

# National training survey 2013: key findings

Each year, we ask every doctor in postgraduate training what they think about the quality of their training. The survey has an impressive response rate – 97.7% this year, up from 95.0% in 2012.

The survey helps to make sure that medical education and training is meeting the standards we set to support high-quality medical care across the UK. The results support postgraduate deans, medical royal colleges and faculties, and local education providers to recognise aspects of training that work well and areas that can be improved. Deans manage local responses to the survey results and report back to us on the action that has been taken. Medical royal colleges and faculties contribute to the survey by providing specialty-specific questions which inform curricula development and help deans to manage training programmes.

Doctors in training provide a great deal of frontline care to patients. They can play a key role in ensuring patient safety by raising concerns if they feel that patients are at risk. Last year, we investigated every patient safety concern raised in the survey by doctors in training – we are doing the same this year. This year

the proportion of doctors in training raising a concern was 5.2% of the population and this is in line with last year.

The survey data is just one source of information about the quality of medical education and training and should be seen alongside other data. Where necessary, information from the survey should be followed up locally with detailed investigation.

This report gives an overview of the main findings of this year's survey. Overall, the 2013 survey shows improvements in the quality of educational supervision and induction to the workplace. Concerns continue in some areas including feedback received from senior clinicians about performance and work patterns that leave doctors feeling fatigued when at work. The quality of handover has improved although the overall rating has changed little. To read the detailed survey results, go to [www.gmc-uk.org/nts](http://www.gmc-uk.org/nts).

## What is different about the national training survey in 2013?

After last year's focus on improving reporting and increasing the reliability of our data, we kept changes to questions in this year's survey to a minimum. No published indicators\* were changed, which has made it easier to compare and identify trends over several years.

For this year's survey, we included some pilot questions. These have not been used for indicators in the reporting tool or reported on in this report.

\* An indicator is a combination of responses to questions about a subject area within the survey. There are 12 indicators in the reporting tool.

However, we will analyse the results of these questions and potential new indicators before deciding whether to use and report on them in 2014. The areas under development are:

- clinical supervision out of hours
- multi-site working
- clinical environment
- socio-economic status (to inform our work on widening access to medicine and student selection).

In previous years, we have published an indicator on undermining (including bullying). This year, we removed the indicator from the online reporting tool, because it became clear that its results could be misleading. Instead, we will publish our analysis of the responses to the questions on undermining this autumn.

We take bullying and undermining very seriously – they are unacceptable in medical training. We share anonymised responses about these with deans, who investigate concerns and tell us what action has been taken. These actions are published on our website in the deans' biannual updates and can be found at [www.gmc-uk.org/education/medical\\_school\\_reports.asp](http://www.gmc-uk.org/education/medical_school_reports.asp).

We have again given doctors in training the chance to tell us of any concerns they have about patient safety in their training environment. We have made changes to this question to collect more detailed information so they can tell us if the concern has already been resolved or if it is a new concern.

Our team of medical experts review every comment on patient safety. This helps postgraduate deans, and local education providers to set priorities for the most urgent concerns. This autumn, we will publish analysis relating to patient safety, clinical environment and clinical supervision out-of-hours.

We have also improved the reporting tool, which we introduced in 2012. It now allows all users to produce reports for individual education sites (not just trusts or boards) and to compare 2012 and 2013 results.

Our website will host a series of short, instructive videos, to show users how to produce certain types of report. To see the videos, go to [www.gmc-uk.org/nts](http://www.gmc-uk.org/nts).

We can now publish aggregated over years data. This means that information about the quality of training at locations where the number of doctors training in a specialty is fewer than three, will be available from August 2013, by combining the 2013 and 2012 survey responses.

## Who did we survey?

We surveyed the following doctors in training:

- foundation
- core
- higher specialty, including general practice and specialist registrar
- fixed term specialty training appointments and locum appointments for training
- military – working within the service on approved programmes
- clinical lecturers and academic clinical fellows in approved posts
- those working for non-NHS organisations, for example, pharmaceutical medicine, occupational medicine and palliative medicine.

Doctors in training were asked about the post they were in on Tuesday 26 March 2013. The survey was open from 26 March to 8 May 2013.

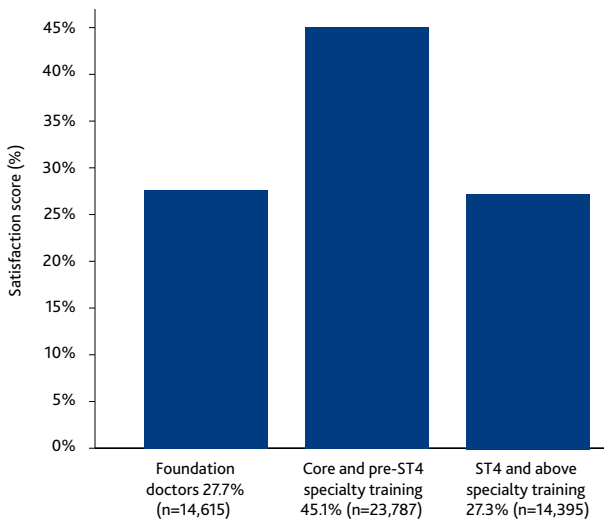
## Who answered the survey?

This year, 52,797 doctors in training completed the survey out of 54,055 who were eligible, giving a response rate of 97.7%.\* This compares with 95.0% in 2012 and 87.0% in 2011 and is the highest response rate since the survey began in 2006.

\* Not all trainees answered all questions, so we have given the total number of doctors in training with valid answers in parenthesis for each key finding. We excluded answers that were not applicable from the analysis. All percentages and scores have been rounded to one decimal place.

The response rate by deanery ranged from 100% to 90.2%.

**Figure 1: Proportion of respondents by training level group (n=52,797)**



55.0% of respondents were female and 45.0% were male (n=52,797).

9.1% said they were in less than full-time training (n=52,797). Of these, 86.4% were female and 13.6% were male.

Doctors in training were asked if their day-to-day activities were limited because of a health problem or disability that has lasted, or is expected to last, at least 12 months. 1216 doctors in training (2.4%) said their day-to-day activities were limited a little or a lot (n=51,433). This compares to 2.0% in 2012.

Of those reporting a health problem or disability that limited their activities, 441 (36.3%) said that they need adjustments to be able to carry out their work 48 (10.9%) of those said that the adjustments they need have not been made.

## Overall satisfaction with training

To measure overall satisfaction with training, we asked doctors in training about five aspects of their current post:

- how they rate the quality of teaching
- how they rate the clinical supervision they receive
- how they rate the experience they gain
- how they would describe the post to a friend who was thinking of applying for it
- how useful the post will be for their future career.

These five items make up the overall satisfaction score, which is a proxy measure for the quality of training.

The overall satisfaction with training score was 80.8 out of a possible 100 compared with 80.4 in 2012 and 78.8 in 2011.

- 65.6% rate the quality of teaching in this post as excellent or good (n=52,484).
- 82.6% rate the quality of clinical supervision in this post as excellent or good (n=52,484).
- 81.7% rate the quality of experience in this post as excellent or good (n=52,484).

- 73.8% would describe this post to a friend who was thinking of applying for it as excellent or good (n=52,484).

- 79.3% feel this post will be very useful or useful for their future career (N=52,484).

Across all five items, 1.9% or less gave these items the poorest rating (very poor), compared with 1.6% in 2012, 1.8% in 2011 and 2.3% in 2010.

Figure 2 shows overall satisfaction for doctors in training by training level group. Doctors in training report higher satisfaction levels the further they are into training and overall satisfaction has increased for all training level groups since last year.

**Table1: Satisfaction score by training level group (n=52,484)**

	Score	N
Foundation (F1 and F2)	77.7	14459
Core and pre ST4 specialty training	81.2	23710
ST4 and above specialty training (ST4 – ST8)	83.2	14315

The 2013 survey shows that doctors in training in general practice posts are the most satisfied, which has remained the same over previous surveys.

Those in surgery posts are the least satisfied, but the score for surgery posts continues to rise from 69 in 2006 to 77.1 in 2013.

Table 2 shows the overall satisfaction score by the specialty in which the doctor in training was

working at the time of the survey, irrespective of their programme specialty and eventual career destination. For example, the score for general practice posts includes foundation doctors in general practice posts.

**Table 2: Doctors in training satisfaction in different post specialties**

	2013 Number of doctors in training	2013 Average satisfaction score	2012 Number of doctors in training	2012 Average satisfaction score
General practice posts	5989	87.9	5586	87.8
Anaesthetics posts	4614	84.8	4441	84.4
Ophthalmology posts	674	84.2	682	83.7
Radiology posts	1545	83.7	1501	83.4
Pathology posts	686	83.4	723	84.8
Psychiatry posts	3857	83.0	3814	82.4
Paediatrics and child health posts	4445	82.5	4296	81.2
Pharmaceutical medicine posts	111	82.1	----	----
Public health posts	242	82.0	232	83.1
Emergency medicine posts	3006	80.7	3027	80.8
Occupational medicine posts	67	79.5	70	81.8
Medicine posts	14621	77.9	14198	78.0
Obstetrics and gynaecology posts	3067	77.6	3062	77.5
Surgery posts	9560	77.1	9458	76.2

## Educational supervision

We measured the quality of educational supervision by asking doctors in training about the support they were getting from their educational supervisor.

- 99.2% said they had a designated educational supervisor (the person responsible for appraising their educational progress) (n=52,278) compared with 98.8% in 2012.
- 87.8% said they had a training or learning agreement with their educational supervisor,

setting out respective responsibilities (n=49,263) compared with 82.5% in 2012.

- 94.4% reported using a learning portfolio (n=50,891) compared with 89.5% in 2012.
- 85.4% said they were told who to talk to in confidence if they had personal or educational concerns (n=48,931) compared with 76.6% in 2012.

All measures of the quality of educational supervision have increased since 2012.

## Clinical supervision

We measured the quality of clinical supervision by asking doctors in training about their clinical supervisor, whether they felt forced to cope with clinical problems beyond their competence or experience, and if they have been expected to obtain consent for procedures where they felt they did not understand the proposed intervention and its risks. A

question on the quality of clinical supervision is part of the overall satisfaction measure and is reported above.

- 85.9% said they always knew who was providing their clinical supervision when they were working and they were accessible, compared with 85.1% in 2012. 6.7% said they knew, but their clinical

supervisor was not easy to access, and 0.3% said there was no one they could contact (n=52,188).

- 94.5% said they were rarely or never supervised by someone who they felt wasn't competent to do so (n=52,373), compared with 94.6% in 2012.
- 5.5% said they were supervised by someone who they felt was not competent to do so: 0.9% on a daily basis, 1.8% on a weekly basis, and 2.8% on a monthly basis (n=52,373).
- 85.0% said they rarely or never felt forced to cope with clinical problems beyond their competence or experience, compared with 84.7% in 2012. Of the 15.0% who said they felt forced to cope with such problems, 0.9% said this happened on a daily basis, 5.2% on a weekly basis, and 8.8% on a monthly basis (n=52,373).
- 95.9% said they have rarely or never been expected to get consent for procedures where they felt they did not understand the proposed interventions and its risks. 0.3% said they were expected to do so daily (n=43,281).

## Feedback to trainees on their performance

We asked questions about feedback that doctors in training had been given. Specifically, this included the quality of informal feedback from senior clinicians, formal meetings with supervisors to talk about progress in the post, and formal assessment of performance in the workplace.

- 31.6% reported that they rarely or never had informal feedback from a senior clinician on their performance (n=52,484). This compares with 32.7% in 2012.
- 65.0% had a formal meeting with their supervisor to talk about their progress in the post and found it was useful. 7.8% had a meeting, but said it wasn't useful (n=52,484).
- 63.2% had a formal assessment of their performance in the workplace in this post and found it useful. 6.7% had a formal assessment but said it wasn't useful (n=52,484).

## Adequate experience

We asked doctors in training about the practical experience and competencies they were getting from their post.

- 75.2% rated the practical experience they were receiving in their post as excellent or good (n=52,484) compared with 74.0% in 2012.
- 81.2% said they were very or fairly confident that their post will help them acquire the competencies they need at this stage of their training (n=52,484) compared with 80.5% in 2012.

## Handover

To measure the quality of handover – which is important to ensure continuity of care for patients – we asked about arrangements before night duty and after night duty.\*

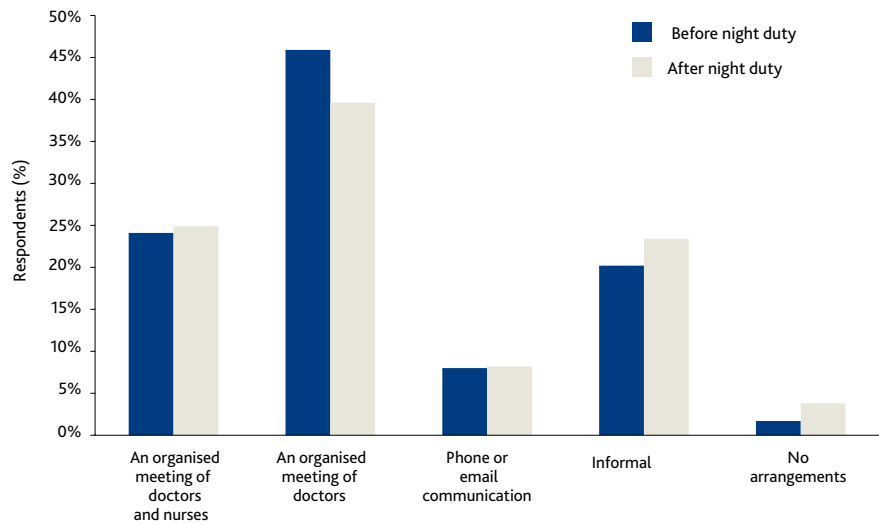
- 45.9% said that in this post, the handover arrangements before night duty were best described as an organised meeting of doctors; 24.1% said an organised meeting of doctors and nurses; and 8.0% said a phone or email communication. 20.2% said the handover arrangements were informal and 1.7% said there were no arrangements (n=34,237).

45.9% said that in this post, the handover arrangements before night duty were best described

\* Responses from doctors in the following post specialties were excluded: Allergy, Audio vestibular medicine, Clinical genetics, General practice, Neuropathology, Paediatric pathology, Histopathology and Occupational medicine.

39.6% said that in this post, the handover arrangements after night duty were best described as an organised meeting of doctors; 24.9% said an organised meeting of doctors and nurses; and 8.2% said a phone or email communication. 23.4% said the handover arrangements were informal and 3.8% said there were no arrangements (n=35,086).

**Figure 2: Handover arrangements before night duty (n=34,237) and after night duty (n=35,086)**



## Induction

We asked questions about the quality of induction to the workplace, which is important for patient safety. We asked doctors in training to rate the quality of induction to the organisation they work in. We also asked whether they received information about their workplace and whether their role, responsibilities and educational objectives were discussed when they took up their post.

- 65.3% said they would rate the quality of induction to the organisation in this post as excellent or good (n=52,484).

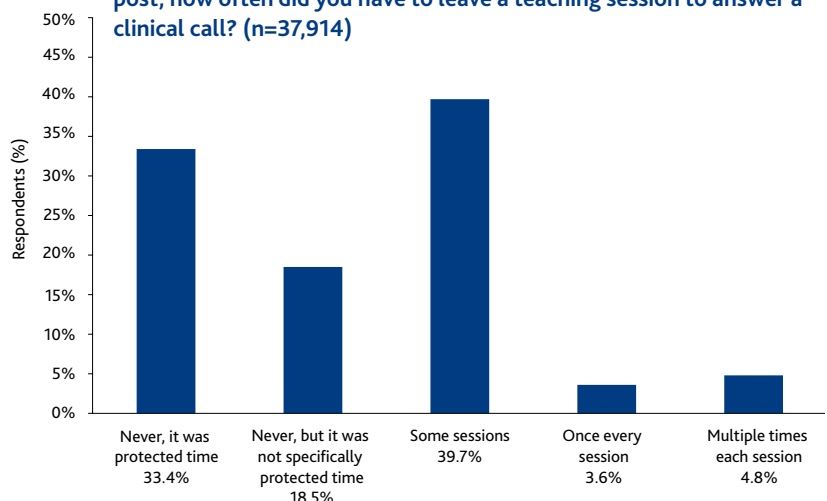
- 85.0% of trainees said they got all the information they needed about their workplace when they started working in this post (n=49,885). This compares with 80.2% in 2012.
- 90.2% said someone explained their role and responsibilities in the unit or department at the start of this post (n=50,662). This compares with 86.5% in 2012.
- 93.0% said they sat down with their educational supervisor and discussed their educational objectives for their post (n=51,667). This compares with 91.7% in 2012.

## Local teaching

We asked doctors in training about the teaching provided locally or in their department,\* including who was providing the teaching and the extent to which the teaching session was protected time.

67.7% said they would rate the quality of local or departmental teaching as excellent or good (n=37,914).

**Figure 3: When attending these local/departmental sessions, in this post, how often did you have to leave a teaching session to answer a clinical call? (n=37,914)**



\* Departmental teaching is in the department where the doctor in training works. Local teaching might take place within the trust or site where the doctor in training works.

3.8% said local or departmental teaching was provided by other doctors in training without senior supervision; 10.5% said it was provided by other trainees with senior supervision; 59.6% said it was provided by both trainees and seniors; and 26.0% said it was provided by senior doctors (n=37,914).

Figure 3 shows whether local or departmental teaching sessions were protected time and, if not, how often a doctor in training had to leave a teaching session to answer a clinical call.

## Workload

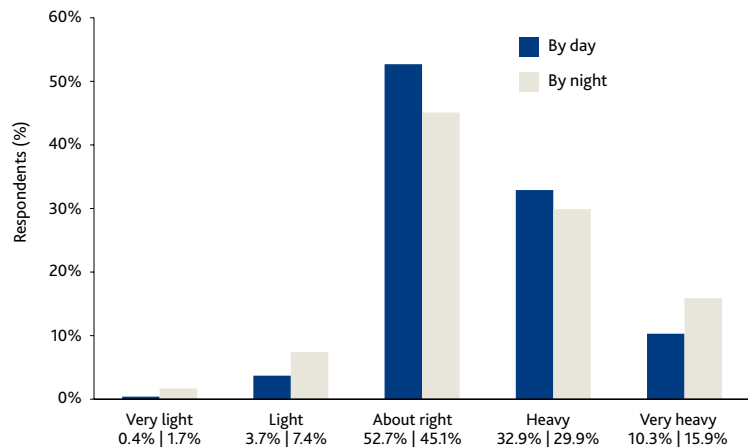
We asked doctors in training about their workload.

22.2% said their working pattern left them feeling short of sleep when at work, on a daily or weekly basis. 57.7% said it rarely or never left them feeling short of sleep when at work (n=52,373).

58.5% said they worked beyond their rostered hours on a daily or weekly basis. 28.8% said they rarely or never worked beyond their rostered hours (n=52,484).

Figure 4 shows how doctors in training rated the intensity of their work in their post, by day and, if applicable, by night.

Figure 4: Intensity of work by day (n=52,484) and by night (n=39,934)



## Other work to improve the quality of medical education and training

The survey contributes to our work to improve the quality of medical education and training in the UK. The Francis report into the care provided by Mid Staffordshire NHS Foundation Trust identified some areas of concern about the education and training of doctors.\*

While improvements have been made since the events at Stafford Hospital, we will do more work to improve the quality of medical education and training.

Last year, we began a comprehensive review into the way that we check the quality of medical education and training in the UK. We have started a review of our standards for training – as part of this review, we will consider the questions in the national training survey and the way that the results are reported.

We will publish an update on this work towards the end of 2013. We are now using focused check visits as a way of responding to specific risks. For example, shortly, we will be publishing a report of visits to seven emergency departments.

We published research on the impact of Working Time Regulations in early 2013. The research highlighted issues relating to the impact of rota design and working practices and how these can affect trainees' education and wellbeing.

We will ask those who deliver doctors' education and training to review the ways that they manage and monitor working patterns, so that rotas strike the right balance between training opportunities and clinical work. This project will include joint work with medical royal colleges and faculties, postgraduate deans, employers and doctors in training.

\* Report of the Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009, chaired by Robert Francis, QC.



It will highlight good practice, identify the working patterns and rotas that are most likely to lead to excessive fatigue, and review how Working Time Regulations compliance and working patterns are managed and monitored.

We are also working to identify professional skills that apply to all postgraduate specialty training curricula. Our focus is on strengthening the professional skills and behaviours elements rather than the clinical skills, which are already well defined in specialty curricula. The issues are particularly relevant to our broader work on professionalism.

Our new core guidance for doctors, *Good medical practice*, was published in March 2013. It is

supported by resources such as *Good medical practice in action* – an online resource, which includes scenarios for doctors in training.

This year, we have also begun the introduction of an approvals framework for all trainers of undergraduate and postgraduate learners. Trainers in four specific roles will be recognised by 31 July 2016.

We are working with our key interest groups to develop our surveys work programme for the next few years. The work programme will include consideration of a new survey of trainers and the potential for surveying other groups, including medical students. We aim to publish our plan by the end of 2013.

## Acknowledgements

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We are grateful to all our partners, including the postgraduate deans and the medical royal colleges and faculties and their staff, for their help with the

national training survey. We particularly wish to thank the doctors in training who completed the survey.