National training survey 2011

Key findings

General Medical Council

Regulating doctors
Ensuring good medical practice

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Foreword

This report sets out the key findings of the 2011 national survey of trainee doctors. It provides a comprehensive picture of the views, experience and perceptions of more than 46,000 doctors working across the UK, providing care and treatment for millions of patients.

Trainee doctors are the future of this profession and the education and training they receive now will affect the quality of healthcare in this country for many years to come. The trainee survey tells us what these doctors think about the training they have received and how it could be improved. It is a vital part of our work to support improvements in medical training and to make sure it meets the standards we require.

The 2011 survey shows that there are many reasons to celebrate. Overall, trainees continue to be very satisfied with their training and their practical experience. They are receiving regular formal and informal education, all of which contribute to encouraging lifelong learning. The evidence suggests that most training is meeting our standards set out in *The Trainee Doctor*, published earlier this year.

But there is no cause for complacency, and some cause for concern.

Too few doctors feel adequately prepared to start the Foundation Programme and all trainees need more feedback from their senior colleagues and supervisors. Too many trainees complain of a lack of training, support and supervision, and among foundation trainees there was significant concern about the e-portfolio they are expected to complete. There are real concerns too about the impact of the Working Time Regulations, especially in specialties with a high emergency workload. The fact that more than 20% of trainees state that they are not having their training requirements met within the 48-hour week remains a major challenge, albeit that this is an improvement on last year's figure. And too many trainees feel forced to cope with problems beyond their clinical competence or experience.

These are matters that need to be tackled with some urgency by senior doctors, managers and by medical educators. As the regulator, we have an important part to play in supporting improvement and change.

Some practical examples of the action we are taking include plans to approve a revised curriculum for Foundation training with new outcomes for the second year of the programme.

We are also developing proposals for the approval and recognition of trainers to help strengthen arrangements for support and supervision. On the issue of Working Time Regulations, we have commissioned research to better understand the impact on education and training. This is described in chapter 5.

We will expect to see a continuous and collaborative focus on these and other areas and will monitor progress through our *Quality Improvement Framework*.

This is the fifth year of the trainee survey, which was introduced by the Postgraduate Medical Education Board (PMETB) and the Conference of Postgraduate Medical Deans (COPMeD) in 2006 and is the second year that the GMC has run the survey. We have used this opportunity to take stock of what trainees have told us and to look at how their experiences and perceptions of training have changed over time. To build a rounded picture of training in the UK, we will also publish our key findings from our survey of trainers.

The trainee survey forms an important part of the evidence base we use to monitor standards in medical education, to support our inspections and to provide feedback to those responsible for education delivery. It provides the basis for further analysis and action, both by us and those on the frontline. This year we are undertaking a thorough review of the survey questions and reporting for 2012. We want to make sure that the questions are closely aligned with our standards, and meet recognised standards for good practice.

We are committed to analysing and sharing the data we collect in all areas of the GMC's work and the most important result of this work is that the survey findings make a difference. This year, we have included a case study illustrating how past findings have been used by a medical education and training provider and how the data from the survey have been used to influence change and improve practice on the ground. We intend that this will be a regular feature of future reports.

We are enormously grateful to all those who gave their time to take part in this year's survey and to all those who have contributed to the design and success of this project. We would very much welcome feedback on the report and in particular whether there are ways future surveys can be improved.

Niall Dickson, *Chief Executive*

Introduction and scope of report

For the past five years, the GMC or PMETB (now merged with the GMC) has worked with COPMeD to survey trainee doctors across the UK.

This report highlights key findings from the 2011 survey and comments on trends over time. It also sets out specific findings for foundation training, given its importance as new doctors start their careers. We hope this report will be useful to education providers, employers and policy makers and to all those committed to improving standards of postgraduate education in this country.

As part of the our wider look at the experience of trainers, we will be publishing a separate report covering themes from the trainer survey over the past four years. This will inform the development of an approval framework for trainers.

Survey data help us monitor the quality of training

The trainee survey is a vital part of our work to ensure that medical training in the UK meets the standards we require.

We review the content and format of the survey each year with researchers, trainees, trainers and other key interests to make sure it stays relevant while allowing us to make comparisons over time.

In 2011, as in previous years, the trainee survey asked questions about:

- clinical and educational supervision
- access to teaching and the quality of that teaching
- delivery of curriculum including assessment
- support and development of trainees
- educational resources and capacity.

Who was surveyed?

Trainees answered the survey between 2 May and 22 July 2011, and were asked to think about the post they held on 2 May 2011. All trainees answered some general questions about their posts. Additional questions were aimed at trainees in specific posts, such as foundation trainees, or were related to their specialty training.

The following trainees were surveyed:

- trainees in the first year (F1) and second year (F2) of the Foundation Programme
- core trainees
- specialty trainees
- General Practitioner (GP) trainees
- fixed term specialty training appointment (FTSTA) trainees
- locum appointment for training (LAT) trainees
- Specialist Registrar (SpR) trainees
- military trainees working in National Health Service (NHS) organisations and within the services
- trainees in clinical lecturer and academic clinical fellowship posts approved by the GMC
- trainees working for non-NHS organisations – for example, Occupational Medicine, Pharmaceutical Medicine and Palliative Medicine.

The following trainees were excluded:

- trainees on maternity leave at the time of the census
- trainees on out of programme training or out of programme research at the time of the census
- public health practitioner trainees who are not medically qualified
- doctors who have been awarded their Certificate of Completion of Training (CCT) but are awaiting a consultant post.

The full results can be accessed through our reporting tool, **http://gmc-onlineeducationreports.org**, which allows results to be viewed by local education provider, specialty and deanery. This forms the shared evidence base that is used across postgraduate medical education to assess the quality of training.

The national survey of trainees is supported by employers and junior doctor representatives from the British Medical Association's Junior Doctors' Committee and the Academy of Medical Royal Colleges Trainee Doctors' Group. All trainees, including foundation doctors, are required to take part.

This year, 46,668 doctors in training answered the survey out of 53,674 who were eligible, giving a response rate of 87.0% compared with 87.5% in 2010. The response rate by deanery varied from 98.3% in Severn Deanery to 70.1% in the Faculty of Pharmaceutical Medicine (Table 0.1).

Table 0.1 Response rate to the trainee survey by deanery

	Number responding	Number targeted	Response rate
NHS Education South West – Severn Deanery	1,968	2,002	98.3%
Kent, Surrey and Sussex Deanery	2,965	3,064	96.8%
London Deanery	9,288	10,115	91.8%
North Western Deanery	3,315	3,629	91.3%
NHS Education for Scotland (North Region)	694	762	91.1%
Wales Deanery	2,226	2,455	90.7%
East of England Multi-Professional Deanery	2,732	3,040	89.9%
South West Peninsula Deanery	1,180	1,319	89.5%
Wessex Deanery	1,856	2,105	88.2%
East Midlands Healthcare Workforce Deanery	2,644	3,007	87.9%
NHS West Midlands Workforce Deanery	3,916	4,468	87.7%
NHS Education for Scotland (South-East Region)	1,055	1,205	87.6%
Oxford Deanery	1,415	1,632	86.7%
NHS Education for Scotland (East Region)	480	566	84.8%
NHS Education for Scotland (West Region)	2,158	2,603	82.9%
Mersey Deanery	1,820	2,267	80.3%
Northern Ireland Medical & Dental Training Agency	1,256	1,618	77.6%
Yorkshire and the Humber Postgraduate Deanery	3,617	4,907	73.7%
Northern Deanery	1,918	2,673	71.8%
Defence Postgraduate Medical Deanery	57	81	70.4%
Faculty of Pharmaceutical Medicine*	108	154	70.1%
Total	**46,668**	**53,672**	**87.0%**

* The Faculty of Pharmaceutical Medicine undertakes deanery functions managing pharmaceutical medicine programmes across the UK.

Free text comment analysis

For most questions, trainees were asked to select the answer, or answers, that best applied to them (ie were quantifiable). But trainees were also invited to give free text comments at the end of the survey (no limit on the size) and 7,225 trainees used this option. All these comments were read and filtered for relevant words or groups of words including:

- clinical supervision
- patient safety
- educational supervision
- educational environment
- workload or intensity
- adequate experience
- resources
- feedback
- study leave
- assessment
- rota or WTR
- bullying
- undermining
- discrimination.

Comments in this report were selected from these filtered lists and are used purely to illustrate the findings of the main analysis. The comments were not selected using any objective method, although they were chosen to reflect the general views expressed in the free text section.

A note on data

- 46,668 doctors in training (87.0%) of 53,674 who were eligible to take part answered the survey.
- 13,228 were foundation trainees, 7,161 were core trainees, and 26,258 were specialty trainees; the training programme was unknown for the remainder.
- Not all trainees answered all questions in the survey.
- We have only given total numbers where this information seemed relevant or where the number of trainees responding to a specific question was substantially different to the total number of trainees.
- This report comments on changes in data from 2010 to 2011. These changes have not been tested for statistical significance.
- The survey data included in this report were locked on 14 October 2011 to allow accurate analysis of the available data. Any amendments to the data after this date have not been taken into account.

Summary of chapters

Chapter 1: Satisfaction with training

This chapter reports on which trainees responded to the survey and presents data on their age, gender, disability and ethnicity. It also examines trainees' overall satisfaction with their training.

Key findings

- Satisfaction remains high and is increasing year on year.
- Trainees in surgery posts are the least satisfied with their training and those in GP posts are the most satisfied, a finding that has been consistent since the survey began in 2006.
- More than half of trainees are female.

Chapter 2: Clinical supervision

This chapter looks at trainees' experiences of clinical supervision, examining the quality of supervision and competence of supervisors, and how often trainees have to deal with situations that they feel are beyond their experience.

Key findings

- Satisfaction with clinical supervision remains high and has increased slightly compared with 2010.
- Our standards for supervision are being met for the great majority of trainees.
- However, some trainees continue to receive poor supervision.

Chapter 3: Feedback and assessment of performance

This chapter examines whether foundation and specialty trainees receive formal and informal feedback about their performance, and looks at how many trainees have a learning agreement with their supervisor and use a learning portfolio.

Key findings

- Most trainees have a designated educational supervisor and a learning agreement.
- Overall, our standards for assessment are now being met for most trainees.
- However, a substantial proportion of trainees do not receive the level of formal and informal feedback required.

Chapter 4: Foundation trainees' experiences

This chapter focuses on the experiences of foundation trainees, looking at how often they have to deal with situations that they feel are beyond them, whether they are receiving feedback about their performance and support with their learning and career planning, and how much constructive training they receive.

Key findings

- A small number of trainees are regularly asked to cope with clinical problems beyond their experience or competence.

- A substantial proportion of trainees do not have any training that is protected from service demands.
- There are concerns about the quality of clinical supervision of foundation trainees and other aspects of their educational experience.

Chapter 5: The Working Time Regulations

This chapter looks at how the implementation of the Working Time Regulations (WTR) has affected trainees, both in terms of their working hours and whether their training needs are being met.

Key findings

- The proportion of trainees who feel that the WTR are affecting their ability to meet their training needs and achieve their competences has decreased compared with 2010.
- The proportion of trainees filling rota gaps has also fallen.
- The WTR are causing continuing problems for trainees in some specialty programmes, especially surgery and foundation trainees.

Chapter 6: Preparedness for practice

This chapter examines how well prepared trainees are to move to the next stage of their training or to become a consultant or GP, and whether they have access to educational opportunities. It also looks at trainees' career choices.

Key findings

- Trainees continue to rate their practical experience highly and to feel confident about meeting their required competences.
- However, the data have changed little since 2010, indicating some areas for concern remain.
- Foundation trainees rate their practical experience less highly and are less likely to feel confident about meeting their required competences than specialty trainees.

Annex: Use of the trainee survey by NHS Education for Scotland

This annex has been written by Stewart Irvine, Deputy Director of Medicine at NHS Education for Scotland. It looks at how an organisation providing medical education and training has used the findings of the trainee surveys to drive improvement.

Chapter 1: Satisfaction with training

This chapter looks at which trainees responded to the survey in 2011, presenting data by age, gender, disability and ethnicity. It reviews overall satisfaction among trainees, whether satisfaction differs between foundation trainees and trainees in various specialty posts, and how satisfaction has changed since 2006.

Key finding: satisfaction rates remain high and are increasing year on year, but some groups of doctors are more satisfied than others.

Who answered the survey?

This year 46,668 trainees responded to the survey (Table 1.1).

Table 1.1: Training programme of trainees who responded to the survey

	Trainees (n=46,668)
Higher specialty training	26,258 (56.2%)
Core training	7,161 (15.3%)
Foundation training	13,228 (28.4%)
Unknown	21 (0.04%)

Gender

51.4% of trainees (n=24,000) were female and 45.9% (n=21,404) were male. The remaining 2.7% chose not to answer this question.

Disability

1,004 trainees (2.2%) reported that they had a disability. Most said that they did not need adjustments or that reasonable adjustments had been made for them to work, but 124 (0.3% of all trainees) said reasonable adjustments had not been made. This number is slightly lower than last year.

Age

Most trainees (n=38,102, 81.6%) were aged 35 years or younger, 5,487 (11.8%) were aged 36–40 years, 1,729 (3.7%) were older than 40 years, and 1,264 (2.9%) did not wish to give information about their age.

Ethnicity

Trainees from a wide range of ethnic groups responded to the survey (Table 1.2). The largest groups were people who defined themselves as white – British or as Asian or Asian British – Indian.

Table 1.2 Ethnicity of trainees who responded to the survey
2,775 trainees chose not to answer this question.

	Trainees (n=43,893)
Asian or Asian British – Bangladeshi	463 (1.1%)
Asian or Asian British – Indian	7,804 (17.8%)
Asian or Asian British – other Asian background	1,875 (4.3%)
Asian or Asian British – Pakistani	2,544 (5.8%)
Black or Black British – African	1,374 (3.1%)
Black or Black British – Caribbean	119 (0.3%)
Chinese	1,431 (3.3%)
Mixed – white and Asian	559 (1.3%)
Mixed – white and Black African	133 (0.3%)
Mixed – white and Black Caribbean	75 (0.2%)
White – British	21,473 (48.9%)
White – Irish	1,143 (2.6%)
White – other white background	2,819 (6.4%)
Other ethnic group	1,351 (3.1%)
Mixed – other mixed background	643 (1.5%)
Black or Black British – other Black background	87 (0.2%)

Flexible training

Most doctors (83.0%) in this survey trained full time, and of the rest:

- 6.1% were in flexible or part time training
- 6.6% wanted to be in flexible training but were not eligible
- 2.3% were waiting to start a flexible training programme
- 0.2% were waiting for funding for flexible training
- 1.8% were waiting for a flexible training post.

Overall, trainees are satisfied with their training

To measure satisfaction, we asked trainees about various aspects of their current post, such as 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 is a proxy measure for the quality of training.[1] The score is calculated from the number of trainees who rate these items as good or excellent.

Over the past five years, this survey has shown consistently high levels of satisfaction, with most trainees rating the quality of teaching and supervision in their current posts as good or excellent. Out of a possible 100, the overall satisfaction score was 76 in 2006, and had crept up to 78 over 2007–10. It now stands at 79.

This high level of satisfaction is reflected in many of the positive free text comments from trainees in the 2011 survey.

'Excellent training I have been very well supported and adequately supervised.'

'Excellent placement! Highly recommend.'

'I feel that the GP specialist training programme and GP placements therein have provided an excellent foundation to become a good GP.'

'Feel I receive excellent training opportunities. This hospital is a fantastic place to work and I would strongly recommend to all trainees.'

'Excellent training at this hospital.'

'I have worked here for 18 months all the consultants helped me to improve my knowledge, skills and confidence.'

'Very good training.'

'Training is excellent at this hospital, thanks to an excellent anaesthetic department and dedicated college tutor.'

In 2011, the scores for individual items are either the same as or slightly higher than in 2010, which in turn were the same or slightly higher than in 2009.

- 79% rated the quality of experience in their current post as good or excellent, compared with 79% in 2010 and 77% in 2009.
- 77% said their current post would be useful for their future career, compared with 77% in 2010 and 76% in 2009.
- 78% rated the quality of supervision in their current post as good or excellent, compared with 75% in both 2010 and 2009.
- 73% would describe the post as good or excellent to a friend who was thinking of applying for it, compared with 72% in 2010 and 71% in 2009.
- 68% rated the quality of teaching (informal and formal) as good or excellent, compared with 65% in 2010 and 63% in 2009.

Across all five items, 1.8% or fewer gave these items the poorest ratings, compared with 2.3% in 2010.

Although trainees say they are, on the whole, very satisfied with the training they receive, some are more satisfied than others and there is room for improvement, especially in foundation training. Foundation trainees gave an average score of 75 for overall satisfaction, a little below the score of 79 for all trainees. Similarly, when foundation trainees were first included in the survey in 2007, they reported less overall satisfaction.

Satisfaction differs between trainees in different specialty posts

Data from previous trainee surveys have shown consistently that some trainees are more satisfied than others.

The 2011 data show that those in GP posts are the most satisfied (Table 1.3), which is the same as in the 2006 and 2008–09 surveys. By comparison, surgical trainees remain the least satisfied, as was the case in the 2006 survey. GP trainees' satisfaction has not changed since 2006 but the score for surgical trainees has risen from 69 to almost 75.

Table 1.3 Trainee satisfaction in different specialty posts

	Number of trainees (n=46,427)	Average satisfaction score
Surgery	8,544	74.6
Occupational medicine	41	75.4
Obstetrics and gynaecology	2,769	75.6
Medicine	13,219	76.5
Emergency medicine	2,825	79.0
Paediatrics and child health	3,914	79.5
Psychiatry	3,616	80.5
Ophthalmology	657	81.3
Radiology	1,363	82.5
Anaesthetics	4,160	82.7
Pathology	656	83.7
Public health	220	83.2
General practice	4,663	87.2

Training needs to respond to the diverse and changing medical workforce

The proportion of trainees responding to this survey has risen steadily during the past five years (since 2006[2]). In 2007, the overall response rate was 66%,[3] compared with 87.5% last year[4] and 87.0% in 2011.

The composition of the 2011 trainee workforce underlines the point made in our recent report, *The state of medical education and practice in the UK 2011*, that the medical workforce in the UK is diverse and changing.[5] The ethnicity, disability and age profiles of trainees remain broadly unchanged since last year – trainees are predominantly young, with a higher proportion of people who define themselves as Black and minority ethnic* (31% of foundation trainees and 43% of specialty trainees) than in the general UK population (8%).[5]

More female than male doctors answered this survey, with the proportion of women rising from 50.4% in 2010 to 51.4% in 2011. By way of context, 58% of registered doctors are male and 42% are female, but more women have been entering foundation training in the UK and this gap has been widening.[5] *The state of medical education and practice in the UK 2011*[5] highlights the increase in female doctors and the need for the profession and service to adapt as a result.

'We need to ensure that doctors with increasingly different backgrounds, skills and experiences are able to deliver consistently high standards of practice. The profession and the system will need to accommodate these changes in a way that promotes the delivery of the care that patients need and want. More than this, though, we want to understand and harness positive aspects of variation so we can continue to drive up standards.'

This need to adapt applies equally to the provision of medical education, including the structure of postgraduate training programmes.

* Includes people who describe themselves as Asian or Asian British, Black or Black British, mixed, or from another ethnic group.

Chapter 2: Clinical supervision

This chapter examines supervision from the trainees' perspective, drawing on survey data from 2011 and comparing it with that from 2010. The discussion looks at changes in the survey findings since 2006.

Key finding: survey results have improved between 2010 and 2011, indicating that trainees feel the quality of clinical supervision has improved in the past year.

What we asked

We used the survey to find out about trainees' experience of supervision.

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

Clinical supervision is improving

Most trainees know who their clinical supervisor is

The proportion of trainees who always knew who their supervisor was and found them easily accessible increased from 2010 to 2011.

- 84.8% said they always knew who their supervisor was and found them easily accessible, compared with 82% in 2010.
- 7.7% said they did not always know who their supervisor was, but there was usually someone they could contact, compared with 9% in 2010.
- 7.3% said they knew who was supervising them but they were not easily accessible, compared with 8% in 2010.
- Less than 1% said they did not know who was supervising them and there was no one they could contact, the same figure as in 2010.

Of 122 public health trainees, 121 said they knew who provided their senior support out of hours.

Most trainees are supervised by consultants or GP trainers

Overall, a greater proportion of trainees reported being supervised by consultants or GP trainers in 2011 than in 2010, and fewer reported being supervised by other grades.

- 43.6% were supervised by consultants or GP trainers, compared with 41% in 2010.
- 26.3% were usually supervised by consultants or GP trainers, and occasionally by other trainees at a higher grade or career doctors, compared with 27% in 2010.
- 19.2% were supervised by trainees or career doctors, with occasional input from consultants or GP trainers, compared with 20% in 2010.
- 8.2% were supervised by trainees of a higher grade, compared with 9% in 2010.
- 2.8% were supervised by specialty or associate grade doctors, compared with 3% in 2010.

Almost a quarter of trainees feel forced to cope with problems beyond their clinical competence or experience

The proportion of trainees reporting that they never or rarely felt forced to cope with problems beyond their clinical competence or experience was higher in 2011 than in 2010.

- 77.1% said they were never or rarely put in this position, compared with 74% in 2010.
- Of the 22.9% who reported being asked to cope with such problems regularly, 1.9% said this happened on a daily basis, 9.8% on a weekly basis, and 11.1% on a monthly basis.

Nearly all trainees say they have never or rarely been asked to obtain consent for procedures where they do not understand the proposed intervention and its risks

In both 2011 and 2010, 15% of trainees answered not applicable to the question of how often they were asked to obtain consent for procedures where they did not understand the proposed intervention and its risks. But of those who provided a frequency, almost all said this happened never or rarely.

- 95.3% said they were never or rarely put in this position, compared with 95% in 2010.
- 0.3% said daily.

Most trainees think their supervisor is competent

- 93.6% said they were never or rarely supervised by someone they felt was not competent to do so, a small improvement from 92% in 2010.
- 2,982 trainees reported that they were regularly supervised by someone they felt was not competent: 0.8% on a daily basis, 2.2% on a weekly basis, and 3.3% on a monthly basis.

Most trainees report high quality supervision

Table 2.1 shows that the proportion rating the quality of supervision as excellent or good rose compared with 2010.

- 77.8% rated their supervision as excellent or good, compared with 75% in 2010.

Table 2.1 How do trainees rate the quality of supervision?
Data are for all trainee grades.

	2010 (n=46,774)	2011 (n=46,668)
Very poor	615 (1.3%)	446 (1.0%)
Poor	2,229 (4.8%)	1,767 (3.8%)
Fair	8,690 (18.6%)	8,116 (17.4%)
Good	19,966 (42.7%)	20,319 (43.5%)
Excellent	15,274 (32.7%)	16,020 (34.3%)

Trainees value high quality supervision

The importance of high quality supervision to trainees – whether from consultants and GPs or from doctors at another grade – is clear from free text comments in the survey.

'I have had excellent clinical supervision in this post, which has been extremely helpful. Having a clinical supervisor take the time to work through cases and assessments thoroughly has helped my practice hugely. Thank you.'

'Although I do not have consultant supervised training in operative obstetrics very often, I receive direct training and supervision from the associate specialists and specialty doctors in the department which is of a very high standard.'

'I have worked in both hospital jobs and in general practice. I feel that in general practice the education supervision is of a high quality and the teaching is made very accessible.'

'As an ST1 I am always supervised, usually by an experienced registrar. I feel that this is appropriate and safe. I have had the opportunity for lots of obstetric operating.'

Lack of clinical supervision, or being supervised by someone they felt was not competent, was also clearly a concern for some trainees who made negative comments.

'My main complaint of the past post was the lack of senior supervision on the ward most days – where often the most senior person on the ward was a F1.'

'Workplace was extremely good which made it enjoyable in this hospital, but I struggled for assessments and procedures both when on call and on ward. Having clinical supervision closely and regularly would make it more fruitful.'

'Many of the Clinical supervisors were not motivated and avoided contact, making filling in mandatory forms and meetings very difficult and stressful.'

'Regarding this post, I felt there was a clear lack of clinical supervision at all times, meant I felt out of my depth. Sometimes the advice I got from senior colleagues was unsafe or incorrect. This led to serious errors and other potential errors.'

Supervision is improving but there remain important gaps to address

The quality of supervision for most trainees meets the standards we set

In February 2011, we published *The Trainee Doctor*,[6] which includes clear standards on how trainees should be supervised.

'Trainees must be appropriately supervised according to their experience and competence, and must only undertake appropriate tasks in which they are competent or are learning to be competent, and with adequate supervision. Trainees must never be put in a situation where they are asked to work beyond the limits of their competence without appropriate support and supervision from a clinical supervisor.'

It also sets out some specific responsibilities for those supervising foundation trainees.

'Foundation doctors must always have direct access to a senior colleague who can advise them in any clinical situation. Foundation doctors must never be left in a situation where their only help is outside the hospital or the place where they work.'

(The data on foundation trainees is discussed in chapter 4, whereas this chapter focuses on all trainees.)

The survey results suggest that our standards for supervision are now being met for the great majority of trainees. All measures of the quality of supervision have improved compared with last year.

However, the data also indicate that there are still some trainees who are poorly supervised (4.8%) and experience challenges that they are not adequately prepared for on a daily, weekly or monthly basis (22.9%).

The quality of supervision has improved since 2006 but some significant problems persist

Over the past five years, the trainee survey has added both quantitative and qualitative evidence about trainees' perception of the quality of their clinical supervision and the effect that it has on their practice and their working environment. We have routinely used the data from this survey alongside other sources of information we have gathered in our work with deaneries.

The findings have highlighted the impact that good supervision can have on a doctor's perception of the quality of their training.

- The 2006 key findings report[2] highlighted that trainees who perceived their supervision as good were more likely to be satisfied with their post. Trainees who rated their supervision as poor were more likely to report making an error.
- The 2007 key findings report[3] showed that trainees who were supervised by someone they perceived as competent also reported making fewer errors.
- The 2008–09 key findings report[1] indicated that 98% of trainees had an educational supervisor.
- The 2010 key findings report[4] looked at the relation between clinical supervision and the culture of error reporting. Trainees who regarded their supervisors as competent were more likely to report working in an environment where reporting of near misses was encouraged and followed up. Where trainees reported that they were regularly supervised by someone they did not regard as competent, they were more likely to report working in departments where reporting of near misses and critical incidents was haphazard or reluctant.

Building on the survey results over the past five years, we are developing proposals for the recognition and approval of trainers, including both educational supervisors and clinical supervisors in postgraduate training.

Chapter 3:
Feedback and assessment of performance

This chapter examines foundation trainees' and specialty trainees' experiences of feedback on their performance, using data from the 2011 survey.

Key finding: although many of the GMC's standards for assessment are now being met for most trainees, a substantial proportion of trainees do not receive the level of formal and informal feedback required.

What we asked

We used the survey to find out about trainees' experiences of feedback on their performance.

- Do trainees have a designated educational supervisor who is responsible for their appraisal?
- Do trainees have a training or learning agreement with their supervisor that sets out their respective responsibilities?
- Do trainees use a learning portfolio?
- How often do trainees receive informal feedback from their supervisor or senior colleagues on how they are doing in their post?
- Do trainees have formal meetings with their supervisors to talk about their progress in their post?
- Do trainees undergo formal assessment of their performance?
- Do trainees receive formal feedback?

Trainees need more feedback on performance

Almost all trainees have a designated educational supervisor who is responsible for their appraisal

Almost all trainees reported that they had a designated educational supervisor.

- 99% of 33,231 specialty trainees had a designated educational supervisor.
- 99% of 13,176 foundation trainees had a designated educational supervisor.

Most trainees have an agreement with their supervisor that sets out the responsibilities of each

Specialty trainees were more likely to have a learning agreement than foundation trainees, but in both cases the proportion was high.

- 91% of 32,201 specialty trainees had a learning agreement.
- 87% of 12,346 foundation trainees had a training agreement.

Most trainees use a learning portfolio

Foundation trainees were more likely to use a learning portfolio than specialty trainees. The usefulness of the e-portfolio for foundation trainees is discussed in chapter 4.

- 89.4% of 32,432 specialty trainees used a learning portfolio.
- 94.7% of 12,840 foundation trainees used a learning portfolio.

More than a quarter of trainees never or rarely receive informal feedback from senior colleagues

28% of foundation and specialty trainees said they never or rarely received informal feedback from a senior clinician, supervisor or senior colleague (Table 3.1). More than half received monthly or weekly feedback and about 10% had daily feedback.

Table 3.1 How often do trainees receive informal feedback from senior colleagues?

	Specialty trainees (n=33,160)	Foundation trainees (n=13,228)
Never	990 (3.0%)	631 (4.8%)
Rarely	7,890 (23.8%)	3,632 (27.5%)
Monthly	10,419 (31.4%)	3,588 (27.1%)
Weekly	10,891 (32.8%)	3,984 (30.1%)
Daily	2,970 (9.0%)	1,393 (10.5%)

Most trainees have had useful formal meetings with their supervisors to talk about their progress

71% of trainees had formal meetings with their supervisor and found them useful; a small proportion had held meetings but not found them useful (Table 3.2). Foundation trainees were less likely to have had formal meetings than specialty trainees.

Table 3.2 Do trainees have formal meetings with their supervisors?

	Specialty trainees (n=33,440)	Foundation trainees (n=13,228)
No, but I would like to	1,050 (3.1%)	785 (5.9%)
No, but this will happen	3,302 (9.9%)	2,416 (18.3%)
Yes, but it wasn't useful	2,635 (7.9%)	1,633 (12.3%)
Yes, and it was useful	25,589 (76.5%)	7,563 (57.2%)
No, but it wasn't necessary	864 (2.6%)	831 (6.3%)

Not all trainees are formally assessed on their performance

Over half of all trainees had undergone a formal assessment of their performance in the workplace in this post, but specialty trainees were more likely than foundation trainees to have had one (Table 3.3).

Table 3.3 Do trainees undergo formal assessment?

	Specialty trainees (n=33,440)	Foundation trainees (n=13,228)
No, but I would like to	1,629 (4.9%)	1,252 (9.5%)
No, but this will happen	4,086 (12.2%)	2,693 (20.4%)
Yes, but it wasn't useful	2,408 (7.2%)	1,205 (9.1%)
Yes, and it was useful	23,989 (71.7%)	7,234 (54.7%)
No, but it wasn't necessary	1,328 (4.0%)	844 (6.4%)

Many trainees receive no formal feedback

As with formal assessments and formal meetings, foundation trainees were less likely to receive formal feedback than specialty trainees (Table 3.4). A small percentage felt it was not useful or not deserved.

Table 3.4 Do trainees receive formal feedback?

	Specialty trainees (n=33,440)	Foundation trainees (n=13,228)
No	6,955 (20.8%)	4,187 (31.7%)
Yes, and it was constructive	24,948 (74.6%)	8,441 (63.8%)
Yes, and it was not constructive	992 (3.0%)	474 (3.6%)
Yes, and it was not constructive or deserved	545 (1.6%)	126 (1.0%)

Trainees have concerns about the quality of assessment

'I honestly believe half of the paperwork and portfolio requirements are unnecessary. I agree that having specified supervisors is useful but meeting them is now an exercise in completing the obligatory forms rather than genuine mentoring or support.'

'E-portfolio is mostly a pedantic tick boxing exercise that does not really reflect the progress of the trainee.'

The usefulness of portfolios in foundation training is considered in greater detail in chapter 4.

Many of our standards for assessment are now being met but trainees need more feedback that is constructive and useful

Trainees need to be assessed throughout their training to make sure that they are meeting the requirements of their curricula and that each post 'enables the trainee to attain the skills, knowledge and behaviours as envisaged in the given approved curriculum'.[6] Assessment and ongoing educational supervision are a central part of our expectations of trainees and trainers.

We don't stipulate exactly how trainees should be assessed, but *The Trainee Doctor*[6] states that a range of methods should be used and that the following must be met.

- Trainees must have a designated educational supervisor.
- Trainees must sign a training or learning agreement at the start of each post.
- Trainees must have a logbook or a learning portfolio relevant to their current programme that they discuss with their educational supervisor (or representative).
- Trainees must meet regularly with their educational supervisor (or representative).
- Trainees must have a means of feeding back, in confidence, their concerns and views about their experience of training and education.
- There must be a review of progress and appraisal within each post, and a process for transfer of information by supervisors of trainees between placements.

The data from this survey indicate that, for most trainees, much of this is already present. For example, 99% of all trainees have a designated educational supervisor. Nearly all specialty trainees have a learning agreement, as do nearly nine of ten foundation trainees. Nearly 95% of foundation trainees use a portfolio, as do nearly nine of ten specialty trainees.

However, many trainees do not receive the level of informal and formal feedback that they should. More than 25% of trainees said they rarely or never receive informal feedback on how they are doing and only 10% receive feedback daily. Three-quarters of specialty trainees had attended formal meetings with senior clinicians and found them useful; the remainder were either waiting for a formal meeting, had held a meeting but not found it useful, or wanted a meeting. A small proportion felt that a formal meeting was not necessary. Among

foundation trainees, just 57.2% had attended a formal meeting they felt was useful. They were more likely than specialty trainees to find meetings not useful, to be waiting for a meeting, or to regard such meetings as unnecessary.

These findings are mirrored in the question about formal assessment. More than 70% of specialty trainees had undergone formal assessment that was useful when they completed the survey, compared with just over half of foundation trainees. Similarly, three-quarters of specialty trainees and just under two-thirds of foundation trainees had received formal feedback that they felt was constructive.

The role of assessment and feedback in training needs to be improved

It is not clear from the survey data why trainees would either regard feedback as unnecessary or view it as unhelpful or undeserved (that is, unfair). The point of assessment as set out in *The Trainee Doctor*[6] is to help ensure that trainees attain the skills, knowledge and behaviours as envisaged in the given approved curriculum. That a minority regard it as not useful or not helpful raises questions about how they regard assessment as well as the quality of the assessment they are receiving.

The difference in experiences between foundation and specialty trainees is worrying, especially as there is a clear standard in *The Trainee Doctor*[6] that 'there must be valid methods for assessing foundation doctors' suitability for full registration, completion of foundation training, and application and entry to specialty training.'

In October 2010, Professor John Collins' evaluation of the Foundation Programme also highlighted concerns about the assessment of foundation trainees.[7]

'Assessment of Foundation doctors is considered to be excessive, onerous and not valued. Although workplace-based assessment and feedback is central to the philosophy of the Foundation Programme, it has not yet gained the widespread support of trainers or trainees. The validity of the assessment tools has been questioned, and their variable application has been attributed to the lack of preparation of the assessors and insufficient time in which to undertake these assessments properly.'

The comments from trainees completing the 2011 survey quoted above echo these concerns.

The GMC is leading a programme of work to review the balance between formative and summative assessment of trainees. There is widespread agreement that Professor Collins' concerns need to be addressed and, working with others, we are determined to tackle this issue.

Chapter 4: Foundation trainees' experiences

This chapter examines the experiences of foundation trainees and looks at changes since 2010. We have past evidence that the quality of Foundation Programme training varies between the 25 foundation schools,[7,8] and it is therefore particularly important to identify whether foundation trainees' experiences are improving.

Since last year's report,[4] Medical Education England (MEE) and the Scottish Government have published their evaluations of the Foundation Programme,[7] and the GMC has launched its education strategy[9] and the standards for foundation and specialty, including GP training, in *The Trainee Doctor*.[6] The survey findings provide an indication of progress towards meeting these standards.

In total, 13,228 foundation trainees answered this survey – 6,610 in their first year (F1) and 6,618 in their second year (F2). (In total around 12,000 responded in 2010.)

The results are based on large numbers of trainees, albeit self-selecting, so are arguably statistically robust. But they should be treated with caution because they refer to foundation trainees' perceptions of their current post and do not reflect the whole of their experience. (Trainees will typically have three posts in a year.)

Key finding: there remain concerns about the quality of clinical supervision of foundation trainees, and other aspects of their educational experience.

What we asked

We used the survey to find out about trainees' experiences during foundation training.

- How often do trainees feel forced to cope with clinical problems beyond their competence or experience?
- How often are trainees expected to obtain consent for procedures where they do not understand the proposed intervention and its risks?
- Does use of a learning portfolio help trainees with their learning needs?
- Do supervisors make clear to trainees the competences needed for sign off from F1 or F2?
- Do trainees receive informal feedback from consultants?
- How many hours of teaching do trainees receive and is this protected from service demands?
- Do trainees carry out routine work of no educational value?
- Do trainees have a chance to discuss their career management skills and career plans, as well as access information to help them with career planning?
- Do trainees' experiences during foundation training influence their career choices?

Foundation trainees' experiences are steady or improving

More than a third of foundation trainees regularly feel forced to cope with clinical problems beyond their competence or experience

- 38.0% of trainees said they were asked to cope with clinical problems beyond their competence or experience on a monthly, weekly or daily basis (Table 4.1), compared with 44.3% in 2010.
- More F2 trainees than F1 trainees said they were asked daily, which is the same finding as in 2010.

Table 4.1 How often do trainees feel forced to cope with clinical problems beyond their competence or experience?

	F1 trainees (n=6,610)	F2 trainees (n=6,618)	All foundation trainees (n=13,228)
Never	833 (12.6%)	1,193 (18.0%)	2,026 (15.3%)
Rarely	3,154 (47.7%)	3,013 (45.5%)	6,167 (46.6%)
Monthly	1,223 (18.5%)	950 (14.4%)	2,173 (16.4%)
Weekly	1,212 (18.3%)	1,175 (17.8%)	2,387 (18.0%)
Daily	188 (2.8%)	287 (4.3%)	475 (3.6%)

Very few foundation trainees are regularly asked to obtain consent for procedures where they do not understand the intervention and its risks

- 91.7% of trainees said they were rarely or never asked to obtain consent for procedures where they did not understand the intervention and its risks (Table 4.2), compared with 90% in 2010.
- Just 68 foundation trainees (0.6%) said they faced this situation daily.
- F1 trainees were more likely to say never than F2 trainees.

Table 4.2 How often are trainees expected to gain consent for procedures where they do not understand the proposed intervention and its risks?

	F1 trainees (n=6,610)	F2 trainees (n=6,618)	All foundation trainees (n=13,228)
Never	4,841 (78.1%)	3,976 (70.5%)	8,817 (74.5%)
Rarely	968 (15.6%)	1,073 (19.0%)	2,041 (17.2%)
Monthly	239 (3.9%)	323 (5.7%)	562 (4.7%)
Weekly	132 (2.1%)	212 (3.8%)	344 (2.9%)
Daily	15 (0.2%)	53 (0.9%)	68 (0.6%)

Only a third of foundation trainees feel that using a learning portfolio helps them meet their learning needs

The Foundation Programme e-portfolio is the trainees' record of achievement for their foundation training. Nearly 95% of foundation trainees use a portfolio (see chapter 3, page 23).

- 33.6% said that the learning portfolio helped them with their learning needs, with F1 trainees more likely to say yes than F2 trainees (Table 4.3).
- The results do not significantly differ from last year's.

Table 4.3 Does use of a learning portfolio help trainees with their learning needs?

	F1 trainees (n=6,608)	F2 trainees (n=6,613)	All foundation trainees (n=13,221)
Yes	2,333 (35.3%)	2,110 (31.9%)	4, 443 (33.6%)
No	3,283 (49.7%)	3,445 (52.1%)	6,728 (50.9%)
Not sure	992 (15.0%)	1,058 (16.0%)	2,050 (15.5%)

Most foundation trainees understand the competences they need to be signed off from F1 or F2

- 79.1% of trainees said their supervisors did make these competences clear, compared with 70% last year (Table 4.4).

Table 4.4 Do supervisors make clear to trainees what competences they must meet to be signed off from F1 or F2?

	F1 trainees (n=6,608)	F2 trainees (n=6,613)	All foundation trainees (n=13,221)
Yes	5,343 (80.9%)	5,114 (77.3%)	10,457 (79.1%)
No	1,265 (19.1%)	1,499 (22.7%)	2,764 (20.9%)

More than two-thirds of foundation trainees receive helpful informal feedback from consultants

- 69.1% of trainees said they had received informal feedback from a consultant in the past four weeks that was helpful to their development (Table 4.5), compared with 67% in 2010.

Table 4.5 Do trainees receive informal feedback from consultants that is helpful to their development?

	F1 trainees (n=6,608)	F2 trainees (n=6,613)	All foundation trainees (n=13,221)
Yes	4,514 (68.3%)	4,627 (70.0%)	9,141 (69.1%)
No	1,936 (29.3%)	1,737 (26.3%)	3,673 (27.8%)
Not applicable	158 (2.4%)	249 (3.8%)	407 (3.1%)

More than half of foundation trainees do not have any training that is protected from service demands

Trainees were asked how many hours of teaching they had received in the past four weeks, either off duty with pagers handed in, or on duty with or without pagers handed in.

Off duty and pagers handed in (Table 4.6)

- 58.9% said they had received no such training, compared with 63.4% in 2010.
- F1 trainees were more likely to report receiving no such training than F2 trainees, which is the same as in 2010.

Table 4.6 How many hours of teaching do trainees receive on average each week, off duty and with pagers handed in?

	F1 trainees (n=6,595)	F2 trainees (n=6,592)	All foundation trainees (n=13,187)
Zero	4,260 (64.6%)	3,508 (53.2%)	7,768 (58.9%)
<1 hour	885 (13.4%)	687 (10.4%)	1,572 (11.9%)
1–2 hours	583 (8.8%)	913 (13.8%)	1,496 (11.3%)
>2 hour	867 (13.2%)	1,484 (22.5%)	2,351 (17.8%)

On duty and pagers not handed in (Table 4.7)

- 38.3% had received no such training, compared with 37.3% in 2010.
- F1 trainees were more likely to report receiving no such training than F2 trainees, which is the same as in 2010.

Table 4.7 How many hours of teaching do trainees receive on average each week, on duty but without pagers handed in?

	F1 trainees (n=6,573)	F2 trainees (n=6,588)	All foundation trainees (n=13,161)
Zero	2,068 (31.5%)	2,973 (45.1%)	5,041 (38.3%)
<1 hour	2,030 (30.9%)	1,314 (20.0%)	3,344 (25.4%)
1–2 hours	1,157 (17.6%)	986 (15.0%)	2,143 (16.3%)
>2 hours	1,318 (20.0%)	1,315 (20.0%)	2,633 (20.0%)

On duty and pagers handed in (Table 4.8)

- 61.9% said they had no such training.
- F2 doctors were more likely to report having no training on duty and with pagers handed in.

Table 4.8 How many hours of teaching do trainees receive on average each week, on duty and with pagers handed in?

	F1 trainees (n=6,579)	F2 trainees (n=6,602)	All foundation trainees (n=13,181)
Zero	3,386 (51.5%)	4,771 (72.3%)	8,157 (61.9%)
<1 hour	1,570 (23.9%)	656 (9.9%)	2,226 (16.9%)
1–2 hours	774 (11.8%)	552 (8.4%)	1,326 (10.1%)
>2 hours	849 (12.9%)	623 (9.4%)	1,472 (11.2%)

Nearly three-quarters of foundation trainees do work they find of no educational value

- 73.3% of trainees said they had often or occasionally been asked to do routine work of no educational value in the past four weeks (Table 4.9), compared with 77.7% in 2010. Nearly 50% said they had been asked to do so often in 2011.
- F1 trainees were more likely to say often than F2 trainees, and were less likely to say never.

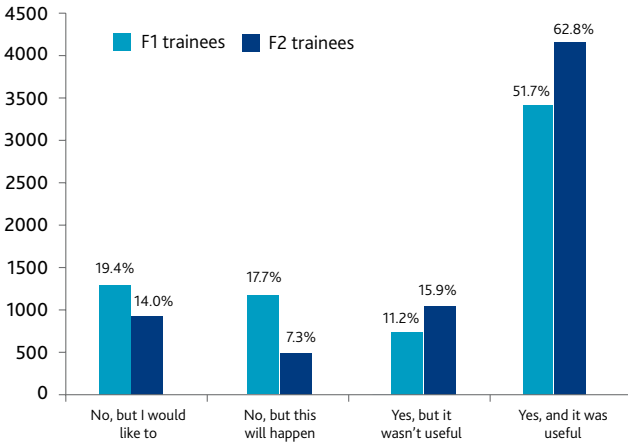
Table 4.9 How often are trainees expected to do routine work of no educational value?

	All foundation trainees (n=13,221)	F1 trainees (n=6,608)	F2 trainees (n=6,613)
Often	6,231 (47.1%)	3,868 (58.5%)	2,363 (35.7%)
Occasionally	3,468 (26.2%)	1,600 (24.2%)	1,868 (28.2%)
Rarely	1,602 (12.1%)	561 (8.5%)	1,041 (15.7%)
Never	1,564 (11.8%)	445 (6.7%)	1,119 (16.9%)
Not applicable	356 (2.7%)	134 (2.0%)	222 (3.4%)

A large minority of trainees do not feel able to develop their career management skills and career plans during the Foundation Programme

- 57.3% of all foundation trainees said they had been able to develop their career management skills and career plans and that the opportunity was useful (Figure 4.1), compared with 53.9% in 2010.
- 19.4% of F1 trainees and 14.0% of F2 trainees said they would like the opportunity but it had not been offered.
- More F2 than F1 trainees said they had received useful advice.

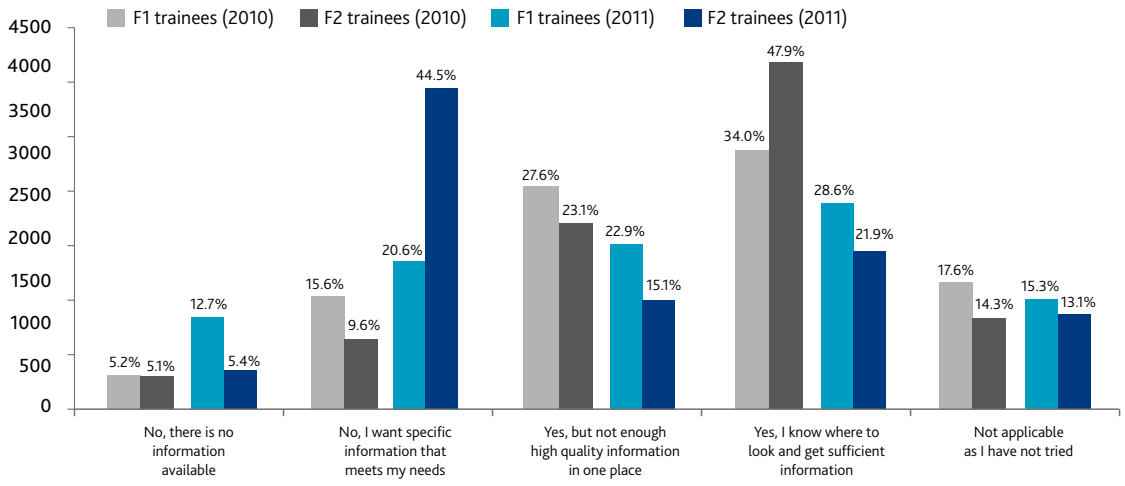
Figure 4.1 Do trainees have a chance to develop their career management skills and career plans?



Fewer foundation trainees know where to find the information they need to help them plan their career

- 25.2% of all foundation trainees said they knew where to look to get sufficient information to help them with their career planning (Figure 4.2), compared with 40.9% in 2010.
- 32.5% of all foundation trainees – 44.5% of F2 trainees – said they wanted information specific to their needs, but it was not there.
- 9% of all foundation trainees said there was no information available, up from 5.2% in 2010.

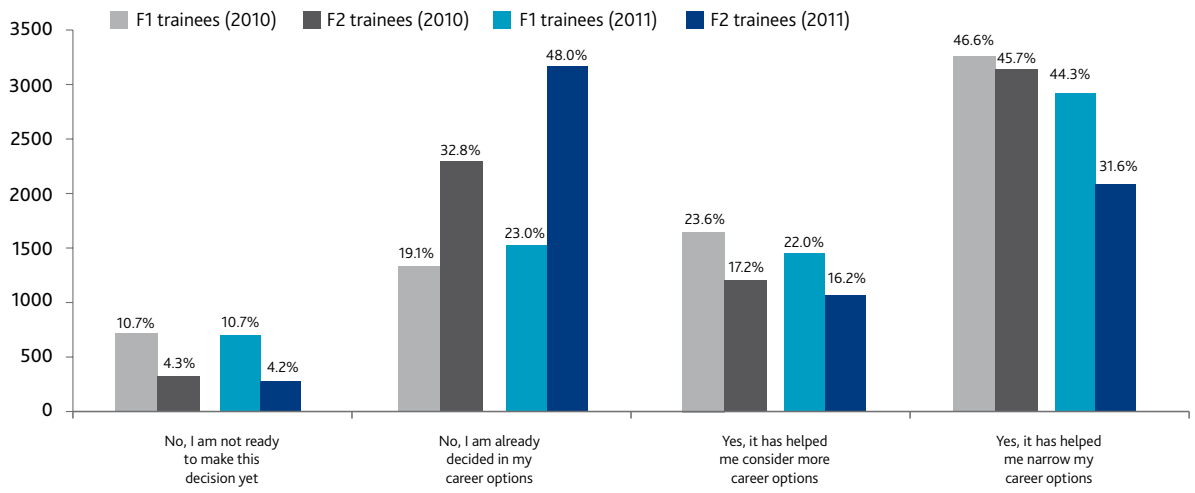
Figure 4.2 Can trainees access information to assist their career planning in their current post?



Trainees' career choices are influenced by their current posts

- Nearly half of F2 trainees and a quarter of F1 trainees had already made their career choice (Figure 4.3), compared with 32.8% of F2 trainees and 19.1% of F1 trainees in 2010.
- Fewer than 10% of foundation trainees said they were not ready to make a career choice.
- More F1 than F2 trainees said their current post had influenced their career choice, but these proportions were lower than in 2010.

Figures 4.3 Do trainees' experiences in their current post influence their career choices?



Trainees have mixed opinions about the Foundation Programme

The survey data show gradual improvements on some key issues but outstanding – and unchanging – concerns in others. Comments from foundation trainees support this mixed picture, with some full of praise.

'So far I have found foundation training a useful transition from medical school to being a doctor. It has allowed me to build confidence, learn medicine and have opportunities I did not have at medical school. It has enlightened my career decisions.'

'This current post is an excellent time for learning, most of this is in informal one-to-one sessions with consultants or higher grade trainees.'

Others tempered their enthusiasm with comments about the feedback they received from senior colleagues.

'I love anaesthetics and ITU. However, I have no idea if I'm any good at it. I have had no feedback, and I'm struggling to understand what I can do to improve. I get no teaching, no daily feedback and my consultants barely communicate with me.'

'Seniors should be actively encouraged to get involved in teaching their juniors. While in GP this happens because it's a necessary part of patient management. But in hospital this is rare, and most my placements have not been useful to learning.'

A few were keen to comment on the variability of posts, saying their current post was good by contrast with their previous post.

'The post I am in currently is excellent and I have enjoyed giving feedback to reflect this. However, my last post was staggeringly different.'

'While my current post is actually going smoothly and I enjoy it, I did not enjoy my last post at all. I was constantly undermined by my consultant to the extent that I didn't look forward to coming into work in the morning.'

Others commented on the lack of protected teaching time, the lack of senior support or the extent to which they did work that they felt had no educational value.

'Most times did not have protected teaching time. The shortage of staff placed so much pressure on us that it was unwise to leave the ward for teaching when I was in cardiology rotation. In my current post there is a big problem of senior cover.'

'The senior support in this post, particularly when on call and at night is particularly poor. Most discussions with registrars are done over the phone, and patients are rarely reviewed. Senior ward rounds for the majority of teams are uncommon.'

'I have enjoyed, on the whole, becoming a new doctor. However, the amount of non-clinical work we do as juniors eg paperwork, chasing scans etc and the amount of time spent on e-portfolio has been the biggest disappointment about starting medicine.'

'The cardiothoracic post contains minimal training. The nature of the work is routine and not suitable for an F2 doctor. There is no opportunity for independent decision making as everything needs to be run past a senior.'

'Teaching was often not included in our rota so we were expected to attend mandatory training in our own time. This was very difficult.'

'More emphasis needs to be made during F1/2 years that we are there for training purposes and not just to complete daily jobs.'

As in 2010, concerns about the e-portfolio featured highly, with only a third of trainees finding it useful.

'E-portfolio is not constructive and is a waste of time. E-portfolio completion does not correlate to clinical competence or ability.'

'The e-portfolio is useful in directing what we should be achieving as F1. However, I feel that it is more of a tick box process. Tedious. Has not really developed me further. Marking on e-portfolio is also very subjective.'

'Too much emphasis on reflection and portfolio – no one seems to care much about experience and quality.'

'Excessive need to "reflect" and "link" in the e-portfolio. We just don't have time to do this when we already work so much overtime! Perhaps protected "reflecting" time or more assessments instead would be better?'

'Linking to the curriculum on the e-portfolio seems a very time-consuming and unhelpful exercise.'

A few trainees commented that although the portfolio was a good idea, it was its execution that was at fault.

'The e-portfolio is a great idea but the website is terrible. It is not intuitive to use and very cumbersome. If it was a better tool I think I would use it much more.'

'Please overhaul the e-portfolio. It is unwieldy and poorly designed. Many supervisors are unable to navigate it themselves, making it a poor joint educational tool. I would prefer a paper system to this monstrosity.'

Issues with the e-portfolio are not new. They were considered in our key findings report last year[4] and by MEE in the evaluation of the Foundation Programme.[7] MEE described the assessment of foundation doctors as 'excessive, onerous and not valued'. It said:

'The range of assessment tools and the frequency of assessments must be urgently reviewed and modified based on the data now available on assessment in the GMC surveys and feedback from trainers; otherwise, the credibility of the Foundation Programme in the eyes of teachers and trainees will be compromised. Improved transfer of information between undergraduate and postgraduate schools should be explored to help to avoid unnecessary and repetitive assessments. Furthermore, methods must be found to support and recognise those who "aspire to excellence".'

The findings presented here show that the ease of use of portfolios and that of assessment in general remains a live issue of concern to many foundation trainees. The Academy of Medical Royal Colleges has been reviewing the foundation curriculum and assessment system in the light of the MEE evaluation and proposals will be submitted to the GMC for approval later in 2011, for implementation by August 2012.

Foundation trainees need more support to make sure they are working within their competence

The survey findings show that many of foundation trainees' experiences are in a steady state compared with last year or have had some small improvement. However, more than a third are regularly being asked to act beyond their competence and a small number are being asked to gain consent for treatments that they do not fully understand. As discussed in chapter 2, trainees should be supervised appropriately according to their experience and competence as set out in our standards in *The Trainee Doctor*.[6] As new doctors, foundation trainees may often feel unprepared and given the knowledge required for clinical practice it is impossible to be fully prepared.[5] Supervision should support developing competence and confidence.

The Trainee Doctor[6] also provides clear requirements on obtaining consent for procedures.

'Before seeking consent both trainee and supervisor must be satisfied that the trainee understands the proposed intervention and its risks, and is prepared to answer associated questions the patient may ask. If they are unable to do so they should have access to a supervisor with the required knowledge. Trainees must act in accordance with the GMC's guidance Consent: patients and doctors making decisions together *(2008).'*

Additionally, nearly half of trainees feel that they are being asked to carry out routine work of no educational value.

These three issues – doing routine work of no educational value, acting beyond competence, and seeking consent for interventions without full understanding – were all raised by Professor Collins in his evaluation of the Foundation Programme,[7] which stated:

'Confusion exists about the role of the medical trainee in the NHS and in NHS-related academic employment. Trainees are postgraduate learners as well as paid employees of the health services. They provide an important contribution to the healthcare of patients and are not supernumerary to service requirements. In return they receive education and training predominantly in the clinical environment. The key is maintaining a balance between the demands of the clinical service and the requirements for their learning. Without a clear understanding of the role of trainees in the NHS there is a real risk that the long-term educational mission of the service will be inappropriately dominated by short-term service requirements. In addition, a lack of understanding of the level of competence of F1 and F2 doctors may have led to their deployment in inappropriate roles and beyond their level of competence. Equally, it is recognised that trainees must be encouraged to extend the boundaries, step up and enhance their contribution, particularly in F2.'

Career management is improving but foundation trainees need better access to information to help career planning

The data on career management show some marked changes from 2010: although more trainees are developing their career management and planning skills in their post, fewer have access to information about careers and more have already made their career choices. Again Professor Collins highlighted this in his report and recommended:[7]

'All of the appropriate organisations must work together to define good practice for the provision of careers information and advice. Such information must be easily accessible, simple to understand and contain transparent data on each specialty, including competition ratios and a potential applicant's "likelihood of success".'

The changing picture presented here may simply reflect discussion in the medical press about careers and heightened awareness of the importance of career management among foundation trainees. Work is underway to improve career information and advice.

Chapter 5: The Working Time Regulations

This chapter looks at how the implementation of the Working Time Regulations (WTR) has affected trainees, including foundation trainees, those in other training programmes and those in different specialty posts. It compares data from 2011 with that from 2010 – the first survey in which the 48-hour working week applied.*

During their training, all foundation trainees work in different posts in different specialties (rotations). Trainees enrolled in a specialty training programme may work in posts within their specialty, but for some programmes they may be required to work in posts within other specialties. For example a trainee in acute care common stem may have been in an anaesthetics post when he or she completed the survey.

Key finding: the proportion of trainees rostered to work a 48-hour week and those working beyond 48 hours has changed little from last year. However, the proportion who feel that the 48-hour week is affecting their ability to meet their training needs or achieve their competences has fallen, as has the proportion of trainees filling gaps in rotas. It is worth noting that the data highlight particular problems not just for surgical and other specialty programmes but also for foundation trainees.

* The WTR implement the European Working Time Directive in the UK. Since 1 August 2009, trainees' working hours have been limited, by law, to an average of 48 hours per week in a 26-week period.

What we asked

We used the survey to find out about trainees experiences of the WTR.

- How many trainees report having a rota that is compliant on paper with the WTR?
- How many trainees report actually working beyond their rostered hours?
- Of trainees in different specialty programmes and posts, which are more likely to report working beyond their rostered hours?
- Are trainees filling gaps in rotas?
- Do trainees feel that their training needs are being met within the 48-hour working week?
- Are trainees taking longer to achieve required educational competences?
- Of trainees in different specialty programmes and posts, which are more likely to report taking longer to achieve their required educational competences?
- Of trainees in different specialty programmes and posts, which are most likely to have been asked to sign a waiver opting out of the WTR?

Some specialties are struggling to meet the requirements of the WTR

Most trainees report that their rota is compliant with the WTR

- 82.4% of specialty trainees said their rostered working hours were compliant with the WTR.
- 4.7% said their rostered working hours were not compliant.
- 13.2% were not sure, the same as in 2010.
- The data for foundation trainees in 2011 were not significantly different from those for specialty trainees.
- In 2010, 81% of all trainees reported that their rota was compliant, compared with 82.2% of all trainees in 2011.

Almost two-thirds of trainees regularly work beyond their rostered hours

Despite most rotas being compliant with the WTR, many trainees say they end up working beyond these hours. A higher proportion of foundation trainees than specialty trainees reported working longer hours.

- 64.5% of trainees report working longer hours on a monthly, weekly, or daily basis (Table 5.1), compared with 66.2% in 2010.
- 35.4% said they rarely or never worked beyond 48 hours a week, compared with 33.9% in 2010.
- Among foundation trainees, 28.9% said they rarely or never worked longer hours and 21.9% said they did so daily.
- Among specialty trainees, 37.9% said they rarely or never worked longer hours and 14.3% said they did so daily.

Trainees in some specialties continue to be particularly affected

- 80.3% of trainees in surgical programmes and 74.8% of those in medical programmes reported working beyond their rostered hours on a monthly, weekly, or daily basis, followed by foundation trainees (see Table 5.1 for a full breakdown).
- 80.2% of trainees with posts in surgery and 77.1% of those with posts in medicine reported working beyond their rostered hours on a monthly, weekly, or daily basis (see Table 5.2 for a full breakdown).
- In both programmes and posts, occupational medicine, general practice and public health trainees were least likely to report working beyond their rostered hours.

Our 2010 study of quality assurance of specialty training and the WTR[10] showed that the five specialties most affected by the implementation of the WTR are surgery, obstetrics and gynaecology, anaesthetics, paediatrics and emergency medicine.

It is perhaps unsurprising to note that, in this year's survey, trainees in these specialties are the most likely to report having to work beyond their rostered hours.

Table 5.1 How often do trainees in different specialty programmes work beyond their rostered hours?

	Never	Rarely	Monthly	Weekly	Daily
Surgery (n=4,404)	2.5%	17.3%	10.6%	43.2%	26.5%
Medicine (n=6,959)	3.5%	21.7%	11.9%	40.3%	22.6%
Foundation (n=13,228)	7.4%	21.5%	11.4%	37.9%	21.9%
Ophthalmology (n=554)	4.5%	28.3%	14.8%	38.6%	13.7%
Obstetrics and gynaecology (n=1,760)	3.9%	28.1%	16.4%	38.1%	13.5%
Paediatrics and child health (n=2,747)	4.6%	27.9%	18.1%	37.0%	12.5%
Acute care common stem (n=887)	4.8%	28.2%	15.2%	39.3%	12.4%
Emergency medicine (n=669)	4.0%	30.3%	16.9%	37.4%	11.4%
General practice (n=7,342)	15.4%	37.4%	11.8%	25.9%	9.5%
Pathology (n=608)	11.7%	38.7%	12.5%	27.8%	9.4%
Radiology (n=1,217)	12.9%	37.1%	11.8%	29.4%	8.8%
Public health (n=172)	17.4%	47.7%	9.9%	18.0%	7.0%
Anaesthetics (n=3,279)	5.8%	38.1%	21.7%	28.6%	5.8%
Occupational medicine (n=40)	30.0%	27.5%	10.0%	27.5%	5.0%
Psychiatry (n=2,673)	12.9%	43.0%	16.5%	23.4%	4.2%
Total (n=46,539)	**7.6%**	**27.7%**	**13.3%**	**34.9%**	**16.4%**

Table 5.2 How often do trainees in different specialty posts work beyond their rostered hours?

	Never	Rarely	Monthly	Weekly	Daily
Surgery (n=8,544)	2.7%	17.1%	11.1%	42.3%	26.8%
Medicine (n=13,111)	3.6%	19.3%	12.1%	40.7%	24.3%
Ophthalmology (n=657)	7.6%	31.2%	13.9%	35.0%	12.3%
Emergency medicine (n=2,825)	7.2%	29.1%	12.2%	39.7%	11.7%
Paediatrics and child health (n=3,914)	6.4%	30.7%	17.7%	34.0%	11.3%
Obstetrics and gynaecology (n=2,769)	5.1%	31.1%	16.5%	36.1%	11.2%
Radiology (n=1,363)	12.5%	35.1%	11.3%	30.9%	10.1%
Pathology (n=656)	13.4%	39.3%	11.7%	26.7%	8.8%
General practice (n=4,663)	23.5%	39.2%	7.9%	20.7%	8.7%
Anaesthetics (n=4,160)	6.6%	38.6%	20.0%	28.6%	6.2%
Public health (n=220)	20.9%	45.0%	9.5%	18.6%	5.9%
Psychiatry (n=3,616)	14.2%	42.7%	16.4%	22.6%	4.0%
Occupational medicine (n=41)	29.3%	31.7%	9.8%	26.8%	2.4%
Total (n=46,539)	**7.6%**	**27.7%**	**13.3%**	**34.9%**	**16.4%**

Most trainees do not feel under pressure to pretend they have worked compliant hours

We asked trainees whether they had felt pressured to submit a record of hours that was compliant with the WTR when their hours were not, in fact, compliant. Foundation trainees were less likely to say yes than specialty trainees.

- 92.9% of trainees said no, compared with 90% in 2010.
- 7.1% said yes, compared with 10% in 2010.
- In 2011, 91.5% of foundation trainees said no and 93.5% of specialty trainees said no.

Most trainees are not asked to opt out of WTR

Some 15.2% of trainees had been asked to sign a waiver opting out of the WTR. However there was less of a link between those who had been asked to sign a waiver and the specialties which trainees tell us had been particularly hard pressed as a result of the WTR. The five specialty programmes with the largest proportion of trainees who had been asked to sign a waiver were:

- obstetrics and gynaecology: 20.3%
- ophthalmology: 19.5%
- surgery: 18.8%
- anaesthetics: 18.7%
- foundation: 18.6%.

Trainees in public health, pathology and occupational medicine were least likely to be asked to sign a waiver.

Surgery and anaesthetics post and programme trainees were most likely to have signed a waiver without being asked.

A large minority of trainees are filling gaps in rotas

The proportion of trainees filling rota gaps has fallen compared with 2010. Foundation trainees are less likely to report filling gaps in rotas than specialty trainees and are less likely to regard doing so as an opportunity for gaining extra training.

- 39.2% of trainees said they had to fill gaps in rotas because of a failure to fill posts, compared with 45.3% in 2010.
- Among foundation trainees, the proportion filling rota gaps was smaller at 33.9%.
- Among specialty trainees, the proportion filling rota gaps was 41.1%.
- However, the proportion of trainees reporting that there were no gaps in the rota was higher in 2011 than in 2010.
- Fewer trainees reported working over their hours to fill rota gaps in 2011 than in 2010 (10.6% compared with 13.5%).
- Fewer trainees reported missing training sessions both during routine daytime work and out of hours in 2011 than in 2010 (4.5% compared with 5.8%).
- The same proportion of trainees in both years (8.8%) reported gaining exposure to extra training as a result of rota gaps in 2011 and 2010.

- Among foundation trainees this fell to 6.7%, while among specialty trainees the proportion was 9.6%.

We also asked trainees how often they covered for patients in a different specialty from their current post. Foundation trainees were less likely than specialty trainees to say never or rarely.

- 83.9% said never or rarely, compared with 82.3% in 2010.
- Among foundation trainees, the proportion reporting never or rarely was 74.8% compared with 87.7% among specialty trainees.

Most trainees feel that their training needs are being met within the 48-hour working week

- 62.9% said that they felt their training needs were being met within the working week specified by the WTR, compared with 58% in 2010.
- 22.1% said no, compared with 27% in 2010.
- 15% were not sure, compared with 16% in 2010.

A large minority of trainees say it is taking them longer to meet the competences they need within the 48-hour working week

Although 31.2% of trainees (excluding foundation trainees) say it is taking longer to achieve their required educational competences as a result of WTR, this proportion has fallen compared with 2010. Some specialty posts and programmes report greater difficulties than others.

- 31.2% said they were taking longer to achieve their required educational competences as a result of the working week specified by the WTR, compared with 35% in 2010.
- 48.9% said no, compared with 44% in 2010.
- 19.9% were not sure.

Responses from foundation trainees have been removed from this question as all trainees currently in the foundation programme will only ever have worked under WTR conditions.

Trainees in obstetrics and gynaecology and in surgery posts and programmes are most likely to report taking longer to achieve their required educational competences

- 60.6% of trainees in obstetrics and gynaecology and 59.9% of those in surgery programmes reported taking longer to achieve their required educational competences as a result of the WTR (see Table 5.3 for full breakdown).

- 44.8% of trainees in obstetrics and gynaecology posts and 43.7% of those in surgical posts report taking longer to achieve their required educational competences as a result of the WTR, followed by those in anaesthetics (see Table 5.4 for full breakdown).
- Occupational health, public health and general practice trainees are the least likely to report taking longer.

Again, the specialties across both posts and programmes in which most trainees report needing longer to achieve competence overlap with those identified in our 2010 study of quality assurance of specialty training and the WTR.[10] This suggests that there are ongoing challenges for surgery, obstetrics and gynaecology, anaesthetics, paediatrics and emergency medicine training structures to adapt to a 48-hour week.

Table 5.3 Do trainees in different specialty programmes report taking longer to achieve required educational competences as a result of the WTR?

Data for foundation trainees are not included in this table.

	Yes	No	Not sure
Obstetrics and gynaecology (n=1,760)	60.6%	23.6%	15.8%
Surgery (n=4,404)	59.9%	21.1%	18.9%
Anaesthetics (n=3,279)	44.3%	34.7%	21.0%
Medicine (n=7,067)	33.8%	44.8%	21.4%
Paediatrics and child health (n=2,747)	33.2%	43.5%	23.2%
Acute care common stem (n=887)	32.7%	39.9%	27.4%
Ophthalmology (n=554)	23.8%	52.3%	23.8%
Radiology (n=1,217)	23.5%	49.5%	27.0%
Emergency medicine (n=669)	17.9%	65.5%	16.6%
Pathology (n=608)	17.9%	56.4%	25.7%
Psychiatry (n=2,673)	11.9%	69.8%	18.3%
General practice (n=7,342)	9.5%	73.8%	16.7%
Public health (n=172)	4.7%	79.7%	15.7%
Occupational medicine (n=40)	2.5%	87.5%	10.0%
Total (n=33,419)	**31.2%**	**48.9%**	**19.9%**

Table 5.4 Do trainees in different specialty posts report taking longer to achieve required educational competences as a result of the WTR?

Data for foundation trainees are included in this table.

	Yes	No	Not sure
Obstetrics and gynaecology (n=2,769)	44.8%	37.7%	17.5%
Surgery (n=8,544)	43.7%	34.6%	21.7%
Anaesthetics (n=4,160)	42.0%	35.7%	22.3%
Medicine (n=13,111)	29.5%	47.6%	23.0%
Paediatrics and child health (n=3,914)	28.3%	48.2%	23.4%
Radiology (n=1,363)	23.5%	50.8%	25.7%
Ophthalmology (n=657)	21.6%	56.2%	22.2%
Emergency medicine (n=2,825)	19.0%	58.7%	22.3%
Pathology (n=656)	18.3%	56.6%	25.2%
Psychiatry (n=3,616)	12.0%	69.7%	18.3%
General practice (n=4,663)	8.9%	75.1%	16.0%
Public health (n=220)	6.4%	76.8%	16.8%
Occupational medicine (n=41)	4.9%	87.8%	7.3%
Total (n=46,539)	**29.4%**	**49.3%**	**21.3%**

Trainees report problems with implementation of the WTR

The WTR continue to be a source of negative comments from trainees, who tend to use the former acronym EWTD (European Working Time Directive). Many called for a complete opt out, especially in surgery.

'EWTD is harmful to my training and I believe it is even more harmful to those in subspecialty training or surgical training. We must opt out at a national level.'

'EWTD compromises the training and make deanery and hospital go with rotas that provide service with minimal training.'

'The EWTD does not work. I am experiencing a workplace that is not safe because there are not enough doctors on the wards and the consultants want juniors in theatre regardless of whether they actually need the extra hands.'

'Very good anaesthetic department – friendly and approachable. Good teaching structure – excellent college tutor. Training limited due to EWTD although department doing their best to help.'

'EWTD has unfortunately had a massive negative impact on training and patient care.'

But some comments highlighted the variability in implementation of the WTR.

'Whilst my post in paediatrics has conformed well to the EWTD and I have been well supported by seniors, my post in general medicine was far from well supported and I was working beyond my scheduled hours on a daily basis.'

'In my first post (unbanded) haematology and oncology, I felt well supported and conformed quite well to the EWTD. In my medicine post I felt I had VERY LITTLE support and I very rarely finished work from a day shift on time. Surgery is similar.'

'I feel the EWTD is restricting our training and also junior consultants are less confident – particularly in gynae operating and therefore this has repercussions for trainees.'

Others highlighted the different factors that interplay with effective implementation of the WTR.

'I believe the problem is not EWTD time limit but the fact that there has been a cut in training sessions but no adjustment in service provision. In three months I am doing only 17 days between Monday–Friday 9am–5pm including long days.'

'The massive number of online modules that F1 doctors are meant to do – from e-portfolios to e-induction to e-pharmacy…now all outside of working hours makes a mockery of the EWTD.'

Training and working hours have improved since implementation of the WTR

This is the second survey since the introduction of the 48-hour working week in 2009. The data show some improvements but these are small and lead to the same conclusion as in 2010: a mixed picture with many positive elements but cause for serious concern in some specialties. There also appear to be ongoing difficulties for some specialties to adapt to a 48-hour week.

As in 2010, the 2011 data show that the vast majority of trainees – 82.2% – have a rota that is compliant with the WTR. But a third work over their rostered hours on a weekly basis and nearly 16.4% do so daily. 92.9% have not felt under pressure to work beyond their rostered hours, and 84.8% have not been asked to sign a waiver opting out of the WTR. Of those that did, most did so willingly.

There are some encouraging signs that trainees are less frequently covering gaps in rotas: the proportion reporting no gaps in rotas has increased slightly from 2010. Furthermore, the proportion who had to work beyond their hours to fill gaps has fallen slightly. As in 2010, only 8.8% of trainees reported that covering gaps in rotas gave them extra training opportunities. 83.9% of trainees said they rarely or never covered a post in a different specialty to their own.

Perhaps most encouraging is that more trainees are confident of meeting their training needs in the 48-hour week (62.9% in 2011 vs 58% in 2010) and fewer feel that they are taking longer to reach their competences (29.4% vs 35%). Although this is a move in the right direction, there is still a long way to go.

Implementing the WTR is causing problems for foundation trainees

Compared with specialty trainees, the picture for foundation trainees is less encouraging. More foundation trainees regularly work beyond their rostered hours and they are more likely to report covering for patients in a different specialty. They were also less likely to regard providing cover as an opportunity for learning than their specialty colleagues. They are more likely to work beyond the 48-hour week, among the most likely to have been asked to sign a waiver opting out of the WTR and also among those most likely to have done so. These findings are worrying, particularly the extent to which foundation trainees cover rota gaps. A third of foundation trainees regularly cover rota gaps due to missing staff and only three-quarters say they never or rarely cover for patients in a different specialty. Professor Sir John Temple's report *Time for training*[11] pointed out that gaps in rotas result in lost training opportunities.

'Rota gaps result in trainees being moved from their daytime, more elective training often at very short notice to fill service gaps. These are usually out of hours where there is minimal supervision and therefore less training opportunity. This results in the trainee missing out on the planned training that day and often the next due to compensatory rest.'

The data indicate that foundation trainees are affected more than other trainees, highlighting problems with rota design and the competing priorities of service and training in this group.

Some specialties continue to be more affected than others

Trainees in surgery and medicine are most likely to work beyond their hours; those in obstetrics and gynaecology, surgery and anaesthetics are most likely to report taking longer to achieve their educational objectives; and those in obstetrics and gynaecology, ophthalmology, surgery, anaesthetics and, foundation training were the most likely to have been asked to sign a waiver opting out of the WTR.

These findings are broadly in line with our 2010 study of quality assurance of specialty training and the WTR.[10] This highlighted concerns about the WTR in surgical specialties, obstetrics and gynaecology, emergency medicine, anaesthetics and paediatrics, but also noted that the WTR is not the only factor contributing to problems.

'The implementation of the 48 hour week is by no means the sole cause of concerns reported here: where difficulties have arisen, they have been magnified by a range of other factors including gaps in rotas and rota design. In those circumstances – which particularly affect specialties with high emergency or high out of house workloads – the effects of achieving compliance with EWTR can include reduced supervision and lost or reduced training opportunities.'

The fact that trainees in these specialties continue to report difficulties as a perceived result of the implementation of the WTR is a real concern. We have commissioned research into the impact of both the WTR and the steps taken to comply with them on the quality of training in the UK, as part of our commitment to work with the royal colleges, postgraduate deaneries and the service to improve what is clearly an unacceptable situation.

Although this survey can only give the trainees' perspective, it supports the finding from the first stage of our research published last year:[12] that many providers and deaneries are managing the process of implementing WTR well. We expect the second stage of our research to be published in the summer of 2012. However, neither that study nor this survey provide any evidence about the outcomes of the changes in working hours. Moonesinghe and colleagues[13] report that very little work has been undertaken in the UK to evaluate the impact of the WTR with outcome measures, either educational or clinical. They concluded:

'Reducing working hours to less than 80 a week has not adversely affected patient outcomes or postgraduate training in the US. The impact of reducing hours to less than 56 or 48 a week in the UK has not yet been sufficiently evaluated in high quality studies. Further work is required, particularly in the European Union, using large multicentre evaluations of the impact of duty hours' legislation on objective educational and clinical outcomes.'

As we move forward with developing and improving this survey in 2012, we will work with postgraduate deaneries and royal colleges to look at ways of securing an outcome-based assessment of the impact of reduced working hours on training.

Chapter 6: Preparedness for practice

This chapter examines how well prepared trainees are to move to the next stage of their training or to become a consultant or GP and, for the first time, compares foundation trainee preparedness with that of specialty trainees at a higher stage in their training. It also looks at factors around career choice.

Key finding: the data show that very little has changed in the past year, although slightly more F1 trainees felt prepared for their first F1 post. However, foundation trainees rate their experience less highly than do specialty trainees, were less confident of gaining the competences they need and were less likely to have discussed their educational objectives with their supervisor.

What we asked

We used the survey to find out about trainees' preparedness and their career choices.

- How well prepared did foundation trainees feel for their first post?
- Do F1 trainees have an opportunity to shadow their first placement before starting work?
- How do trainees rate their practical experience?
- How confident are trainees of acquiring required competences?
- How do trainees rate the quality of their induction?
- Do trainees discuss their educational objectives with their supervisors?
- What access do trainees have to educational opportunities?
- Do trainees discuss their career plans with a senior colleague?
- Where do trainees wish to work after completing their training?
- What are trainees most likely to do in the next 12 months?
- Do trainees coming to the end of their training feel ready to take up a consultant or GP post?
- If not, in which areas do trainees coming to the end of their training feel least prepared?

Preparedness continues to need attention

A quarter of foundation trainees do not feel they were adequately prepared for their first job

We asked foundation trainees to think about the start of their F1 year.

- 61.0% of trainees said they did feel adequately prepared for their first F1 post (Table 6.1), compared with 58% in 2010.
- 24.4% said they did not feel adequately prepared, compared with 28% in 2010.
- 14.6% were not sure, which is the same as last year.

Table 6.1 Do trainees feel they were adequately prepared for their first F1 post?

	F1 trainees (n=6,608)	F2 trainees (n=6,613)	All foundation trainees (n=13,221)
Yes	4,094 (62.0%)	3,975 (60.1%)	8,069 (61.0%)
No	1,555 (23.5%)	1,671 (25.3%)	3,226 (24.4%)
Not sure	959 (14.5%)	967 (14.6%)	1,926 (14.6%)

Most F1 trainees shadow their first placement before starting work

- 88.3% of F1 trainees said they did shadow their first placement before starting work.
- 11.7% said they did not.

Most trainees have good practical experience

- 72.7% of trainees rated their practical experience as good or excellent, compared with 72% in 2010.
- 63.4% of foundation trainees rated their practical experience good or excellent, compared with 64% in 2010.
- 76.3% of specialty trainees rated their practical experience as good or excellent.

Most trainees are confident that they will gain the competences they need

- 79.6% of trainees were fairly or very confident of acquiring the competences needed at their particular stage of training, compared with 78% in 2010.
- 75.6% of foundation trainees were confident or fairly confident, compared with 74% in 2010.
- 81.3% of specialty trainees were confident or fairly confident.

Almost two-thirds of trainees rate their induction as good or excellent

Responses from trainees about induction were not included in the key findings analysis for 2010. For 2011, responses showed the following.

- 64.1% of trainees rated the quality of their induction as good or excellent.
- 9.4% rated induction as poor or very poor.
- 65.4% of foundation trainees rated induction as good or excellent.
- 63.6% of specialty trainees rated their induction as good or excellent.
- 9.9% of foundation trainees rated induction as poor or very poor.
- 9.2% of specialty trainees rated their induction as poor or very poor.

We received a number of free text comments on foundation and specialty induction programmes. One trainee highlighted the positive impact that high quality induction can have.

'The six-week radiology induction programme and the physics teaching were both excellent (as a result all 10 first years passed both parts of the part 1 Fellow of Royal College of Radiologists at first attempt). My thanks to the organisers. It has been a good first year.'

But most comments were negative and highlighted the poor quality of induction and the practical difficulties of attending formal induction sessions. These comments were typical.

'My experience of the Ear Nose Throat department has been excellent. The only down side to this post is the cross cover of orthopaedics – we have no induction, no teaching and very little supervision. I have ended up doing multiple incident forms.'

'No induction as started on nights. No provision put in place for the staff that started the post on nights. No assigned educational supervisor, had to chase the consultant involved to find out who I should be talking to.'

'Lack of induction due to October start dates. Lots of [NHS] Trust mandatory induction [which was] useless and a waste of time, sometimes unable to attend due to clinical commitments.'

'Difficult induction as I was the only trainee (FY2) coming into the placement.'

'We should have been paid for our induction week. No other profession is expected to have non paid induction (and no other profession has the level of debt as doctors from pure undergraduate training). It's appalling and I feel totally undervalued.'

'The induction for this post was inadequate – I am still struggling to work out how the teams work, am expected to manage clinical situations and risky dynamic function tests when I have inadequate training and supervision.'

'There need to be more opportunities for scheduled teaching that is relevant to the post a trainee is in, not just at induction, but throughout the post. This would help with continuity of care and also improve patient safety.'

'I have done three four-month posts within my current hospital. My latest ward was excellent and gave me a full induction. When I started there was NO hospital or ward induction or instruction how to use e-prescribing.'

'I did not attend any of the formal teaching at my trust as I work part time…The induction at my trust was really bad due to the snow.'

'The induction process was very poor. I feel that I should have had a proper induction for obstetrics and gynaecology covering my responsibilities and common/serious presenting complaints in obstetrics. Departmental teaching also virtually nonexistent.'

'The e-induction was so time consuming that I think it requires two days. It needs regular breaks and you are unable to complete at work as always got something to do. I was told study leave was unacceptable for this.'

Most trainees discuss their educational objectives with their supervisor

Again, responses from trainees were not analysed in the key findings report for 2010. For 2011:

- 92.6% of trainees discussed their educational objectives with their supervisor
- 91.2% of foundation trainees had done so
- 93.1% of specialty trainees had done so.

Most trainees have formal teaching and access to educational opportunities after medical school but the number being taught medical ethics has fallen

- 87.6% of trainees had received formal teaching since leaving medical school (Table 6.2), compared with 85% in 2010.
- 90.1% of foundation trainees had received such teaching in 2011, compared with 86.7% of specialty trainees.
- The three most common areas in which both groups of trainees had received formal teaching were communication, teaching skills and patient safety.
- The number of trainees receiving teaching in medical ethics fell from 45.9% of all trainees in 2010 to 28.5% in 2011.

Table 6.2 In which areas do trainees receive formal teaching after leaving medical school?

	Foundation trainees (n=13,228)	Specialty trainees (n=33,440)
Patient safety	8,277 (62.6%)	13,694 (41.0%)
Communication	7,655 (57.9%)	20,898 (62.5%)
Teaching skills	5,322 (40.2%)	17,127 (51.2%)
Team working	5,251 (39.7%)	13,311 (39.8%)
Medical ethics	5,194 (39.3%)	8,126 (24.3%)
Leadership	3,484 (26.3%)	11,935 (35.7%)
Appraisal skills	2,987 (22.6%)	9,658 (28.9%)
Time management	2,265 (17.1%)	3,831 (11.5%)
None of the above	1,307 (9.9%)	4,463 (13.3%)

We asked a series of questions about trainees' access to different learning opportunities. In most cases, the answers were very similar to 2010.

- 66.7% of trainees were leading or helping on one or more clinical audits, compared with 65% in 2010; and 13.8% had no involvement, compared with 14% in 2010.
- 73.1% had access to relevant e-learning material, compared with 69% in 2010; and 23.1% were not aware of any such material, compared with 26% in 2010.
- 44.6% said they had the opportunity to learn with other healthcare professionals on a monthly, weekly or daily basis, compared with 44% in 2010; and 55.4% said they never or rarely did this, compared with 56% in 2010.
- 67.1% said they found it easy to access library services in their current post, compared with 67% in 2010; and 9.1% found it difficult, compared with 10% in 2010.
- 67.8% said the library covered the areas they needed to follow their curriculum, compared with 68% in 2010.
- 86.6% had access to internet at work for training purposes, compared with 86% in 2010.
- 31% had the opportunity to be involved in research, which was the same as in 2010; and 49.1% said they did not have the opportunity and might have been interested, compared with 51% in 2010.
- 32.4% had undergone procedural skills training using a simulator, compared with 30% in 2010 (these figures exclude the 13.9% who said this was not applicable to their post).

We also asked trainees about their access to study leave and courses.

- 68.2% of trainees said they had no difficulty obtaining study leave, compared with 66.5% in 2010. As in 2010, the most common reasons were difficulties due to local rota policies, fixed leave patterns and failure to find prospective cover.
- 53.4% rated as good or excellent the encouragement they received for taking study leave, compared with 53% in 2010.
- 67.5% said no leave was deducted from their annual allowance for taking compulsory training, compared with 68% in 2010.
- 53.8% were able to access funds to cover the cost of all courses recommended for them to complete, compared with 53% in 2010.

Access to organised courses and study leave varied widely.

- Over 90% of all trainees took part in organised educational activity every week.
- Most had between one and three hours a week.
- 18.2% of trainees said they received no days of study leave.
- 67.7% had between one and ten days' study leave.

Three-quarters of trainees discuss their career plans with a senior colleague

- 69.0% of trainees said they discussed their career plans with a senior colleague and that it was useful, compared with 70% in 2010.
- 11.3% said they had not needed to discuss their plans, compared with 10% in 2010.

Most trainees want to stay in the same deanery after training

- 64.1% of trainees said that after they completed their training, they wanted to work in the same deanery where they currently worked.
- 18.2% said they wanted to work in another deanery.
- 13.7% said they did not know.
- The remainder wanted to work abroad.
- Answers differed by less than 1% compared with 2010.

In the next 12 months, most trainees are aiming to continue training

- 80% of trainees said that in the next 12 months, they wanted to continue their training or apply to continue their training.
- 9.8% were ready to take up a consultant or GP post.
- 0.4% were planning to leave medicine permanently.
- The remainder were planning to leave medicine temporarily, go into research or go abroad to work in medicine.
- Findings were unchanged from 2010.

Most trainees becoming consultants or GPs feel prepared

The survey asked the 4,566 doctors coming to the end of their training whether they felt ready to take up a GP or consultant post.

- 85.3% said they felt ready to take up a GP or consultant post, compared with 84% in 2010.
- 6.4% said they did not feel ready, compared with 6% in 2010.
- 8.4% said they did not know, compared with 10% in 2010.

Of the 290 trainees who did not feel ready, they felt least prepared to plan and manage the service and to deal with managers (Table 6.3), which is the same finding as in 2010.

Table 6.3 For trainees not ready to take up a consultant or GP post, in which areas do they feel least prepared?

Trainees could respond that they felt unprepared in more than one area.

	Trainees who feel unprepared (n=283)
Planning and managing the service	212
Dealing with managers	146
Leadership	120
Clinical	111
Building a team	59
Training juniors	48
Dealing with colleagues	25

Preparedness for practice has changed little in the past year

There has been little or no change from last year in the extent to which trainees felt they are being adequately prepared for practice. Most rate their practical experience highly and feel confident about acquiring the necessary competences, and the majority rate the quality of their induction as good or excellent. Over 90% of trainees discuss their educational objectives with their supervisors, and most have undertaken formal education since leaving medical school participated in organised educational activity every week, and are actively encouraged to take study leave. Most of the resources that underpin high quality education – such as well equipped, accessible libraries, e-learning and the internet – are in place. Most trainees plan to continue their training and want to remain in their current deanery after training, and most of those nearing completion of their training feel ready to take up the role of consultant or GP.

At the same time, too few have the chance to be involved in research or to work alongside other professionals on a regular basis.

The slightly worse perceptions of foundation trainees may reflect the uncertainty they face at this stage of their training as new doctors. But they may also underline the variation in foundation programme experiences reported in this report and by the Collins review.[7]

The fact that the data have not, by and large, changed over the course of a year should not come as a surprise. The issue of preparedness is one of the most complex facing medical education as a whole and at all transitions between stages of training – it is about making sure doctors are not just competent but also confident to undertake their current role and move to the next stage of their career. The data we present here, and elsewhere,[5] indicate that most doctors trained by the current education system do practise well and safely. But some do not and there is still much to be done to address this. The challenge is to make improvements at a time of rapid change in medical education, reorganisation of the NHS, the pattern of health service delivery and patient expectations. There is no quick fix, although the issue remains one of the most serious: patients have a right to be treated by doctors who are competent, safe and confident.

Preparedness is a key focus of our strategies

Over the last three years, there has been a sharper focus on the issue of preparedness across all stages of medical education and training. Research undertaken by Professor Jan Illing,[14] as part of our review of *Tomorrow's Doctors*[15] has informed development of a more robust set of standards and requirements across a range of practical and non-clinical skills, among others, prescribing, team working and communication.

We have built on *Tomorrow's Doctors*[15] and *The New Doctor*[16] to publish *The Trainee Doctor*,[6] covering the standards for foundation and specialty training, and *The state of medical education and practice in the UK 2011*.[5]

Preparedness is a key underlying theme of our education strategy for 2011–13.[9] This sets out how we will develop outcomes of medical education and training that are clearer, coherent and complementary across all stages, with clear progressions between the various stages. We will define the outcomes required to complete the second year of the Foundation Programme by the end of 2011, and have begun to consider generic outcomes for postgraduate training, including a review of the specialty curricula. By early 2012, we will have completed our review of equivalence routes to the specialist and GP registers, and will consult on proposals for change. This is all relevant to preparing doctors for independent practice as consultants and GPs.

This is why we must make sure that the transition from undergraduate, through foundation to specialty training is through a spiral of learning which builds progressively at each stage.

Transition from student to doctor

In addition to the revised edition of *Tomorrow's Doctors*,[15] we published supplementary advice on clinical placements for medical students.[17] This sets out what medical students can expect from their placements and student assistantships, particularly in their final years as students. The advice also explains the relationship between student assistantships, induction and shadowing.

88.3% of F1 trainees now have the opportunity to shadow their first placement before starting work. Pathiraja and Outram[18] note the importance of this transition.

'*Being prepared for practice is a critical success factor in the transition from student to doctor, and shadowing can help facilitate a smooth transition by familiarising new F1 doctors with their hospital, ward, and clinical team, and by addressing their major concerns. Furthermore, understanding the first day competences of an F1 doctor allows appointees to benchmark their abilities against the required standard. This is of enormous value for the first few months as a new doctor.*'

Financial impact

The fact that most of the data have remained steady at a time of financial austerity – when history teaches us that the training budget is one of the first to be cut – is encouraging but needs to be kept under very close review. We expect local education providers to provide planned managerial support, treat medical education as a board level consideration, and provide educational resources and facilities.

We have already warned that training must be properly funded in our 2011 report *The state of medical education and practice in the UK 2011*.[5]

'Wider resource constraints and the need for health systems to find efficiency savings may also have a damaging impact on the training of doctors throughout their careers. We need to ensure that training is properly funded, and that it is clear what money is being spent for what outcomes. Training is expensive and, at a time when money is tight, it is more important than ever that that expenditure can be accounted for and protected. Funding for education and training should be transparent, follow the trainee, and set against robust and agreed measures of quality, which link directly to the standards set and data required.'

Future shape of training

We are among those contributing to a steering group set up by MEE to review the current variable standards and recommend a national shadowing strategy.

Clearly there is much to be done to improve preparedness and to capture trainees' experiences and outcomes. To this end, we will explore how we might in future extend the scope of surveys, including looking at the experiences of staff grade and associate specialist doctors, recently qualified doctors, and consultants and GPs to assess how well their medical education prepared them for their new responsibilities. At that stage we will go on to consider whether the survey should cover all doctors holding a licence to practise.

Annex:

Use of the trainee survey by NHS Education for Scotland

This annex has been written by Stewart Irvine, Deputy Director of Medicine at NHS Education for Scotland (NES). It looks at how the findings of the trainee surveys have been used from the perspective of an organisation providing medical education and training.

Survey results used to drive improvements

The release of the GMC survey results is a major event in the national quality management calendar, and its results are a key starting point for NES deanery processes of triangulating with other sources of evidence and action planning.

At a national level, the survey indicators are grouped according to whether they look at:

- patient and trainee safety (and therefore require the most urgent attention)
- quality of the educational environment
- educational process.

The underpinning data are then used to generate tables of red and amber flags (signifying areas of potential concern) and green flags (signifying areas of potential good practice) for each indicator score, summarised for each NHS board, local education provider, training level and specialty, and showing trends compared with the previous year's data. Additionally, the GMC's postgraduate trainee survey data is combined with locally derived undergraduate survey data. These summary reports are then distributed to board chairs and chief executives, as well as to directors of medical education and training programme directors, and have proven very effective for drawing attention to areas of good practice and areas of concern across NHS Scotland.

NES also make extensive use of the anonymised raw data from the GMC to undertake detailed analyses of the key issues at a national level, and to provide reports and commentary to the Scottish Government and to the Scottish specialty training boards.

At deanery level, the flags generated by the survey are fully explored using the GMC's survey tool, but then are further triangulated against:

- the results of the previous year's survey
- outcomes of any previous investigations
- reports and comments from training programme directors and directors of medical education
- the NES post-assessment questionnaire.

Importantly, NES seek to identify and share good practice, as well as to properly explore and understand areas of concern.

On the basis of this triangulation and use of formal action planning algorithms, actions are assigned to each flag in the full confidence that the best use has been made of all available data. These actions also allow a spread of investigation, from the more involving nature of a visit, through to a focused enquiry or check, or to simple ongoing monitoring.

The blend of visits and structured enquiries allows deanery and service resources to be appropriately channelled to the areas of greatest need, while still ensuring that all areas of concern are being addressed.

When applied to the high-profile and publicly available results of the GMC's surveys, this process is proving highly effective and efficient for identifying the genuine issues and driving the improvements necessary to address them. The following case studies, provided by colleagues across the NES postgraduate deaneries, show this process in action.

For the future, NES sees a pressing need to review the questions used by the survey to ensure its continued value and relevance to the GMC's standards, while seeking to limit its extent. Similarly, there is an urgent need to review the current norm-referenced approach to the generation of outliers and, replace this where possible with a criterion-based approach.

Case study: foundation training

In the 2010 key findings report, there were many red flags in foundation training, most notably in general medicine and general surgery. There were difficulties in clearly identifying a local consultant responsible for foundation trainees in these specialties in some locations. As a result, a process was developed under which Foundation Programme directors assumed responsibility for a portfolio of specialties. The Foundation Programme director works with a consultant lead for foundation training within the specialties. This joint working has led to increased awareness of foundation trainee issues and to improvements in services. These changes additionally involve the service clinical leads and the associate director of medical education for the local education provider. Local feedback suggests that there has been improvement, although we await the GMC's survey results for 2011 to confirm this.

Case study: induction

Departmental induction can vary widely in terms of content, quality and organisation, but it is a very important part of a trainee's experience.

The quality management team share examples of best practice in this one clinical area. The GMC's survey results are used to identify all programmes that have received green flags for induction. The flags can then be fully investigated to identify those which relate to departmental induction as opposed to hospital induction. We then contact the programmes directly to request further information or copies of induction programmes or documentation. These are then circulated more widely to the training programme director group within the deanery, and are sent directly to programmes that have received red flags for induction.

Case study: undermining

Trigger issues

The 2009 trainee survey identified possible concerns in one unit for both foundation and higher trainees in several areas:

- consultant undermining and a culture of undermining generally
- handover
- inappropriate consenting
- WTR compliance
- workload and work intensity
- availability and quality of local teaching.

Deanery's action and recommendations

The deanery triggered a rapid response visit in mid-2009 to meet with the cohort of trainees who had completed the survey. Trainees were told they could contact a nominated deanery representative in confidence to raise any concerns. All educational supervisors and senior medical staff in the unit completed a pre-visit survey. The visit team met with trainees, consultant trainers, the medical director, the director of medical education, and the local Foundation Programme director.

The concerns about workload, clinical supervision (consenting), teaching and undermining were substantiated during meetings with trainees. The team also learned that trainees had been approached by senior staff before the visit and asked what they had said in the survey.

The deanery report recommended:

- WTR monitoring
- protected teaching time for foundation trainees and increased specialty content in their teaching
- more formal teaching for middle grades
- a review of consent protocols
- urgent attention to known problems with undermining in one clinical area
- review of the ratio of trainees to educational supervisors.

Separately from the formal report, the visit team leader also privately discussed the behaviour of particular consultants with the medical director.

Department's response

- Full training of all educational supervisors and appointment of additional educational supervisors
- Medical director undertook one-to-one meetings with consultants reported to be undermining trainees
- Numerous measures to reduce F1 workload, including the appointment of additional F1 doctors and a business case for appointment of advanced nurse practitioners
- Review of hospital at night procedures to ensure access to middle grade advice for juniors
- Increase in teaching with pagers handed in
- Increased provision of weekly teaching and monitored attendance
- Content of foundation teaching addressed by director of medical education and Foundation Programme director
- Nurse manager addressed undermining in one area

Indicators of improvement

- Only one red flag in the 2010 trainee survey (difficulty taking study leave)
- No reports of undermining in the deanery's post-assessment questionnaire (2010)
- Very positive GMC visit to the specialty programme in April 2010

Case study: wide ranging issues

Trigger issues

There were identified, ongoing concerns within a department, but the 2009 trainee survey specifically raised concerns about:

- clinical supervision
- overall satisfaction
- workload and work intensity
- WTR
- redistribution of tasks
- educational supervision
- access to educational resources
- other learning opportunities
- adequate experience
- feedback
- hours of education
- local teaching
- induction.

Deanery's action and recommendations

The deanery visited the department in November. The usual pre-visit arrangements were made, including completion of trainee and trainer surveys, and the director of medical education provided a substantial file of information relating to the issues of concern.

- Concerns with clinical supervision were substantiated.
- Most specialty trainees said they would not recommend their post.
- Working time issues were substantiated.
- Redistribution of tasks was substantiated, with many assessment duties going to advanced nurse practitioners.
- Lack of adequate experience was substantiated for specialty trainees, including a lack of opportunity to do workplace based assessments.

The deanery report recommended:

- anonymised trainee assessment of all consultant clinical supervisors
- urgent attention to shift times to allow overlap for handover
- investigation into work balance between F1 trainees and advanced nurse practitioners
- increased rigour in delivering and documenting departmental inductions
- each trainee to be rostered for at least one clinic per week with consultant supervision
- urgent attention to timing of ward rounds to allow trainee attendance.

Department's response

The director of medical education provided a very detailed response to the deanery's visit report. Reconciling this response with the deanery's recommendations required an additional meeting between the director of medical education and the associate dean for quality to agree a final set of recommendations and an update on actions already underway or completed. These included:

- an audit of the quality of clinical supervision during on-call periods
- introduction of a clinical supervisor appraisal tool in which trainees name and appraise their consultant clinical supervisors
- discussions launched to redesign rota to allow for shift overlap and ward rounds
- audit of work balance between foundation trainees and advanced nurse practitioners
- documented specialty departmental induction
- greatly improved clinic attendance.

Indicators of improvement

- Number of red flags greatly reduced in the 2010 trainee surveys
- The deanery's GMC survey analysis and action planning identified the need for only one enquiry into one specialty training area, which the director of medical education is undertaking
- Positive GMC visit to the Foundation Programme in April 2010 (teaching quality commended)

Case study: **patient safety**

Trigger issues

The 2009 trainee surveys highlighted possible concerns in:

- clinical supervision in F1
- consultant undermining F1 trainees
- clinical supervision in specialty training
- adequate experience in specialty training
- overall satisfaction
- induction for specialty training
- overall satisfaction in specialty training
- feedback in specialty training.

Deanery's action and recommendations and department's response

The concerns raised in the trainee survey triggered a visit from the deanery in late 2009. Through meeting with trainees, the team was able to discount the concerns relating to consultant undermining and the specific concerns in one specialty.

However, discussions revealed other concerns among the junior doctors. A major restructuring of staffing and the management of acute care had failed to bring the expected benefits, and both junior and senior doctors were raising serious concerns about patient safety and work intensity.

The dean wrote immediately to the medical director to highlight these concerns and to pass on the recommendations which has been made by the trainees themselves. The medical director provided a detailed response to all concerns and an assurance that ongoing work to implement the new care model would be undertaken in conjunction with the doctors in training.

The deanery recommended a second visit, which happened in early 2010. The report from this visit noted 'a very substantial improvement in the training experience for junior doctors in the department since the last visit'.

Indicators of improvements

- F1 trainees removed from isolated clinics and increased use of advanced nurse practitioners
- Increased length of ward attachments for F1 trainees and increasing contact with consultants
- Introduction of team-based working with very positive reports from F1 trainees
- Improved and documented departmental inductions
- Several substantial improvements in acute care, which had greatly increased the trainees' confidence regarding patient safety
- Specialty and GP trainees also reported a substantial improvement in their training experience

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National training survey 2011

Key findings

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