs?
- Have supervisors made clear the competences needed for sign off?
- Have trainees received informal feedback from consultants?
- How many hours of teaching did they receive and was this protected from service demands?
- Did they carry out routine work of no educational value?
- Did they have a chance to discuss their career management skills and career plans as well as information to help them with career planning?
- Have their experiences as foundation doctors influenced their career choice?

All questions were answered by all respondents.

Did foundation doctors feel they were adequately prepared for their first job?

The survey asked foundation doctors to look back to their first F1 job as they answered this question and answer no, yes, or not sure:

- 58% said yes
- 28% said no
- 15% were not sure.

Table 4.1 gives a breakdown by F1 and F2; the grade differences were small.

Table 4.1 Do you feel that you were adequately prepared for your first F1 post?

		No	Yes	Not sure	Total
F1	Number	1,706	3,772	914	6,392
% within Grade		26.7%	59.0%	14.3%	100%
F2	Number	1,794	3,534	972	6,300
% within Grade		28.5%	56.1%	15.4%	100%

[14] Please note two foundation trainees have been removed from the analysis in this chapter.

4.8%

of foundation doctors said they daily felt forced to cope with clinical problems beyond their competence or experience

Did they feel forced to cope with clinical problems beyond their competence or experience?

The survey asked foundation doctors about how frequently they had felt forced to cope with clinical problems beyond their competence or experience in their current post:

- over half of F1 and F2 trainees said never or rarely
- over one third of F1 and F2 trainees said monthly or weekly
- 4% of F1 trainees said daily and 6% of F2 trainees said daily.

Table 4.2 gives more detail.

Table 4.2 In this post how often did you feel forced to cope with clinical problems beyond your competence or experience?

		Never	Rarely	Monthly	Weekly	Daily	Total
F1	Count	594	2,865	1,249	1,434	252	6,392
% within Grade		9.3%	44.8%	19.5%	22.4%	3.9%	100%
F2	Count	843	2,764	1,071	1,262	359	6,300
% within Grade		13.4%	43.9%	17.0%	20.0%	5.7%	100%
Total	**Count**	**1,437**	**5,629**	**2,320**	**2,696**	**611**	**12,692**
%		**11.3%**	**44.4%**	**18.3%**	**21.2%**	**4.8%**	**100%**

Has using a learning portfolio helped them with their needs?

The Foundation Programme portfolio is the trainees' record of achievement for their entire foundation programme. The survey asked whether it had been useful in helping them with their learning needs:

Table 4.3 In your foundation training to date, has using a learning portfolio helped you with your learning needs?

Foundation		No	Yes	Not sure	Total
F1	Count	3,223	2,173	996	6,392
% within Grade		50.4%	34.0%	15.6%	100%
F2	Count	3,202	2,077	1,019	6,300
% within Grade		50.8%	33.0%	16.2%	100%
Total	**Count**	**6,425**	**4,251**	**2,016**	**12,692**
	%	**50.6%**	**33.5%**	**15.9%**	**100%**

Have supervisors made clear the competences needed for sign off?

The survey asked foundation doctors whether, in their training to date, their supervisors had made clear what competences they needed to achieve in order to be signed off from the F1/F2:

Table 4.4 In your foundation training to date, has your supervisor made it clear what competences you must meet in order to be signed off from F1/F2?

Grade Final		No	Yes	Total
F1	Count	1,932	4,460	6,392
% within Grade		30.2%	69.8%	100%
F2	Count	1,877	4,423	6,300
% within Grade		29.8%	70.2%	100%
Total	**Count**	**3,809**	**8,883**	**12,692**
	%	**30%**	**70%**	**100%**

67%

of all trainees said they had received helpful informal feeback from a consultant

Have trainees received informal feedback from consultants?

The survey asked trainees whether they had received informal feedback from a consultant that was helpful to their development. See table 4.5.

Table 4.5 In the last 4 weeks have you received informal feedback from a consultant which was helpful to your development?

Grade Final		No	Yes	Not applicable	Total
F1	Count	2,086	4,202	104	6,392
% within Grade		32.6%	65.7%	1.6%	100%
F2	Count	1,825	4,330	145	6,300
% within Grade		29.0%	68.7%	2.3%	100%
Total	Count	3,911	8,532	249	12,692
	%	30.8%	67.2%	2%	100%

How many hours of teaching did they receive and was this protected from service demands?

The survey asked foundation trainees how many hours of teaching they had received in the last four weeks:

- off duty and pagers handed in
- on duty and pagers not handed in.

Off duty and pagers handed in

The answers varied widely, from zero hours to one trainee who reported 48 hours.

In summary see table 4.6.

Table 4.6 In the last 4 weeks how many hours of teaching have you received on average each week. a) Off duty and pagers handed in?

Grade Final		0hr	⩾ 1hr	1-2hrs	⩽ 2hrs	Total
F1	Count	4,263	739	493	897	6,392
% within Grade		66.7%	11.6%	7.7%	14.0%	100%
F2	Count	3,778	531	675	1,316	6,300
% within Grade		29.8%	8.4%	10.7%	20.9%	100%
Total	Count	8,041	1,270	1,168	2,213	12,692
	%	63.4%	10%	9.2%	17.4%	100%

53%

of all trainees said they had been expected to do routine work of no educational value

On duty and pagers not handed in

Again the answers varied widely, from zero hours to ten trainees who reported 30 hours or more.

In summary see table 4.7.

Table 4.7 In the last 4 weeks how many hours of teaching have you received on average each week. b) On duty but pagers not handed in?

Grade Final		0hr	⩾ 1hr	1-2hrs	⩽ 2hrs	Total
F1	Count	2,126	1,576	1,028	1,662	6,392
% within Grade		33.3%	24.7%	16.1%	26.0%	100%
F2	Count	2,609	1,164	946	1,581	6,300
% within Grade		41.4%	18.5%	15.0%	25.1%	49.6%
Total	**Count**	**4,735**	**2,740**	**1,974**	**3,243**	**12,692**
	%	**37.3%**	**21.6%**	**15.6%**	**25.6%**	**100%**

Did they carry out routine work of no educational value?

The survey asked foundation trainees whether they had been expected to do routine work of no educational value in the last four weeks and 78% said this occurred often or occasionally; only 9% said never. The survey did not ask about the nature of this work or define routine. The results are shown in table 4.8.

Table 4.8 In the last four weeks have you been expected to do routine work of no educational value?

	Number	%
Yes – often	6,751	53.2%
Yes – occasionally	3,114	24.5%
Yes - rarely	1,436	11.3%
No – never	1,105	8.7%
Not applicable	286	2.3%
Total	**12,692**	**100%**

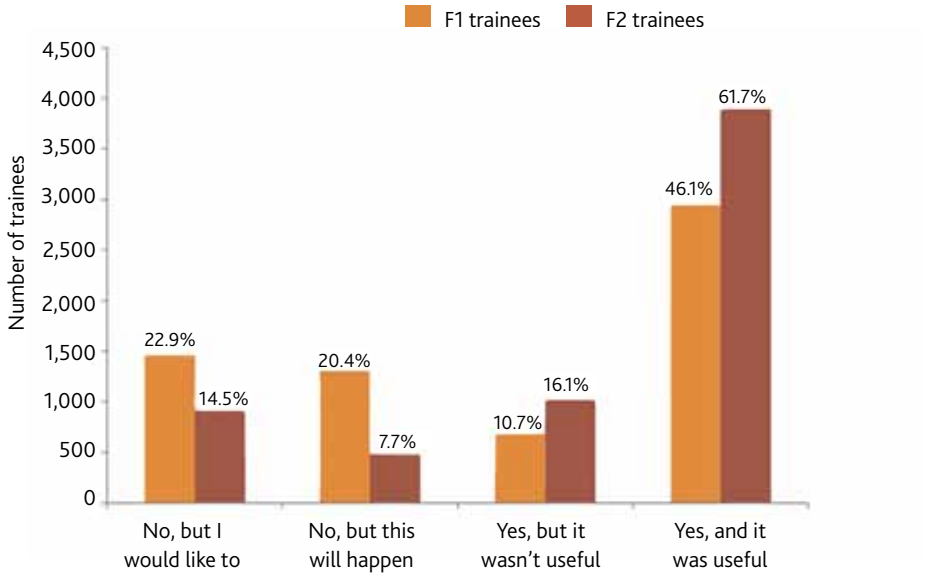
Career management

The survey asked trainees several questions about their career management. They were asked to tick one of a series of options on the following questions.

- Had they been able to develop their career management skills and career plans during the Foundation Programme?
- Had they been able to access information to assist their career planning in their current post?
- Had their experience in this post influenced their career choice?

The answers are set out in figures 4.1 to 4.3.

Figure 4.1 Have you been able to develop your career management skills and career plans during the Foundation Programme?



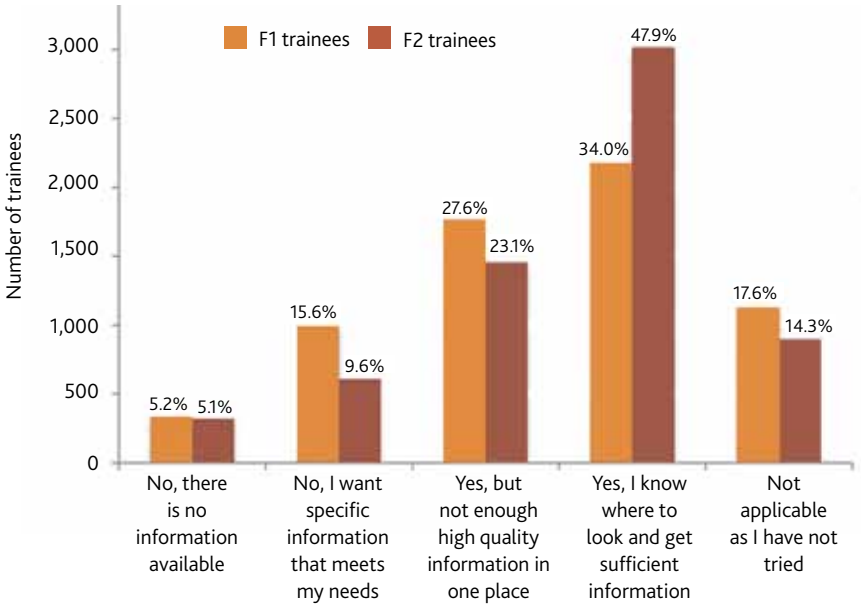
Career management skills and planning

Just over half of all foundation trainees said they had been able to develop their career management skills and career plans and that the opportunity was useful. More F2 than F1 trainees (62% compared with 46%) said they had received useful advice. Figure 4.1 provides more detail.

Information to assist career planning

Overall, four in ten foundation trainees said they knew where to look to get sufficient information and another quarter said they had received information but felt there was not enough high quality information in place. More F2 trainees (48% compared with 34% of F1 trainees) were clear about where to look.

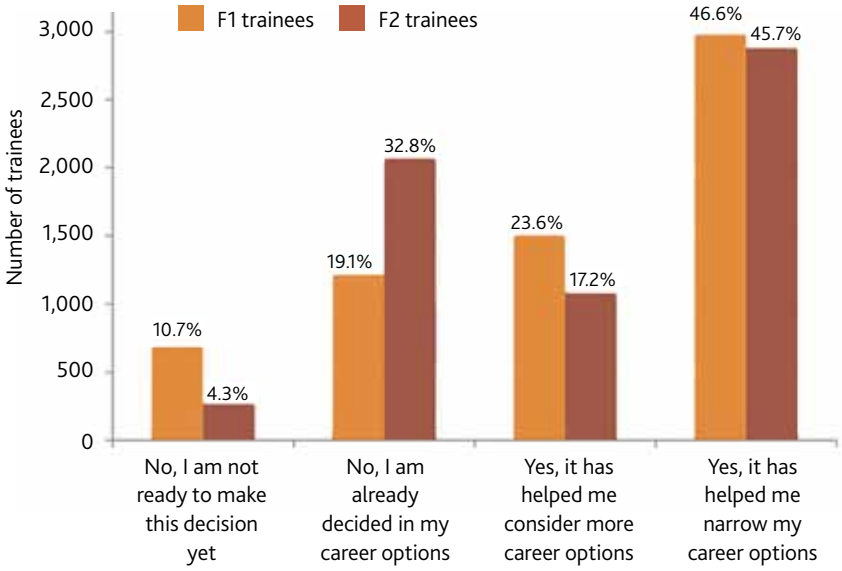
Figure 4.2 While in this post, have you been able to access information to assist your career planning?



Influence of post on career choice

Just under half said their current post had helped influence their career choice. Figure 4.3 shows the breakdown by grade.

Figure 4.3 Has your experience in this post influenced your career choice?



Discussion

The results presented here should be treated with caution as they refer to foundation trainees' perceptions at a single point in time. However, with 12,692 foundation doctors taking part, the sample is large and the answers may provide some insights into the perceptions of Foundation Programme training for the profession and the regulator.

At the time of writing, the Scottish Medical Training Programme Board and NHS Medical Education England were evaluating the Foundation Programme and publication of the reports and recommendations about the future of the programme were awaited. The findings presented here are therefore too late to add to the reviews but do underscore comments made by the GMC in March 2010.[15] In particular, the GMC noted:

'There is no doubt that implementation of the Foundation Programme is variable across the UK. While we have found some excellent aspects of delivery, in other areas we have had to impose significant requirements in order for the standards to be met.'

The mixed results presented here would support this.



On the positive side:

- more than half the trainees in this survey felt they were prepared for their first job
- over half said they never or rarely felt forced to cope with clinical problems beyond their competence or experience
- seven in ten were clear about the competences they needed to be signed off from the Foundation Programme
- two thirds had received informal feedback from consultants
- overall, around half had information and support on career management.

Data from other chapters help build a more rounded picture. For example, the chapter on supervision, which shows that 90% of foundation doctors report rarely or never being asked to obtain consent for procedures that they did not understand and 65% rate the quality of their supervisors as good or excellent. The questions around preparedness in chapter 6 indicate that 64% of foundation trainees rated their practical experience good or excellent and 73% were confident or fairly confident of acquiring the competences needed for the foundation stage. Across all these measures, however, foundation trainees score slightly lower than those at higher grades.

This analysis also raises some issues of concern:

- two thirds were not sure of the usefulness of the learning portfolio

[15] The GMC's submission to NHS Medical Education England's *Evaluation of the Foundation Programme*. March 2010.

- over one third said they felt forced to cope with clinical problems beyond their competence or experience on a monthly or weekly basis
- two thirds had not received training while off duty and with pagers handed in
- over nine in ten reported carrying out routine work of no educational value, and half reported that they had often done so.

Also notable are the data on trainees' perception of preparedness for their first job. More than half the trainees in this survey felt they were prepared for their first job. However, of the F1 and F2 doctors who replied, over a quarter did not feel adequately prepared. This is consistent with concerns over graduates' preparedness which arose from research commissioned by the GMC to support the review of *Tomorrow's Doctors*, the GMC's outcomes and standards for undergraduate medical education. This led to the revision of *Tomorrow's Doctors* with clearer outcomes and a focus on clinical placements and Student Assistantships, which give students more practical, hands-on experience. The new outcomes and standards come into effect for the 2011/12 academic year.

Overall, comments from foundation doctors support the mixed picture shown by the data presented here. A few were full of praise:

'I really enjoyed my F1 placements. Excellent deanery. Very good teaching especially in medicine. Could do with more surgical teaching. But the support from my supervisors has been immensely helpful.'

'In any placement you get out what you put in. To some people F1 orthopaedics seems like an awful rotation but I loved it and took a lot out of it.'

But more commonly they were not:

'I do not feel that my F1 year (not just this post, but all three) has been a training post. The emphasis is on service provision.'

'The weekly training (bleep free hour) should be far more focused on matters that we as F1s come across in our day-to-day duties on the ward.'

'F1 are just asked to stick to the curriculum, and at times told not to show enthusiasm in procedures that are not in the curriculum. The clinical teaching is very basic.'

'Teaching wise, we have four hours a week (three hours of lunchtime teaching and one hour of F1 teaching before work once a week). The teaching is very useful but we are not able to hand in our bleeps, and if they go off we answer them and therefore miss some of the teaching. On ward rounds, especially on this placement, I rarely have any teaching off my consultant as the ward rounds are always so rushed. As a medical student I received teaching on ward rounds and cannot see why we do not get any while we are F1s.'

"*I really enjoyed my F1 placements. Excellent deanery. Very good teaching especially in medicine. Could do with more surgical teaching. But the support from my supervisors has been immensely helpful.*"

The survey did not explore what trainees might consider 'routine' or offer any definitions as this is an area of ambiguity, as demonstrated by trainees' comments. Some commented on missed training opportunities as they undertook what might be considered routine



tasks; others commented on how not undertaking some routine tasks in their foundation programme might impact on them in future:

'I find that in the F1 year I am often required to undertake many tasks which are mainly repetitive, eg venepuncture, or secretarial, eg ordering tests for which the reasoning is often not clear or there is no opportunity to ask why it is necessary. I think that this is acceptable as long as adequate teaching time is also given. However teaching is very ad hoc and only really available if you are persistent, have the time between essential tasks or find a senior doctor who is willing and has time to teach you.'

'It really dismays me to hear of valuable training opportunities taken away from junior doctors and given to nurse practitioners as they are thought of as "routine". Clerking a patient is not just about filling a form in and writing a lot down on paper, each new patient is a valuable training and learning opportunity. The nurse practitioners are on the top pay band, likely more than the junior doctors, but produce verbose, over-long clerkings with no conclusion and management plan, just a "box-ticking", form-filling exercise. I heard recently that ITU nurse practitioners will replace FY1 doctors on the arrest team in this trust. This saddens me. This means an F1 doctor could do the whole year with no experience of an arrest, then the next year be expected to be the SHO, and occasionally lead arrests. This is absurd.'

The portfolio emerged as a source of discontent with only 34% (n=12,692) of trainees saying it was useful. GMC requires that foundation trainees maintain a personal record of educational achievement to describe and record their experiences, summaries of feedback from educational supervisors and results of assessments but is agnostic on whether this is paper-based or electronic. In practice, most trainees use an e-portfolio. Comments made by trainees and trainers in this survey were overwhelmingly negative about the way in which the e-portfolio is used.

The following were typical from trainees:

'The e-portfolio is a waste of time and generally regarded by all doctors of all grades as a tickbox exercise that doesn't judge who is competent or incompetent.'

'Foundation portfolio is useless. No senior staff have the time and/or desire and/or knowledge to fill out assessments. They treat them as a necessary evil and annoyance.'

'Please scrap the utterly pointless e-portfolio system that causes stress without imparting any educational value whatsoever. It will never detect excellence, and I have my doubts as to whether it would even be beneficial in detecting underperforming doctors.'

'E-portfolio often feels like a box-ticking exercise rather than a record of education attainment.'

'I hate the e-portfolio. I find it an unhelpful waste of my and my seniors' time. I think it is an almost criminal waste of money that encourages perjury and damages service provision.'

And from trainers:

'The e-portfolio is far too time consuming.'

'The e-portfolio is poorly implemented. It frequently crashes or runs slowly increasing the length of time it takes to carry out box-ticking exercises.'

'As an experienced trainer I am very unhappy with e-portfolio to the extent that I plan to resign as a trainer within the next two years as soon as partner qualifies as trainer. It is overly administrative and burdensome, not to mention competence-driven framework dumbing down medical education. Entries are taken on face value so the whole system is potentially subject to abuse. I fear that the system favours trainees who just log lots of entries rather than those who are clinically competent.'

'The e-portfolio has assumed a worth that far exceeds its value. At one level it almost substitutes for a final examination in Medicine and at another it preoccupies trainees at times assuming more importance than the job itself. This fetishism can lead to a lack of engagement of the trainee in the clinical environment.'

This is not consistent with the literature. A 2009 Best Evidence Medical Education (BEME) review of 56 articles from 10 countries involving seven healthcare professions found 'good evidence that, if well implemented, portfolios are effective and practical in a number of ways including increasing personal responsibility for learning and supporting professional development.'[16] However, a study of junior doctors by Hrisos et al noted in 2008:[17]

'Many trainee doctors and educational supervisors are yet to be convinced of their educational value. Gaining multi-source feedback, a substantial component of trainee doctors' portfolios, impacts on the wider clinical team and presents a significant challenge to trainees. Educational supervisors continued to rely on feedback from clinical colleagues, rather than portfolio evidence, to monitor trainee doctors' development. Such factors may serve to disengage trainees with the portfolio process by overshadowing any perceived educational gains.'

The respondents to this survey would appear to agree with this study and are yet to be persuaded of the evidence cited by BEME. However the degree of discontent highlighted by this survey must be a cause of concern.

> ***"I find that in the F1 year I am often required to undertake many tasks which are mainly repetitive for which the reasoning is often not clear or there is no opportunity to ask why it is necessary. I think that this is acceptable as long as adequate teaching time is also given. However teaching is very ad hoc and only really available if you are persistent, have the time between essential tasks or find a senior doctor who is willing and has time to teach you."***

[16] Tochel C, Haig A, Hesketh A, Cadzow A, Beggs K, Colhart I, Peacock H. *The effectiveness of portfolios for postgraduate assessment and education: BEME Guide No 12 2009*, Vol. 31, No. 4 , Pages 299-318.

[17] Hrisos S, Illing JC, Burford BC. *Portfolio learning for foundation doctors: early feedback on its use in the clinical workplace. Med Educ*. 2008 Feb;42(2):214-23.


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Chapter 5: European Working Time Regulations (EWTR)

This chapter explores the impact of the European Working Time Regulations (EWTR) on training as reported by trainees and trainers. Since the last survey, the NHS has moved to compliance with a 48 hour working week, compared with 56 hours in 2009.

This chapter uses survey data to answer the following questions.

Trainers

- Are they able to deliver training to the same standard on a rota that complies with the EWTR of 48 hours a week compared with a 56 hour working week?
- Have trainers changed the way they teach in response to the 48 hour week?
- Do trainers report that overall training needs are met within the EWTR working week?
- How often do they report their trainees working beyond EWTR limits?

Trainees

- What proportion of trainees is working to an EWTR compliant rota?
- How many report actually working hours that are EWTR compliant?
- Are trainees filling gaps in rotas?
- Do trainees feel that their training needs are being met within the working week specified by the EWTR?
- Is it taking them longer to achieve educational competences?

Trainers

Are trainers able to deliver training to the same standard on a 48 hour rota as on a 56 hour rota?

The survey asked trainers whether their department delivers training to the same standard on an EWTR-compliant (ie 48 hour) rota as on a 56 hour rota, and whether they made changes to achieve this.

In summary:

- 48% (n=14,555) of consultants and 56% (n=2,672) of GP trainers answered yes; 10% reported making changes to achieve this.
- 35% of consultants and 9% of GP trainers answered no.
- 18% of consultants and 35% of GP trainers answered don't know.

More detail is given in table 5.1 (overleaf).

56%

of GP trainers answered yes when they were asked whether their department delivers training to the same standard on an EWTR compliant rota

Table 5.1 Our department delivers training to the same standard on an EWTR compliant rota as on a 56 hour rota.

	Number of consultants	%	Number of GPs	%
Yes	3,297	22.7%	1,242	46.5%
Yes, but our department has made some changes to the training	1,256	8.6%	113	4.2%
Yes, but our department has made some changes to how we devise the rota	2,074	14.2%	131	4.9%
Yes, but our department made some other changes that aren't listed	289	2.0%	14	0.5%
No	5,016	34.5%	250	9.4%
Don't know	2,623	18.0%	922	34.5%
Total	**14,555**	**100%**	**2,672**	**100%**

Have trainers changed the way they teach in response to the 48 hour week?

The survey asked consultants and GP trainers if they had changed the way they train in response to the shorter working week and, if so, how?

In summary:

- 52% (n=14,555) of consultants said they had changed the way they teach.
- 30% (n=2,672) of GPs said they had changed the way they teach.

Table 5.2 shows the different ways these doctors had changed. The survey gave a range of options and respondents were invited to select all those that applied. The most common changes were restructuring the training and encouraging more self-directed learning by trainees.

Table 5.2 How have you changed the way you teach your trainees in response to the shorter working week and changes to the rota?

	Number of consultants	%	Number of GPs	%
I have restructured the training	3,098	49.5%	429	53.6%
I have taken on fewer trainees	683	10.9%	26	3.3%
I have encouraged more self-directed learning amongst my trainees	3,592	57.4%	360	45.0%
I have delegated training	1,514	24.2%	159	19.9%
I made some other changes	1,009	16.1%	148	18.5%

Do trainers report that overall training needs are met within the EWTR working week?

The survey asked trainers to agree or disagree with the following statement:

'Overall the training needs of my trainees are met within the hours specified by the European Working Time Directive (currently a maximum 48 hour week average for trainees).'

- 53% (n=14,555) of consultants reported that the training needs of their trainees were met in the 48 hour working week.
- 89% (n=2,672) of GPs reported that the training needs of their trainees were met in the 48 hour working week.

How often do they report their trainees working beyond EWTR limits?

The survey asked trainers how often their trainees stayed to work beyond the EWTR limits.

In summary:

- Over half of consultants said rarely or never.
- Nine out of ten GP trainers said rarely or never.
- 24% (n=14,555) of consultants said weekly.
- 6% (n=2,672) of GP trainers said weekly.

More detail is given in table 5.3.

81%

of trainers answered yes when they were asked whether, in this post, their rostered working hours were compliant with the EWTR, regardless of how many hours they actually worked

Table 5.3 How often do your trainees stay and work beyond EWTR limits?

	Number of consultants	%	Number of GPs	%
Never	2,004	13.8%	1,281	47.9%
Rarely	6,820	46.9%	1,104	41.3%
Monthly	1,466	10.1%	96	3.6%
Weekly	3,417	23.5%	167	6.3%
Daily	848	5.8%	24	0.9%
Total	**14,555**	**100%**	**2,672**	**100%**

55%

said there were no doctors missing on the rota

Trainees

What proportion of trainees is working to an EWTR compliant rota?

The survey asked trainees whether, in this post, their rostered working hours were compliant with the EWTR, regardless of how many hours they actually worked:

- 81% (n=46,650) said yes
- 6% (n=46,650) said no
- 13% (n=46,650) were not sure.

How many trainees report actually working hours that are EWTR compliant?

The survey asked trainees whether they had in fact worked beyond 48 hour week and, if so, how often.

In summary:

- 34% (n=46,650) said rarely or never.
- 35% (n=46,650) said weekly.
- 18% (n=46,650) said daily.

More detail is shown in table 5.4.

Table 5.4 In this post, how often have you worked beyond your rostered hours?

	Number of trainees	%
Never	3,246	7.0%
Rarely	12,534	26.9%
Monthly	6,366	13.6%
Weekly	16,110	34.5%
Daily	8,394	18.0%
Total	**46,650**	**100%**

The survey also asked trainees whether they had felt pressured to submit a record of hours that was compliant with the EWTR when their hours were not in fact compliant.

In summary:

- 90% (n=46,650) said no.
- 10% (n=46,650) said yes.

Next, the survey asked trainees if they had been asked to sign a waiver opting out of the EWTR. Overall, 83% (n=46,774) had not been asked to sign a waiver.

More detail is shown in table 5.5.

Table 5.5 In this post, have you been asked to sign a waiver opting out of the EWTR?

	Number of trainees	%
I have not been asked and I have not signed an opt-out	39,010	83.4%
I have been asked but did not sign an opt-out	2,577	5.5%
I have been asked and did sign an opt-out willingly	3,296	7.0%
I have been asked and signed an opt-out but felt under duress to do so	504	1.1%
I have signed an opt-out without being asked to do so	1,387	3.0%
Total	**46,774**	**100%**

Are trainees filling gaps in rotas?

The survey asked trainees whether, in this post, there were gaps in the rota due to a failure to fill posts. If so, they were given a range of options to tick.

In summary:

- 55% (n=46,650) said there were no doctors missing on the rota.
- Where there were gaps, trainees most commonly reported missing training opportunities or working beyond their hours.
- 9% (n=46,650) reported gaining exposure to extra training as a result of rota gaps.

Table 5.6 gives more detail.

Table 5.6 In this post were there gaps in the rota you were working due to a failure to fill posts?

	Number of trainees	%
Yes – I had to work over my hours to fill rota gaps	6,280	13.5%
Yes – I had to miss teaching or training opportunities to cover routine daytime work as a result of rota gaps	8,022	17.2%
Yes – I had to miss teaching or training opportunities to cover on-call commitments out of hours as a result of rota gap	2,707	5.8%
Yes – I had exposure to extra training opportunities as a result of rota gaps	4,117	8.8%
No – there were no doctors missing on the rota	25,524	54.7%
Total	**46,650**	**100%**

68%

of trainees said they didn't have to cover for patients in a different specialty from their current post

The survey also asked trainees how often they covered for patients in a different specialty from their current post.

In summary:

- 68% (n=46,650) said never.
- 2% (n=46,650) said daily.

Table 5.7 gives more detail.

Table 5.7 How often did you cover for patients in a different specialty to this post?

Valid	Number of trainees	%
Never	31,847	68.3%
Rarely	6,804	14.6%
Monthly	3,528	7.6%
Weekly	3,523	7.6%
Daily	948	2.0%
Total	**46,650**	**100%**

Do trainees feel that their training needs are being met within the working week specified by the EWTR?

The survey asked trainees whether they felt their overall training needs were met within an average 48 hour working week.

In summary:

- 58% (n=46,773) said yes.
- 27% (n=46,773) said no.
- 16% (n=46,773) were not sure.

Table 5.8 gives more detail, showing the breakdown by grade.

Table 5.8 Overall do you feel that your training needs were met within the average weekly working hours specified by the EWTR?

Grade	Count / Percent	No	Yes	Not sure	Total
F1	Count	2,053	3,268	1,072	6,393
F1	% within grade	32.1%	51.1%	16.8%	100%
F2	Count	1,396	3,919	986	6,301
F2	% within grade	22.2%	62.2%	15.7%	100%
ST1 or CT1	Count	1,837	4,119	1,229	7,185
ST1 or CT1	% within grade	25.6%	57.3%	17.1%	100%
ST2 or CT2	Count	1,767	4,014	1,081	6,862
ST2 or CT2	% within grade	25.8%	58.5%	15.8%	100%
ST3 or CT3	Count	1,548	4,358	1,044	6,950
ST3 or CT3	% within grade	22.3%	62.7%	15.0%	100%
SpR	Count	1,540	2,840	679	5,059
SpR	% within grade	30.4%	56.1%	13.4%	100%
ST4	Count	1,158	1,903	560	3,621
ST4	% within grade	32.0%	52.6%	15.5%	100%
ST5	Count	890	1,638	437	2,965
ST5	% within grade	30.0%	55.2%	14.7%	100%
ST6	Count	256	601	128	985
ST6	% within grade	26.0%	61.0%	13.0%	100%
ST7	Count	112	167	45	324
ST7	% within grade	34.6%	51.5%	13.9%	100%
ST8	Count	46	59	23	128
ST8	% within grade	35.9%	46.1%	18.0%	100%
Total	**Count**	**12,603**	**26,886**	**7,284**	**46,773**
Total	**% within grade**	**26.9%**	**57.5%**	**15.6%**	**100%**

Are trainees taking longer to achieve educational competences?

The survey asked trainees whether, as a result of working 48 hours a week, they were taking longer to achieve their required educational competences.

In summary:

- 35% (n=46,773) said yes.
- 44% (n=46,773) said no.
- 21% (n=46,773) were not sure.

Table 5.9 gives more detail.

Table 5.9 As a result of having your weekly working hours specified by the EWTR, is it taking you longer to achieve the required educational competences?

Grade	Count / Percent	Yes	No	Not sure	Total
F1	Count	2,139	2,579	1,675	6,393
	% within grade	33.5%	40.3%	26.2%	100%
F2	Count	1,991	2,909	1,401	6,301
	% within grade	31.6%	46.2%	22.2%	100%
ST1 or CT1	Count	2,469	3,076	1,640	7,185
	% within grade	34.4%	42.8%	22.8%	100%
ST2 or CT2	Count	2,499	3,009	1,354	6,862
	% within grade	36.4%	43.9%	19.7%	100%
ST3 or CT3	Count	2,060	3,462	1,428	6,950
	% within grade	29.6%	49.8%	20.5%	100%
SpR	Count	1,869	2,247	943	5,059
	% within grade	36.9%	44.4%	18.6%	100%
ST4	Count	1,485	1,374	762	3,621
	% within grade	41.0%	38.0%	21.0%	100%
ST5	Count	1,142	1,280	543	2,965
	% within grade	38.5%	43.2%	18.3%	100%
ST6	Count	298	522	165	985
	% within grade	30.3%	53.0%	16.8%	100%
ST7	Count	149	136	39	324
	% within grade	46.0%	42.0%	12.0%	100%
ST8	Count	67	49	12	128
	% within grade	52.3%	38.3%	9.4%	100%
Total	**Count**	**16,168**	**20,643**	**9,962**	**46,773**
Total	**% within grade**	**34.6%**	**44.1%**	**21.3%**	**100%**

Discussion

The impact of the EWTR on postgraduate medical training remains hotly debated. The picture is very variable and specialty specific. These 2010 surveys of trainers and trainees are the first to ask the questions analysed here of this number of trainers and trainees since the final stage of the directive was implemented in August 2009 when the 48 hour 'working week' was introduced.

A year ago, when the working week was 56 hours, the PMETB's *National training surveys key findings report* in 2009 noted several positive effects associated with the shorter working week. Trainees who were compliant with the 56 hour week were more likely to report being encouraged to take study leave; less likely to report leaving local study teaching sessions and found it easier to attend training events. The report noted: 'The statistical analysis…shows broadly that compliance with the EWTD went hand in hand with a better reported experience of training.'[18]

In May 2010 Professor Sir John Temple delivered his report on the impact of the EWTR on training in England[19], which was commissioned by NHS: Medical Education England at the request of the Government. The report's authors noted that they accepted responses and information as a proxy for evidence. Broadly, the report said that high quality training can be delivered in the 48 hour week, but noted that learning opportunities are being missed because some junior doctors increasingly have to fill rota gaps in secondary care. It concluded that traditional ways of service delivery and training wasted learning opportunities in some specialty training. Consultants' ways of working tended to support these traditional approaches. Further, consultants' job plans did not prioritise training and they were not rewarded for delivering high quality training. The GMC welcomed the Temple report, and commented:

'It is still fairly early days in assessing the full impact of the 48 hour week on training and more evidence will be needed to ensure we have a full picture. But the report clearly highlights a number of problems at the frontline and, as the regulator of all stages of medical education and training across the UK, the GMC has a key role, with others, in ensuring that these problems are addressed so that the quality of training is maintained and enhanced. We will be monitoring the impact of EWTD on an ongoing basis, and we will make further evidence available as it becomes available.'

The analysis presented here forms part of that evidence.

In brief, this report shows a mixed picture with many positive elements.



Unsurprisingly, given the nature of the service provided, primary care has made significant progress in successfully implementing the EWTR. Overall, GP trainers were more likely to report being able to achieve training to the same standard as in the 56 hour week, less likely to report making changes in the way they teach to achieve this and more likely to report that they could meet training needs within an EWTR-compliant week; nearly 90% of GP trainers said they could meet training needs in the 48 hour week compared with 53% of consultants. GP trainers were less likely to report that their trainees worked over the 48 hour limit than consultants, a quarter of whom said their trainees worked longer hours on a weekly basis.

In secondary care, around half of trainers reported that they are able to deliver training to the same standard in a 48 hour week compared with

[18] *National training surveys 2008-09: Key Findings.* PMETB 2009.

[19] *Time for training: a review of the impact of the European Working Time Directive on the quality of training*. NHS: MEE May 2010. Downloaded from http://www.mee.nhs.uk/PDF/14274%20Bookmark%20Web%20Version.pdf

"I feel that the EWTD has had a negative impact upon my training and working life. It has reduced my training opportunities by reducing my emergency and elective working time and reduced my income, necessitating locum work – increasing my working week!"

a 56 hour week. A minority had implemented changes to achieve this, either in the way they work or the way they deliver training. Over half had adapted their training to accommodate the EWTR, and were asking their trainees to carry out more self-directed learning.

Among trainees, the vast majority (nine in ten) reported working an EWTR-compliant rota. About one third reported working over their rostered hours on a weekly basis and a quarter of consultants said their trainees were working beyond 48 hours a week. It is positive to note that most (nine in ten) had not felt pressured to sign a rota saying their working hours were EWTR-compliant when in fact they were not.

Very few (two in ten) had signed a waiver opting out of the EWTR, although among those that did, many were willing to do so. More than half said their training needs were being met in the 48 hour week and 44% said it was not taking longer to achieve their required educational outcomes; this is a positive message overall. However, a notable minority said that their training needs were not being met in the 48 hour week and that they were taking longer to achieve their required educational outcomes. A more detailed (and at the time of writing unpublished) analysis of the survey data on the EWTR and overall quality assurance activity by the GMC has shown that some specialties are experiencing more difficulty than others, notably the specialties of surgery, paediatrics, anaesthetics, obstetrics and gynaecology, and emergency medicine.

Despite the positive signs of progress demonstrated by the data, the comments gathered in these surveys were largely negative (they usually referred to EWTR as EWTD – European Working Time Directive). In this, they reflected the complexities of what is a very large service change that is affecting not just training but service delivery overall. Surgical trainees were particularly damning, and the following were typical comments:

'The EWTD is destroying surgical training in the UK.'

'Our on-call commitments have increased to accommodate the EWTD, which means we lose out on our training sessions.'



'My current post is the first I have worked which is EWTD compliant. The detriment to training and patient continuity of care I have experienced since working this type of shift pattern is unbelievable and I believe only further serves to drive surgical training in a negative direction.'

'I feel that the EWTD has had a negative impact upon my training and working life. It has reduced my training opportunities by reducing my emergency and elective working time and reduced my income, necessitating locum work – increasing my working week!'

But this trainee pointed out that departments that were not EWTR compliant also had an excessive workload:

'The hours that we work in all departments of the hospital are not compliant with the EWTD as the workload is excessive (in some departments more than others) and the distribution of staff is not delivered to meet these needs. There are firms with too many doctors for the workload and vice versa. There are many firms where you have to stay much later to finish work.'

Trainers were more mixed in the tone of their comments. A few trainers were positive about the health and safety aspects and recognised that change is needed to deliver high quality training in a 48 hour week:

'I trained in Australia and did not work long hours, but got very good training. The rotas were better structured for training. I do not think the 48 hour week is a problem, but the rota structure and tasks that doctors do lead to training deficiencies.'

'Applying the EWTD is a very positive thing. The clinical work organisation should be much improved. The trainees are spending long hours doing not appropriate jobs (endless venflons, blood sampling – these should be the nurses'/healthcare assistants' jobs – also covering too many wards on call etc.) instead of gaining experience outlined in the curriculum.'

'We have to be honest with ourselves and the public; what we are able to produce as an end point of training with EWTD is not that previously obtained end point of independent practise. We must recognise these are 'safe' doctors but only to a certain level – the old senior registrar. The way we integrate and work these new trainees needs to be different from the systems that currently exist in the NHS.'

Others were negative, such as these from trainers:

'EWTD has meant lesser trainee exposure to clinical scenarios, leading to lesser confidence and competence in patient management.'

'I believe the hours reduction associated with EWTD has been the most destructive influence on junior training… The trainees simply are not around enough to take advantage of some of the best training opportunities that do occur according to a schedule.'

'Our trainees are highly committed individuals. As trainers we do our best to ensure that they are trained to the highest standard. The EWTD has placed an unacceptable burden on both parties.'

The GMC is building up robust evidence about the impact of the EWTR on medical training and education. The analysis presented here shows that there has been some significant progress: compliance with EWTR is increasing; satisfaction with training continues to rise; and many trainers are adapting their approach to training in the new circumstances. However, it is clear that both trainers and trainees are experiencing serious problems in some areas. It is of real concern that less than half of consultant trainers consider they can deliver training of the same standard on a 48 hour as on a 56 hour rota, that a substantial minority of trainees report having to fill rota gaps and that more than 25% feel their training needs are not being met in the 48 hour week. While some of these problems may be capable of being ameliorated as good EWTR practice spreads, others seem to be systemic and will require systemic solutions.



Chapter 6: Preparedness

This chapter examines what the survey data tell us about how well prepared trainees are to move to the next stage of their training or to becoming a consultant or GP. It goes on to look at factors around career choice.

The following questions are addressed.

Trainers

- Do they restrict trainees' activities – and why?
- How do trainers rate trainees' confidence compared with their own at a similar stage of their careers?
- Are trainers aware of any trainees who were signed off a stage of training but who had not, in their view, reached the appropriate standard?
- What proportion of trainees did not display the expected outcomes?

Trainees

- How do trainees rate their practical experience?
- How confident are they of acquiring competences?
- What access do they have to educational opportunities?

Careers

- Where do trainees wish to work after completing their training?
- What are they most likely to do in the next 12 months?
- Did they have a discussion with a senior colleague about their career plans?
- In which areas do they feel least prepared?

Trainers

Do trainers restrict trainees' activities – and why?

The survey asked trainers whether they occasionally restricted the activity of their trainees, even though the trainees were competent and asked them why. Trainers were able to give more than one answer.

In summary:

- 37% (n=17,263) of trainers do not restrict the activity of their trainees.
- Of those that do, the most commonly cited reasons were concerns about patient safety and other professional pressures.
- Service targets and government productivity targets, at 16% each, were the next most commonly cited.

Table 6.1 gives more detail (overleaf).

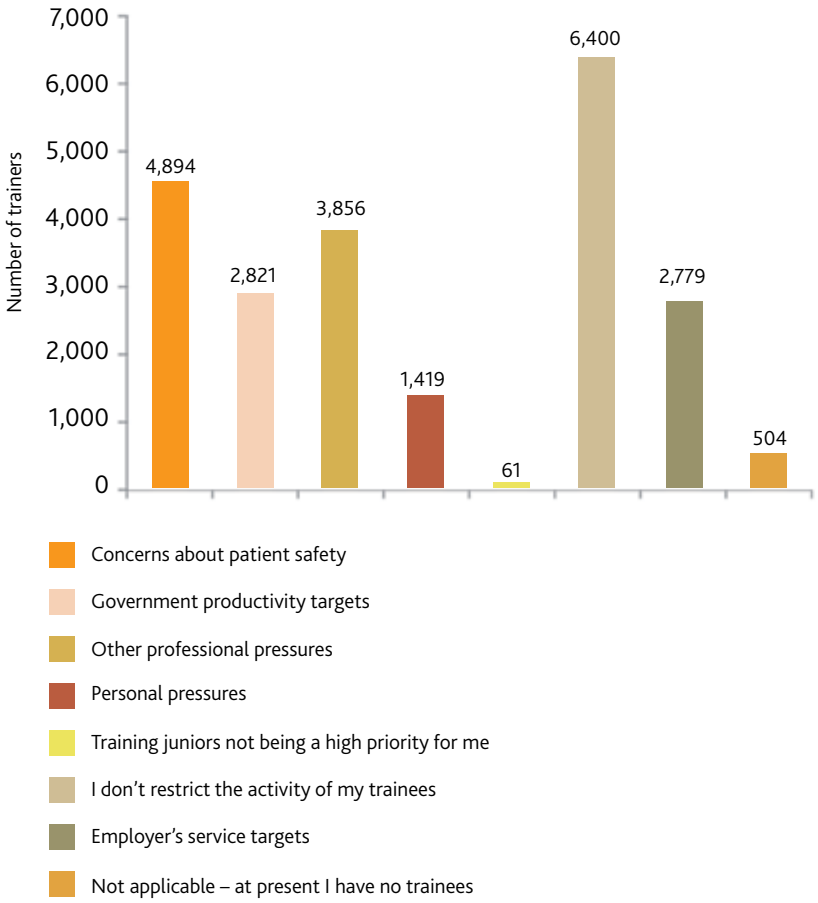
37%

of trainers do not restrict the activity of their trainees

25%

of all trainers restrict trainees because of concerns about patient safety

Figure 6.1 Reasons trainers give for restricting their trainees' activities



Please note: The counts will not add up to the total as some respondents have answered with more than one option

How do trainers rate trainees' confidence compared with their own at a similar stage of their careers?

The survey asked trainers to agree or disagree with the following statement:

'My trainees are less confident and so less able to work independently in comparison to me and my peers when we were trainees.'

- 74% (n=14,434) of consultants agreed or strongly agreed.
- 50% (n=2,630) of GP trainers agreed or strongly agreed.

Are trainers aware of any trainees who were signed off a stage of training but who had not, in their view, reached the appropriate standard?

The survey asked trainers whether they were aware of trainees within their deanery being signed off on their ARCP/RITA/Foundation when in the trainer's view the trainee had NOT reached the appropriate standard:

- 81% (n=14,555) of consultants said they were not aware of any such trainees
- 90% (n=2,672) of GP trainers said they were not aware of any such trainees.

What proportion of trainees did not display the expected outcomes?

The survey asked trainers what percentage of their current trainees was not displaying the expected competences for the level of training. The answers ranged from zero to 100%.

In summary:

- 46% (n=12,005) of consultants said no trainees were failing to display the expected competences for the level of training.
- On average, consultants said 13% of their trainees were not displaying the expected competences for the level of training.
- 73% (n=2,028) of GP trainers said no trainees were failing to display the expected competences for the level of training.
- On average, GP trainers said 10% of their trainees were not displaying the expected competences for the level of training.

The survey did not ask trainers how many trainees they supervised in respect of this question nor the extent to which they considered their trainees were failing to meet the expected competences.

Trainees

How do trainees rate their practical experience?

The survey asked trainees to rate their practical experience, on a scale from very poor to excellent:

- 72% (46,774) of trainees rated their practical experience good or excellent
- 64% (n=12,694) of foundation trainees rated their practical experience good or excellent.

How confident are trainees of acquiring competence?

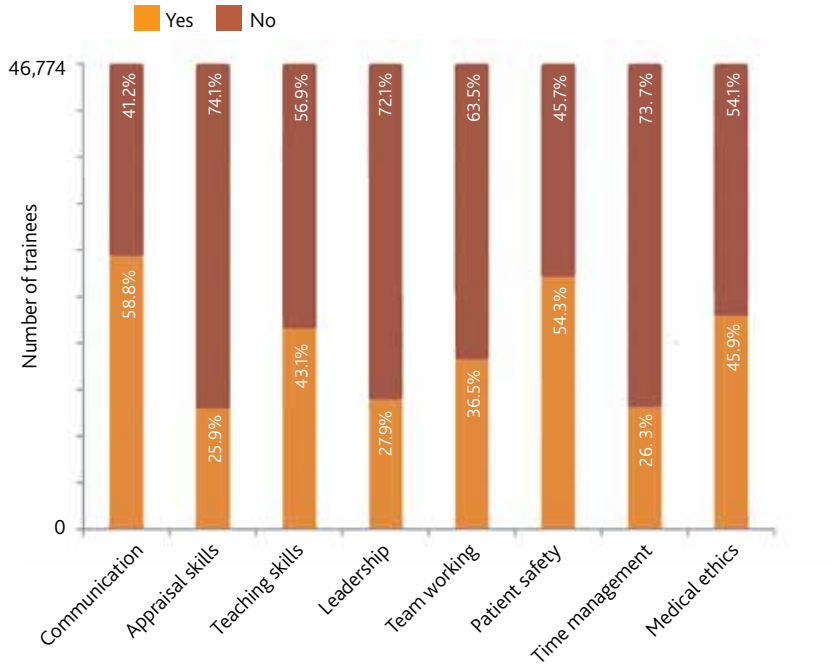
The survey asked trainees how confident they were of acquiring the competences needed at their particular stage of training:

- 78% (n=46,774) of trainees were fairly or very confident
- 74% (n=12,694) of foundation trainees were confident or fairly confident.

What access do trainees have to educational opportunities?

The survey asked trainees about how much formal teaching they had received since leaving medical school. Figure 6.2 shows that 85% of trainees had received formal education, most commonly covering communication, patient safety and medical ethics. Two thirds of foundation trainees reported that they had received formal teaching in patient safety.

Figure 6.2 Up to and including this post did you receive any formal teaching since leaving medical school in any of the following?



The survey also asked a series of questions about trainees' access to different learning opportunities:

- 65% (n=46,650) of trainees were leading or helping on one or more clinical audits; 14% had no involvement
- 69% (n=46,774) had access to relevant e-learning material; 26% were not aware of any such material
- 44% (n=46,457) said they had the opportunity to learn with other healthcare professionals on a monthly, weekly or daily basis; 56% said they never or rarely did this
- 67% (n=46,774) said they found it easy to access library services in their current post; 10% found it difficult
- 68% (n=46,774) said the library covered the areas they needed to follow their curriculum
- 86% (n=46,774) had access to the internet at work for training purposes
- 31% (n=46,774) had the opportunity to be involved in research; 51% said they did not have the opportunity and might have been interested
- 30% (n=40,095) had undergone procedural skills training using a simulator.

Study leave and courses

The survey also asked about access to study leave and courses:

- 53% (n=40,380) rated as good or excellent the encouragement they received for taking study leave
- 53% (n=30,073) were able to access funds to cover the cost of all courses recommended for them to complete
- 68% (n=32,116) said no leave was deducted from their annual allowance for taking compulsory training
- 67% (n=40,379) said they had no difficulty in obtaining study leave. The most commonly cited difficulty was local rota policies.

Figure 6.3 and table 6.1 give more detail.

Figure 6.3 In this post did you have difficulty obtaining study leave?

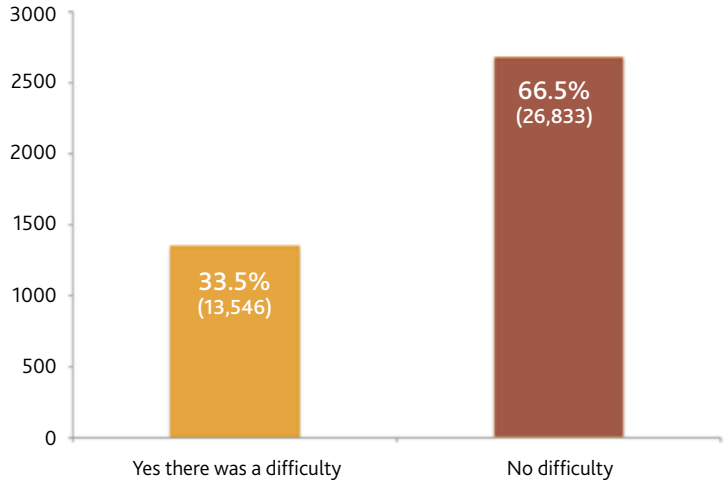


Table 6.1 If you answered yes, what was the main difficulty you experienced?

	%
Yes – fixed leave pattern	17.1%
Yes – other difficulties due to local rota policies	32.7%
Yes – failure to find prospective cover	27.8%
Yes – active discouragement from seniors	6.1%
Yes – leave refused as reason deemed educationally inappropriate/unhelpful	4.2%
Yes – administrative difficulties	12.1%
Total	**100%**

33%

of all trainees who answered yes on having difficulty obtaining study leave said it was due to local rota policies

Careers

The survey asked trainees where they wanted to work after completing their training:

- 65% (n=46,650) said they wanted to stay in the same deanery where they currently worked
- 18% said they wanted to work in another deanery
- 15% said they did not know
- the remainder wanted to work abroad.

The survey also asked trainees about their immediate plans over the next 12 months:

- 80% (n=46,774) said they wanted to continue their training or apply to continue their training
- 10% were ready to take up a consultant or GP post
- 0.4% were planning to leave medicine permanently.

The survey asked trainees whether they had discussed their career plans with a senior colleague:

- 70% (n=46,774) said yes
- 10% said they had not needed to.

The survey asked trainees, who were coming to the end of their training, whether they felt ready to take up a GP or consultant post:

- 84% (n=4,555) said yes, they did feel ready
- 10% (n=4,555) answered that they did not know
- 6% (n=4,555) answered no they did not feel ready.

Those that did not (276 in total) were then asked in which areas they felt least prepared. The most common areas were planning and managing the service; dealing with managers; and clinical.

Table 6.2 gives more detail.

Table 6.2* In which areas did trainees, who did not feel ready to take up a consultant or GP post, consider themselves least prepared?

Area where feel least well prepared	Count
Clinical	136
Leadership	111
Building a team	54
Planning & managing the service	198
Dealing with managers	151
Dealing with colleagues	31
Training juniors	49
Total number of trainees	**276**

* **Please note:** The counts will not add up to the total as some people have answered with more than one option.

Discussion

The structure and delivery of postgraduate medical education and training have gone through many changes in the past two decades. Meanwhile, patterns of service delivery and patient expectations have also changed. Against this background, one of the most frequently asked questions is whether today's postgraduate medical education and training fully prepares trainees for the real world of health service delivery with all its inherent pressures and demands? This is not just a question of whether doctors are competent but also whether they are confident to undertake their roles as doctors at all levels. These issues have been examined most recently in PMETB's work on *Future Doctors*, which has informed the GMC's evidence base.[20] In this context, the data presented here are of particular interest, highlighting trainees' and trainers' perceptions of preparedness at a number of levels.

The results show a mixed picture with some causes for concern and some real positives. It would be useful to read this chapter alongside Chapter 4 about foundation doctors, which amongst other things examines trainees' perceptions of preparedness; and Chapters 2 and 3 which examine trainers' perceptions on supervision and workplace based assessment.

> *"The tools used to assess students are poor and long winded. The portfolio lends itself to degeneration to a tickbox exercise and can lack accuracy. The trainees' goal can be skewed from learning medicine to getting the boxes ticked which are very different things."*

On the positive side, the data show that three quarters of trainees rated their practical experience highly and feel confident about acquiring the necessary competences. By and large, trainees wanted to continue their training, with two thirds of them saying they want to remain in their current deanery. Nearly nine in ten trainees nearing the end of their training were confident about taking up a new role as a consultant or GP. On the educational side, a large majority had received formal training since leaving university; a similar number had access to libraries that meet their needs; and most were involved in clinical audit, an activity that the GMC would encourage and one that is likely to become increasingly important in a health service focused on outcomes. Nearly nine in ten had access to the internet. This all indicates that the underpinning resources required by trainees are, by and large, in place.

Among the causes for concern were the number of trainees signed off whom consultants and GP trainers felt had not showed the necessary competence. Around one in ten GP trainers and consultants indicated that they were aware of such instances and this must ring alarm bells. Similarly, GP trainers and consultants reported that a small but significant number of their trainees (between one in 20 and one in ten) do not display the required competences for the stage of training. This data runs to the heart of the debate about preparedness and warrants further investigation.

On the trainee side, just over half said they never learn alongside other professionals. In the era of multidisciplinary team working, this is lower than might be expected. Similarly, only a third had undergone procedural training using a simulator; again this is an increasingly popular method for increasing skills while maintaining a safe service. The overall

[20] *Future Doctors: a statement on the future of postgraduate medical education and training*. PMETB October 2009.

figure for all trainees presented here may mask specialty differences.

The extent to which consultants and GP trainers restricted the activity of trainees whom they regarded as competent highlights one of the tensions in modern health service delivery. Trainers are constantly trying to balance their responsibility for training with their responsibility to provide a safe service and this is apparent in the data presented here, which show that two thirds of trainers restrict their trainees' activity, with patient safety the most commonly cited reason.

The comments from trainees and trainers around confidence and competence varied widely with some addressing the core issue of whether or not today's doctors are prepared for the future healthcare system. Among trainers, there were frequent comments about the perceived 'tickbox' nature of postgraduate medical education already mentioned in previous chapters; this was often coupled with comments about the move away from the apprenticeship model towards academic learning. For example:

'The main problem with training is trying to replace learning by experience with learning by lectures. Most of the latter replicates the medical student learning process.'



'I feel that (and my current and previous trainees concur) the recording of the training process has become more important than the process itself. My trainees worry more about completing the required number of e-portfolio entries with the required level of reflection than they do about their knowledge base. This creeping process is reducing the enjoyment and the quality of training for both trainers and trainees.'

'I am concerned that the tickbox nature of the training programme increases the chance of borderline trainees slipping through. As with trainee teachers, it is easier to give the benefit of the doubt and pass than put one's head above the parapet and prove that you have all the evidence to fail someone and are not racially motivated. This process can be replicated by scores of assessors in a single trainee's progress. While recognising the breadth and rigour of the assessments in WPBA, I am disappointed that no attempt is made to recognise the apprenticeship element of the training. I feel my lifelong training has been influenced as much by personalities and events as by reading and exams.'

This trainer commented on how the assessment process made it difficult to fail a trainee who was not meeting requirements:

'The tools used to assess students are poor and long winded. The portfolio lends itself to degeneration to a tickbox exercise and can lack accuracy. The trainees' goal can be skewed from learning medicine to getting the boxes ticked which are very different things. Once the portfolio has been partly



completed it is difficult to go back and fail trainees, the consequential time and effort in such circumstances can be off-putting for trainers, and the legal consequences are probably not far away either.'

There were a number of trainers who commented that standards were, in their view, slipping:

'I lament the decline in the hunger to learn and lack of competitiveness over my consultant career and view with trepidation the prospect of needing surgery in my old age from the current generation of trainees who will then be the consultants. In my view the educationalists have failed surgery as a profession.'

'Trainees must try and [be] more proactive. They should not just appear in clinics and theatres only when they want to be taught. They should aim as much as possible to help their fellow colleagues with clinical responsibilities so more time can be available for their training. More trainees should try and attend the monthly regional training organised for them.'

Others were concerned that trainees made their career decisions too early. For example:

'Please can we try and introduce more flexibility into the training so trainees do not have to commit so soon to specialty and have the ability to get into training programmes at a later date if they initially fail.'

Trainees' comments tended to focus narrowly on their current jobs rather than preparedness overall. A number mentioned feeling confident about their role as a result of their training. For example:

'In my current post I feel satisfied with specialty training – and feel confident about the quality of clinical care I provide.'

'The departments themselves have tried to be supportive, and it is an excellent experience, providing a very wide range of experience in both general and specialist medicine. I feel much more confident as a doctor now.'

Conversely, a few were worried that they would not be prepared for their next post, such as this trainee:

'I am very concerned that I will not be prepared for registrar posts by ST4, I think and have been told by many colleagues and seniors that three years is not enough time to become confident to do a registrar post by ST4. Although there is excellent exposure in this post to clinical cases, there is not very much time for bedside teaching. The teaching we do sometimes get is mainly drug rep teaching and a recent one was regarding hand washing. Although the teaching given by trainees is very helpful, there is rarely consultant led teaching.'

A few gave considered responses which mirrored consultants and GP trainers' concerns. This trainee's comment summed up all the concerns:

'I think medical training in the UK has become a tick box exercise... which is nicely echoed in this survey itself. My current training is fine. I'm working with professionals whom I respect, even if they don't hold my hand on the ward rounds. Sometimes there are problems and sometimes it is all hugely frustrating and disheartening. Most of the time we just get on with it all. However, my experience of trainees around me and in other specialties, which has also been noticed by others at my level with whom I have discussed this, is that standards are slipping.

Somehow you took a good idea – to formalise training and make the process more transparent – and ended up with something quite different. I'm all for change, but it needs to work, not just be seen to be working... with boxes ticked that don't necessarily translate into the production of good doctors. I'm sure the European Working Time Directive hasn't helped much either, nor the fact that people have to choose to specialise before they've really experienced any of the specialties enough to make an informed decision. I'm not really talking about my current trust here, but more generally. I think everywhere is very similar just now. People ask their peers to sign them off for everything. Who knows if they're really meeting standards? It's all just paperwork and I'm not sure how well it reflects fact. People are working fewer hours and seem keen to leave bang on time no matter what. I'm not sure that's always safe. I think the overall feel is that more junior doctors, from whom we all receive referrals these days, are generally less well equipped to be doing what they're doing than people at that level used to be. They frequently don't have a handle on the cases they are discussing and their team's plan as it stands. I often feel less than confident in their clinical assessment and this can make further discussion and the giving of professional advice relatively difficult. I don't think this can be their fault, but they are presumably ticking all the boxes to get where they are at the moment. I'm not exactly sure that means anything in itself though. I think these sort of surveys might not be the place for this sort of rant so, apologies... but if not now, then when? I think my training currently is going well and I'm enjoying it on the whole, but I guess I'm just glad I was trained, in the most part, within the old system.'

This survey – and the comments – highlight a debate that is ongoing in medical education. Have the reforms to post graduate medical education achieved their aim of delivering a more formal and transparent education system in which competencies are clearly defined, communicated and understood and then trainees assessed against them in a transparent manner? Or have they simply introduced a tickbox exercise that is time consuming and makes it difficult for trainers to identify and take action in the case of trainees who are at risk of failing? This is a crucial debate and it is to be hoped that the data presented here will inform it further.

> ***"I'm all for change, but it needs to work, not just be seen to be working... with boxes ticked that don't necessarily translate into the production of good doctors."***




Customer service
Ability to plan
Teamwork
Ranked first
Ranked second

Chapter 7: How is the survey data used?

The GMC disseminates the results widely. On a national basis, the surveys have informed various Medical Education England reviews and the COPMeD Overarching Data Group, which will be looking at the wider use of these data and linking via GMC number to other sources, with the long-term prospect of a developing a postgraduate medical education data warehouse.

The GMC reporting tool allows results to be viewed by local education provider, specialty and deanery and there is extensive local use of the survey data at local and deanery level. All deaneries use the national surveys of trainees and trainers to inform their quality management programmes and accreditation of local education providers. For example:

London Deanery

In previous years the London Deanery has made extensive use of the trainee survey results in its quality management processes. The Deanery uses the reporting tool website and its own additional analysis of the aggregated and respondent level data. The Deanery distributes tailored links to the relevant reports on the reporting tool, its own analysis and its own written interpretation of reports to its providers and Heads of School. The results are triangulated against other local data to help highlight areas of concern, which are then raised with trust liaison associate deans and others. In 2010 the following additional pieces of work will be undertaken:

Actions raised in response to the 2009 survey will be followed up using the 2010 data. For example if a provider has said they will be taking action that can be measured using the survey and in 2009 the provider had outliers on the relevant indicator(s), we will be checking whether these groups are outliers on the relevant indicator(s) in 2010. Using the outlier download file this process should be done automatically in our database.

We will be comparing survey outliers against self-assessment statements from providers' DMEs and local faculty groups by mapping survey indicators to the self-assessments. We will be doing this via our database.

We have used the respondent level file to answer questions of broader interest, for example we have had a submission to the AMA – CMA – BMA International Conference on Physician Health, Oct 3-5, 2010 accepted that analyses London 2009 respondent data. The submission is entitled: *Self-reported stress amongst London doctors in training: results from an annual survey*. We anticipate making further use of the 2010 data in this way, but feel these sorts of issues are best addressed using a UK-wide research cut of the data that could be made available to deanery partners.

We are exploring importing data from the survey (for example the outliers) into a database used to design rotations, so that training programme directors can see information gathered from the survey about particular posts when designing the rotation.

"The Wales Deanery uses the annual survey data to create 'traffic light' reports in order to provide an indication of those areas that are working well and those which may require further attention."

The London Deanery looks forward to working more closely with the GMC to ensure maximum use is made of these data: for example defining reports for the reporting tool that meet our clinical leaders' requirements, such as reports by post specialty with no break by programme specialty and linking over time to produce reports by location for specialties with small numbers of cases; using the respondent data to address policy issues of national importance; making improvements to the survey processes (for example better definition of the entities to be reported on and the use of validation control files following review of distinct values contained in deanery databases); and contributing to new survey items, for example those proposed by CQC looking at trainees' perceptions of service quality.

Due to problems with defining the population and the low response rate the London Deanery makes little use of the trainer survey data. Deanery staff who had tried to access these trainer data for their work, for instance for a project on educational supervision for the Academy of Medical Educators, were refused the necessary access in 2009. With appropriate access to data it would be easier to ensure deanery engagement was maintained.

Severn Deanery

All trainees receive an email thanking them for their participation and all trainers are thanked via their local education providers. In addition to giving all stakeholders access to the surveys reporting tool, we prepare a summary of 'green flag' and 'red flag' areas (those indicators in the top and bottom quartiles and with a mean outside the 95% confidence intervals of the national mean) by local education provider and specialty. The results of the surveys are also analysed for trends using previous years' data and the free text comments which are reviewed by the Deanery's Quality Manager. Bespoke packs of data concerning both surveys are circulated to Directors of Medical Education and Heads of Schools. In addition, those with green flags receive a letter of congratulations and those with red flags are asked for an action plan, which feed directly into their Deanery annual report. Green and red flag areas for both surveys are published on the Deanery's website, along with other top level information.



Wales Deanery

The Wales Deanery uses the annual survey data to create 'traffic light' reports in order to provide an indication of those areas that are working well and those which may require further attention.

We triangulate the data from the surveys with other sources of evidence and works with relevant specialty leads and local education providers to investigate issues further.

Wessex Deanery

Feedback from trainees is an important element of educational quality management in Wessex Deanery. The national survey data, combined with end of post feedback questionnaires and reports from educational leaders and external assessments, form the basis of an Issues and Actions log. All issues are regularly reviewed from both a Trust/department and School/Specialty view, given an action plan and are tracked through to resolution. This gives direction to the Deanery on how to support local educators to improve training.

We also publish an analysis of the top 25 educational questions from the national trainee survey data referenced against expected standards. This is known as SEAP data (Standardised Educational Audit Project).

Oxford Deanery

Heads of schools present an annual report to a Deanery Approval Committee for approval of the programmes within their specialty school. These annual reports triangulate evidence from a range of sources that include trust reports produced by directors of medical education, and specialty reports produced by programme directors and specialty tutors, as well as information from any school visits. The GMC national trainee and trainer surveys underpin all the reports, which are used to grade the training programmes and make recommendations and set conditions for improvement.

Scotland (North) Deanery

The Scotland (North) Deanery uses the surveys results in a number of different ways;

We share access to the surveys results with all stakeholders (TPDs, FPDs DMEs etc) and produces high level summary sheets that are also shared.

The summary sheets contain 'amber' flags, in addition to the 'green' and 'red' flags. The amber flags are

indicators either in the bottom or on the cusp of a quartile but not outside the 95% confidence intervals of the national mean.

All TPDs, FPDs and DMEs are asked to comment and provide action plans in response to the survey findings in their annual deanery reports.

We will also use the survey data to help inform if any targeted visits are to take place outside its routine visiting cycle.

We use the survey results as one tool to help support our quality management processes.

Scotland (South East) Deanery

The Scotland (South East) Deanery takes the survey results and uses a flagging system to prioritise areas for review. The results are split by factor into the following three priorities:

1. patient or trainee high risk issues
2. trainee experience Issues
3. educational process issues

By programme and LEP we assign a flag to each factor using the red and green flags as assigned by the GMC. We also have an amber flag that gives us an indication of 'danger of becoming red'.

Following on from the flagging process, we decide using the above priorities in conjunction with the flags whether or not we should undertake triggered visits to LEPs and/or programmes.

We also triangulate the GMC Survey information with our own information, either gathered through our own surveys or from other activities such as focus groups, TPD reports, etc.

We find the surveys useful because they give us another source of information to triangulate, from an independent source. Long term we would be looking to undertake bench-marking exercises with other Deaneries, based on the comparative flags but we are not at that stage yet.

Amalgamated information by Board, although not available in 2010, will be particularly helpful for programmes such as psychiatry where trainees are spread widely in various hospitals and therefore do not manage to make n≥3 by LEP.

Northern Ireland Deanery

The results of the national surveys are used in a number of ways;

It is used as a source of information, and is discussed at the Deanery's Quality Management Group. The surveys assist the Deanery by highlighting areas of concern which we need to address or investigate further. The surveys results also enable the Deanery to identify if the same problem exists on a number of sites or if a problem is recurring and has not been addressed.

We may use the surveys results, along with others sources of information, to trigger a deanery visit to the LEP. The surveys results are responded to by each specialty school within the annual report to the Deanery. Specialty schools will produce action plans to address issues of concern, and will assist the Deanery in responding to these.

North Western Deanery

The North Western Deanery uses the results of the GMC national training surveys to inform the Deanery visiting teams when they undertake the biennial monitoring visits to local education providers. This enables a focused visit to be planned to targeted programmes. In addition, each local education provider is sent their own results and asked to comment on how they plan to follow up the areas requiring attention. These comments and action plans then help inform the next cycle of visits.

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The GMC is responsible for the contents of this report.

The report's authors are: Daloni Carlisle, Mark Dexter, Nick di Paolo and Arkadius Kazmierczak.

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Annex

Ethnic breakdown of trainee respondents

	Number	%
Asian or Asian British – Bangladeshi	446	1.0
Asian or Asian British – Indian	8,187	17.5
Asian or Asian British – other Asian background	1,825	3.9
Asian or Asian British – Pakistani	2,421	5.2
Black or Black British – African	1,332	2.8
Black or Black British – Caribbean	125	0.3
Chinese	1,354	2.9
Mixed – White and Asian	499	1.1
Mixed – White and Black African	124	0.3
Mixed – White and Black Caribbean	51	0.1
White – British	21,226	45.3
White – Irish	1,158	2.5
White – Other White background	2,894	6.2
Other ethnic group	1,292	2.8
Mixed – other mixed background	644	1.4
Black or Black British – other black background	55	0.1
Do not wish to answer	3,174	6.8
Total	**46,774**	**100**

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