



General  
Medical  
Council

# National training survey 2014

concerns about patient safety

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Since 2012, we've asked doctors in training if they have any concerns about patient safety in their workplace. This report describes how we've dealt with these comments and takes a look at some of the main areas of concern raised this year. It also looks at reporting systems in more detail through a series of case studies.

- 85.0% of doctors in training who indicated a patient safety concern in this year's survey told us that these concerns were being addressed locally (n=5,088). This suggests that, on the whole, local reporting systems within local education providers (LEPs) work.
- However, our data also suggest that in some instances, local systems don't deal adequately with patient safety issues. For example, some doctors in training told us negative stories about their experiences of raising concerns at their workplace. In this report, we explore some of this information and outline the action that we intend to take.
- We received 404 patient safety comments this year – down from 2,746 in 2013 and 2,444 in 2012. Part of the reason for this reduction is because we made some changes to the way that respondents can submit a concern. For example, we gave much more guidance on what kind of information we need to take action on a concern. These changes meant that we've been able to tackle a greater proportion of the issues raised through the survey than ever before because the information respondents gave was much more specific.
- We support calls for a reporting culture underpinned by the values of openness and transparency – the prospect of underreporting due to fear of reprisal is something we take seriously. In addition to our ongoing work to support those who raise concerns,\* we're developing the survey to capture information that will let us build a broad picture of the ways that concerns can be reported at LEPs across the UK. This will help us identify where there are problems and where things already work well.

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\* See our guidance *Raising and acting on concerns about patient safety*, available at [www.gmc-uk.org/guidance/ethical\\_guidance/raising\\_concerns.asp](http://www.gmc-uk.org/guidance/ethical_guidance/raising_concerns.asp). Our Regional Liaison Service offers workshops with doctors around the UK on the theme of reporting concerns. We have recently commissioned a review of the way we work with and support whistleblowers, available at [www.gmc-uk.org/news/25306.asp](http://www.gmc-uk.org/news/25306.asp). This is discussed further below.

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# Introduction

The national training survey was developed as an educational tool to measure the perceptions that doctors in training have about their training environments.\* It was not primarily designed as a whistleblowing tool, though it has become an important place for doctors in training to raise the alarm where they feel that local reporting systems have fallen short.

This process is not designed to replace local reporting systems, which should always be used in the first instance. However, it does allow us to become aware of instances where local systems have not resolved issues.

Survey responses indicate that the majority of doctors in training either do not have any patient safety concerns in their posts (88.7%, n=47,069) or that they previously had patient safety concerns, but that these have been dealt with locally (9.6%, n=5,088).

Nevertheless, when local processes for addressing patient safety concerns have failed for one reason or another, doctors in training can use the survey to tell us about this.

When these issues are reported to us, we take action. This report includes a number of case studies that describe how patient safety issues reported through the survey are investigated and resolved.

## The experiences doctors in training have of local reporting systems

This year, we also collected some feedback on the experiences of doctors in training around local reporting. The responses we received were worrying; they often described concerns about the reporting and management of patient safety issues. In other instances, doctors in training were not being given basic information about how to raise concerns and who to report to. A notable theme that emerged was that some doctors in training do not have confidence in their local systems for reporting concerns, often down to a lack of feedback or too little transparency in the processes.

We want to introduce a number of test questions in future surveys to gather information to help us, deaneries, local education and training providers (LETBs) and LEPs identify poor reporting systems so that we can take action to make improvements.

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\* For more information on the background to the survey, see [www.gmc-uk.org/education/survey\\_background.asp](http://www.gmc-uk.org/education/survey_background.asp).

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# What do we do with patient safety comments raised through the national training survey?

We share every issue we receive with deaneries and LETBs who report back to us on the actions they are taking. We review these responses to make sure they are appropriate.

Working together with deaneries, LETBs and doctors in training across the year, we reviewed and modified the process deaneries and LETBs use to report back to us. This allows deaneries, LETBs and LEPs more time to carry out detailed investigations\* while making sure that the process remains robust.

## How we monitor progress

Depending on the type of issue, deaneries and LETBs can tell us about their progress using the twice yearly deans' reports† or, if more regular reporting is required, through enhanced monitoring‡.

Enhanced monitoring is a collaborative approach, which allows us, deaneries, LETBs and LEPs to work together and lets us keep close track of how problems are being addressed.

We continue to monitor each issue until it has been resolved. In this way, we can make sure that the problems that doctors in training tell us about lead to action and, more importantly, to solutions.

The following case study looks at enhanced monitoring in more detail. It highlights the work that goes into resolving issues through this route.

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\* Full details of the national training survey comments management process is in briefing note 4. Available at [www.gmc-uk.org/NTS\\_2014\\_briefing\\_note\\_4\\_comments\\_management\\_process.pdf\\_55481362.pdf](http://www.gmc-uk.org/NTS_2014_briefing_note_4_comments_management_process.pdf_55481362.pdf).

† Published on our website at [www.gmc-uk.org/education/annual\\_deanery\\_reports.asp](http://www.gmc-uk.org/education/annual_deanery_reports.asp).

‡ Details of published enhanced monitoring issues can be found on our website at [www.gmc-uk.org/education/enhanced\\_monitoring.asp](http://www.gmc-uk.org/education/enhanced_monitoring.asp).

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## CASE STUDY: Tackling longstanding problems in an anaesthetics department

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### We have been working closely with one deanery/LETB to support improvements and monitor progress.

Issues were first identified in the anaesthetics department of a busy hospital towards the end of 2012. The department was put into enhanced monitoring and a number of risk summits were organised, which we participated in.

There had been particular worries around the supervision of doctors in training at the site, particularly during out of hours. There were reports of undermining, leadership issues, rota pressures and of a lack of responsiveness to patient safety concerns. It was possible that anaesthetic doctors in training could have been removed from the site altogether as the department struggled for a number of years with wider cultural, leadership and financial challenges.

### We've seen positive changes

We accompanied the deanery/LETB on a visit to the department in autumn 2013 and again in July 2014. We were happy to see that a number of new appointments within the department had helped to start embed the cultural changes needed and we are starting to see a positive impact on training and education. It is clear that progress is being made, but we are keen to continue to monitor this to make sure the changes are sustainable.

We met with a number of doctors in training who told us that they felt supported and that they thought it was a good place to train. We were pleased to see that the 2014 survey results reflected the changing story, with the department receiving

much better results. For the time being, no doctors in training will be removed from the site.

However, problems do still remain, so we're supporting the deanery/LETB and LEP to make progress on these. Previous issues regarding the lack of supervision have now been replaced with doctors in training reporting too much supervision and not getting suitable independent experience. During our latest visit, we told managers at the LEP that doctors in training should have work lists of their own and increasing levels of responsibility, with consultants available if needed.

### Wider issues still need to be addressed

Educational resources were identified as a longstanding problem for the specialty and the LEP. The site is very dated and this is an issue they are tackling, but this will take time and money. There will be a requirement by the deanery/LETB that anaesthetic doctors in training must have an area where they can discuss confidential issues, have appraisals and talk with their educational and clinical supervisors, without interruption.

Handover remains a low scoring area in the survey. Doctors in training said handover was good in the intensive care unit but was lacking in obstetrics and gynaecology and when working with the surgical team. Again, we have advised that work lists of patients need to be prioritised in a routine and appropriate manner, potentially being led by the anaesthetic consultant.

Overall, the department is a work in progress, but it is an improving picture and we continue to work with the LEP and the deanery/LETB towards getting things back on track.

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## How are patient safety comments used to improve training?

All patient safety issues raised in the survey are investigated and reported on. These issues, along with the rest of the survey, are also used as an important piece of evidence when looking at the overall quality of training at an LEP.

We use survey information when deciding what areas and specialties to visit. For example, survey responses were used to determine which departments to visit as part of our emergency medicine checks in 2012 and 2013.\* This year, survey responses were used to identify where to visit as part of our undermining checks.†

The case study, *Triggered visits – a closer look at a visit to an acute medical unit* (on page 6), shows how deaneries and LETBs use survey data as part of their own quality management work. The survey is used as part of a suite of evidence that functions to escalate issues where there are problems and helps to generate the support needed to address them.

## What do we do with service issues raised in the survey that impact on patient safety?

Concerns about patient safety sometimes arise as part of a general service issue – such as an excessive workload, or inadequate staffing or resources. We can only take direct action on these concerns when they affect education and training. Where comments are made in the survey about service issues, we expect these to be investigated by the deanery or LETB. Where appropriate, they can share the information with system regulators, such as the Care Quality Commission.

Nevertheless, data from our national training survey can be an impetus to making service improvements. The case study, *Reporting patient safety issues that arise from problems with work expected of doctors in training* (on page 7), shows how patient safety concerns raised in the national training survey were found to relate to an inadequate phlebotomy service. This meant that treatment was delayed because patients often had to wait a long time for their blood test results.

Issues like this can have very real effects on patient safety because it means that doctors are spending their time covering routine tasks that could be carried out by other professionals, diverting them from the ward. A longer term consequence is that doctors in training end up carrying out repetitive, routine service tasks, which may affect their progress towards being a well-trained doctor in the future. The service provision/education balance is important and it is our priority that doctors in training learn how to manage this, and that they learn and develop in safe environments.

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\* See our emergency medicine checks report, available at [www.gmc-uk.org/education/23174.asp](http://www.gmc-uk.org/education/23174.asp).

† Throughout the autumn, we are carrying out a series of short, targeted check visits to investigate how concerns around bullying and undermining are being responded to. These will focus on obstetrics and gynaecology and on surgery. We will publish our report on these check visits in early 2015.

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## CASE STUDY: Triggered visits – a closer look at a visit to an acute medical unit

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### A staff member at one deanery/LETB explains how they make sure improvements are made following a triggered visit.

As well as visiting the key training sites of each training programme once every three years, our deanery/LETB quality management team also arranges triggered visits.

Triggered visits happen if concerns are raised – either through the national training survey or through other surveys of doctors in training, through previous visits, or by the training programme director.

A triggered visit to the acute medical unit of a busy LEP was made in January 2014. Feedback from the survey and visits to medical training programmes in 2012 and 2013 had uncovered concerns around length of rotations, patient safety, induction and undermining. Specifically, almost half of the free text comments recorded in the 2013 survey related to the acute medical unit and/or the wider medical floor.

Our visit team met with two enthusiastic groups of doctors in training who liked the breadth of clinical work available on the unit, but were concerned about the heavy workload and their educational experience. Consultants were aware of the majority of issues that doctors in training faced and were open to suggestions for change. They were keen to facilitate improvement wherever possible.

During the visit, the team commended the excellent levels of supervision available to doctors in training in

the unit. It noted that the unit followed nationally agreed guidelines in relation to high-level decision making, which were entirely appropriate for patient safety. The visit team agreed that patient safety was not, at that time, a concern, and acknowledged that many of the previously reported survey comments related to heavy workload and staffing issues rather than to specific incidents. The team found no evidence of doctors in training being subject to undermining or bullying behaviour at that time.

### Making sure recommendations are addressed

The final report included 18 recommendations, which were directed to appropriate personnel within the acute medical unit, trust, deanery/LETB or office of the director of medical education. All visit recommendations are logged on a quality management spreadsheet, which is checked and updated each month – those with assigned tasks are chased up as required. Recommendations that haven't been acted on are reported to the regional quality management group on a quarterly basis and can be escalated to the associate dean for quality and/or postgraduate dean for action.

Six months on from the visit, a number of the recommendations from the visit have been completed, but some are still being followed up by the quality management team. A sign of positive change is that the 2014 survey presented a significantly lower number of free text comments in general. But of the comments received, only two related to the acute medical unit.

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## CASE STUDY: Reporting patient safety issues that arise from problems with work expected of doctors in training

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### Here, the director of medical education at one LEP explains how they addressed issues raised through the survey.

Historically, the phlebotomy service in our hospital has been underfunded, recruitment has been difficult and sickness levels have been high. This has meant that the service has provided only partial cover with very limited out of hours provision. Doctors in training raised this as a significant concern in the 2013 national training survey.

The survey showed that on-call doctors were spending on average four hours taking blood on both weekend days. Doctors in training and senior clinicians recognised that this had an inevitable impact on patient management, workflow and patient safety.

In response, we implemented a comprehensive seven day working phlebotomy service. An additional £80,000 funds were added to the existing service. Now, six or seven phlebotomists cover all the wards at weekends and the weekday service has also been increased. We've launched an advert to recruit more personnel and introduced an active human resources policy to deal with long term sickness.

The changes introduced to the phlebotomy service – along with other urgent care improvement schemes that have been introduced – have meant that the hospital has been able to significantly increase the number of discharges we can make, which has greatly improved patient flow.

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# How did we change the patient safety questions for 2014?

Gathering and acting on sensitive information from potentially thousands of doctors in training is a necessarily resource intensive exercise – not least because the safety of patients is at stake.

We aim to continuously improve the effectiveness and efficiency of the process. Because of this, we introduced three main changes to this year's patient safety question.

## **Change 1: Greater encouragement to report locally**

This year we emphasised to doctors in training that the organisation where they were currently working was the most appropriate and effective place to raise a concern in the first instance. We told respondents that reporting to their LEP should be their first consideration.

If they chose to go on to raise a concern through the survey, we asked them to tell us why they were reporting an issue to us, rather than at their place of work. It's important to understand what leads

doctors in training to use the survey to raise concerns about patient safety. We need to know more about what is happening at the local level with reporting if doctors in training feel the need to flag their concerns up in the survey.

That said, we also know that doctors in training often use the survey to tell us about issues that are already under investigation. Information from deaneries and LETBs suggests that in the 2013 survey, around 80.0% of the issues raised were previously known about. Because of the way in which we investigate concerns, this can lead to duplication of resources and takes attention away from previously unreported and potentially urgent concerns. This year, we asked doctors in training to specify if, and where, the concern they were submitting had been previously reported. This is so that we could more effectively prioritise concerns.

Again, this raises questions about why doctors in training are going outside their LEP to report their concern. The reasons respondents gave when we asked them about this are discussed more fully on pages 19–21.

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## Change 2: More detailed comments

In 2012 and 2013, we received high numbers of patient safety comments in the survey. Although we shared all comments and made sure that they were appropriately looked into and reported on, not all comments could be adequately investigated. For example, many doctors in training didn't give enough detail to launch an investigation, or raised issues that were too general to resolve (for example, stating things such as 'not enough doctors').

This year, we gave much more guidance to doctors in training on the kinds of comments and details to share. We advised them to:

- include a clear description of the incident or process that gave rise to the risk, including location (for example: ward)
- use accurate and factual examples relating to their personal experience (not hearsay)
- avoid commenting on wider general service issues that don't relate to a specific incident
- suggest the improvements that they think would secure the safety of patients.

By changing the guidance in this way, we hoped to capture much more detailed, specific and actionable data.

Over half of the issues (60.0%, n=244) raised by doctors in training this year were either previously unknown, or were known about but provided new evidence to active issues.\* We believe our improved guidance added value to the concerns response process, though it is something that we will continue to improve for future surveys.

## Change 3: A more transparent process

This year, we amended the guidance we give to respondents when they make a patient safety comment – we wanted to be much more open and transparent about how comments are shared and investigated. We told respondents frankly that their anonymity in this part of the survey could not be guaranteed, since the safety of patients must come first and they may be called upon to assist in further investigations. However, we assured them that we would do everything in our power to support them through this process.

### There were fewer comments in 2014

Following these changes, respondents made far fewer comments this year than in previous years. In 2014, 0.8% of survey respondents raised a concern (404 comments). This is down from 5.2% (2,746) in 2013 and 4.7% (2,444) in 2012.

This reduction is welcome if it means that doctors in training are not reporting issues that we are already aware of, or if local reporting systems are dealing with more issues on the ground.

However, it is a concern if doctors in training don't feel confident to report a concern either to us or locally. To help us understand this better, we have been collecting feedback from doctors in training regarding the changes to our guidance, including their views on the confidentiality statement. We have found that while respondents appreciate the increased transparency in general, the prospect of foregoing complete anonymity has been offputting for some doctors in certain circumstances. The reasons for this are often complex, and these issues are discussed more fully on pages 15--16.

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\* It is important to note that the dean's report is a report by exception. Not all issues are escalated to the GMC via this route and some are monitored locally. Therefore, a new issue in this context refers to an issue not previously reported to us, rather than an issue that was previously unknown to the deanery/LETB.

# What were the themes of concerns in 2014?

This year, we reviewed each concern and categorised them using the same coding system that was used in the analysis of last year's comments. This let us compare the themes between the two years. However, due to the changes that we introduced into our process for capturing patient safety concerns, it is difficult to draw any firm conclusions about shifts in clusters of concerns. Nevertheless, we can see from the figure below that the themes follow broadly the same pattern as last year.

As in 2013, the majority of patient safety concerns raised by doctors in training relate to a lack of staffing or resources. It is perhaps unsurprising that service and economic pressures continue to have the greatest impact on perceptions that doctors in training have of patient safety and risk.

Problems with processes of care can refer to any concern about the individual treatment of patients, whereas problems with patient management refer to ways that patients are organised in a particular system and how they move through it.

Sometimes these are interlinked, for example with the issue in the issue of handover (see the case study on pages 22–23).

Figure 1: 2014 patient safety concerns by theme compared with 2013



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Linked to wider systemic pressures on resources and staffing are concerns arising from problems with the work expected from doctors in training. For example, doctors in training being put in situations where they are required to look after too many patients (see the case study below), often with inadequate levels of supervision.

Problems with working culture can refer to issues such as lack of communication between teams or issues with intimidation from more senior colleagues, management or other healthcare staff. We acknowledge, along with others, that bullying and undermining is a patient safety issue and we take this very seriously (see our 2014 report on bullying and undermining).\*

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## CASE STUDY: Raising concerns over patient safety due to out of hours workload

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### A GP doctor in training who was working in a surgical ward told us about his experience of reporting patient safety concerns through the national training survey.

The respondent had used the survey to express concern over the workload of doctors in training, especially during out of hours service.

He noted that this concern was well known and had been reported previously by other doctors in training to the department, but financial restrictions on the trust had led to a sense of inertia around the issue.

'I commented in the national training survey that I was working in a busy trust,' he explains. 'On weekends, a junior member of the team had to do a ward round on their own of around 80 patients – as well as covering emergencies coming in. I said this was an unsafe number of patients for a junior member of the team to see (and discharge) and that patients suffered because they had to be seen before they could be discharged and many ended up waiting until late in the evening.'

'Within weeks of submitting my national training survey, the department sent an email informing all doctors that they were enlisting a second junior member of the team to cover the workload effective immediately. Initially this had to be locums, but I understand they have built it into the rota now'.

*Continued>>*

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\* E. Paice & D. Smith (2009), "Bullying of trainee doctors is a patient safety issue" *The Clinical Teacher*, 6:13–17.

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## Problems at senior levels affected doctors in training

The school of GPs had been monitoring these problems since 2011, when a visit had revealed that the department had been struggling with problems associated with being under-resourced at senior levels that were being compounded by long term sickness.

Not only did this have a potential impact on patient safety but the quality of supervision for lower grade doctors in training was being impaired because less senior staff were being forced to act up. The excessive workload was also preventing doctors in training from getting to their teaching sessions.

In response, the department permanently increased the numbers of doctors in training at the site (resulting in those at a higher grade being on hand to supervise those at a lower grade). Both the deanery/ LETB and the school of GPs noted that doctors in training then reported improved levels of clinical supervision and satisfaction with arrangements for workplace based assessment.

This respondent used the survey as a last resort to flag up an issue that he felt was not being adequately addressed by the training provider. Although the problem was being investigated and had been monitored for some time, by using his voice in the national training survey, this doctor in training increased the evidence base around the issue and therefore contributed to justifying the case for extra funding and some long term improvements.

He told us: 'I think the department was relieved to be prompted by the national training survey as well, because it allowed it to approach the trust for money to pay for extra staffing.'

## Who is most likely to use the survey to report a concern?

The figures below show the proportion of doctors in training who raised a patient safety concern split by ethnicity, gender and place of study.

Due to the relatively small numbers of comments submitted to this year's survey, it is difficult to draw any firm conclusions about the profile of those who raise concerns through the national training survey. The information is presented here for reference.

Figure 2: Proportion of doctors in training who raised a patient safety concern by ethnic group

Ethnic group	Comments	Respondents	%
White	246	31,148	0.8%
Black and minority ethnic community	129	18,975	0.7%
Prefer not to say	29	2,954	1.0%
<b>Total</b>	<b>404</b>	<b>53,077</b>	<b>0.8%</b>

Figure 3: Proportion of doctors in training who raised a patient safety concern by region of primary medical qualification

Region of primary medical qualification	Comments	Respondents	%
European Economic Area	12	2,004	0.6%
International medical graduate	30	7,153	0.4%
UK	362	43,920	0.8%
<b>Total</b>	<b>404</b>	<b>53,077</b>	<b>0.8%</b>

Figure 4: Proportion of doctors in training who raised a patient safety concern by gender

Gender	Comments	Respondents	%
Male	202	23,583	0.9%
Female	202	29,494	0.7%
<b>Total</b>	<b>404</b>	<b>53,077</b>	<b>0.8%</b>

## Concerns by specialty

The figure below shows variations in themes of patient safety concerns, split by programme specialties grouped by royal college.

Figure 5: Proportion of comments received for each college group, split by comment type

	Lack of staffing/resources	Problems with supervision	Problems with patient management	Problems with work expected of trainee
Academic	28.6%	28.6%	0.0%	42.9%
Anaesthetics	44.4%	14.8%	18.5%	22.2%
Emergency medicine	72.4%	13.8%	44.8%	13.8%
General practice	33.3%	0.0%	33.3%	0.0%
Medicine	70.0%	13.2%	17.0%	23.9%
Obstetrics and gynaecology	74.2%	5.9%	41.2%	0.0%
Ophthalmology	52.9%	0.0%	50.0%	0.0%
Paediatrics and child health	50.0%	10.0%	5.0%	20.0%
Pathology	20.0%	40.0%	0.0%	0.0%
Psychiatry	44.4%	3.7%	18.5%	22.2%
Radiology	50.0%	12.5%	12.5%	12.5%
Surgery	69.0%	14.0%	17.0%	14.0%
<b>Total</b>	<b>65.3%</b>	<b>12.9%</b>	<b>19.3%</b>	<b>18.8%</b>

Comments could be coded to more than one theme, so total percentages do not equal 100%.

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# How does the training environment support reporting?

Although we hope that the majority of the fall in reported patient safety issues noted between the 2013 and 2014 surveys is due to better local resolution, we are also mindful of the possibility of underreporting, especially following the change in our survey guidance.

We are aware that there are many barriers to reporting concerns, and these barriers often stem from the environment that doctors in training are working in.\* To help us explore this within our own data, we have investigated the link between raising a concern in the survey, and the relationship that this has with respondents' general indicator scores.

We looked at the mean scores for those doctors in training who made a patient safety comment compared with the mean indicator scores for those who did not. As with last year, we found that doctors in training who report patient safety concerns have lower scores in every indicator.

The indicator that demonstrates the biggest difference in score is the currently unreported test indicator – it looks at how supportive the environment is that a doctor in training works in. This is a new indicator that we have been testing in 2014 with a view to publishing it in 2015.

Our report on bullying and undermining talks about this indicator in more detail, but it measures how much doctors in training feel they are treated fairly and with respect. Because respondents who report patient safety concerns to us in the survey have either not reported their concern locally or are not satisfied with how their concern has been dealt with, we could reasonably infer that the less a doctor in training feels they are treated with respect, the less supportive a training environment is, the less likely concerns are to be reported and dealt with locally.†

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\* See also our guidance, *Raising and acting on concerns about patient safety* (especially part 1), available at [www.gmc-uk.org/guidance/ethical\\_guidance/raising\\_concerns.asp](http://www.gmc-uk.org/guidance/ethical_guidance/raising_concerns.asp).

† We have, together with the Nursing and Midwifery Council, launched a consultation on draft guidance about the professional duty of doctors, nurses and midwives to be open and honest when things go wrong. See [www.gmc-uk.org/guidance/news\\_consultation/25878.asp](http://www.gmc-uk.org/guidance/news_consultation/25878.asp). The draft guidance includes a duty to encourage a learning culture so that all errors and near misses are reported and future patients protected from harm.

**Figure 6: Mean indicator scores for those who made a patient safety comment compared with mean indicator scores for those who did not**

Indicator	No comment raised		Patient safety comment		Difference
	Mean	n	Mean	n	
Supportive environment*	75.57	52,191	56.12	397	19.45
Induction	84.93	51,982	67.48	395	17.45
Study leave	68.97	40,178	51.56	293	17.41
Overall satisfaction	81.36	52,191	65.31	397	16.05
Workload	46.09	52,064	30.73	397	15.37
Feedback	76.64	45,357	61.56	346	15.08
Access to educational resources	68.82	50,642	54.48	382	14.34
Adequate experience	81.56	52,191	68.26	397	13.30
Local teaching	64.03	37,213	51.08	265	12.95
Clinical supervision	89.01	51,929	76.10	397	12.92
Clinical supervision out of hours	88.46	45,903	76.84	383	11.62
Undermining	96.21	49,938	85.84	383	10.37
Educational supervision	90.02	52,151	82.93	397	7.08
Handover	67.90	34,711	62.10	314	5.79
Regional teaching	71.34	28,072	65.57	188	5.77

\* The results for the supportive environment were not published for 2014 because it was a test indicator.

It is clear that where a doctor in training is bullied or fears reprisals, they are much less likely to report any patient safety concerns that they have. Some respondents told us, when we asked why they didn't report their concern locally, that they were afraid of being singled out and blamed for raising this concern. This is clearly unacceptable and is totally contrary to the goal of encouraging local reporting. Doctors in training, and others within departments, must be encouraged to raise any concerns they have, and must also be supported when they do. The earlier problems are identified and raised, the easier it is to fix them.

Patient safety concerns arise, mistakes and near misses do happen. In order to properly deal with

these and to prevent avoidable harm to patients, it is important to involve doctors in training in identifying and combating issues.

Professor Michael West, who has conducted research into cultures of high quality care within healthcare settings, has spoken of the benefits of high involvement cultures, where all staff are authentically involved in identifying problems and contributing ideas for improvement.<sup>†</sup> The group in the case study below is a good example of one LEP encouraging just such an approach. The following case study gives a good example of the benefits of this, particularly in terms of the impact that the support of senior managers can have on creating and encouraging effective reporting cultures.

<sup>†</sup> See [www.kingsfund.org.uk/audio-video/michael-west-developing-cultures-high-quality-care](http://www.kingsfund.org.uk/audio-video/michael-west-developing-cultures-high-quality-care). See also West et al (2006) Reducing patient mortality in hospitals: The role of human resources management *Journal of Organizational Behaviour*; 27:983–1002 where, drawing on data from the NHS staff survey amongst other evidence, West et al show the link between human resource management practices and patient mortality.

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## CASE STUDY: A forum for doctors in training to raise and address concerns

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### **A growing number of doctors in training were bringing concerns to a foundation educational forum that wasn't equipped to deal with them. In response, one LEP set up an expanded forum.**

The expanded forum was officially established in early 2013 and meets on a monthly basis. It is a space for doctors in training to raise issues and concerns that affect their training and service and that need further clarification or improvement.

Doctors in training are encouraged to come along to meetings and freely contribute, in confidence, their ideas and opinions to a full and frank discussion on a range of issues. Meeting facilitators collect concerns at each session, then go away and find out why the issue currently occurs. If there are opportunities for change or improvements, these will be discussed. If it is felt that there are robust or intractable reasons for the existing state of affairs, these will also be presented back to doctors in training and opened up for debate. Relevant personnel are invited to the meetings to talk through problems and concerns.

Doctors in training are actively encouraged to take ownership of issues they bring and see them through to resolution.

### **The importance of backing from senior management**

The group has enjoyed the support of senior management, including the chief executive, medical director, director of HR and executive director of nursing, who have all attended sessions. This involvement has created a cascade effect down to middle management and beyond.

Though it remains early days, the group has seen a number of practical and useful improvements introduced into the training and working environment, such as the introduction of dedicated cordless phones carried around to answer bleeps and a recreation room for doctors in training. The group has also secured an audit process for crash trolleys and changes to the internal phone directory, which make it much easier to use. Though these victories may appear small, they affect the day to day working culture of many different individuals and teams for the better. And they are the thin end of a potentially much larger wedge as a culture of improvement hopefully expands.

Future plans for the forum include involving doctors in training in the improvement of the existing policy library, improving systems such as phlebotomy, ongoing safety and quality improvement audits.

In the context of a period of rapidly changing management teams, the group has functioned as leverage to win long-needed improvements.

One of the meeting facilitators, who is also the foundation programme director, said: 'the biggest win [of the group] is the involvement of very junior medical staff in safety and governance issues, and the recognition of many of the most senior management staff that this is not inappropriate.'

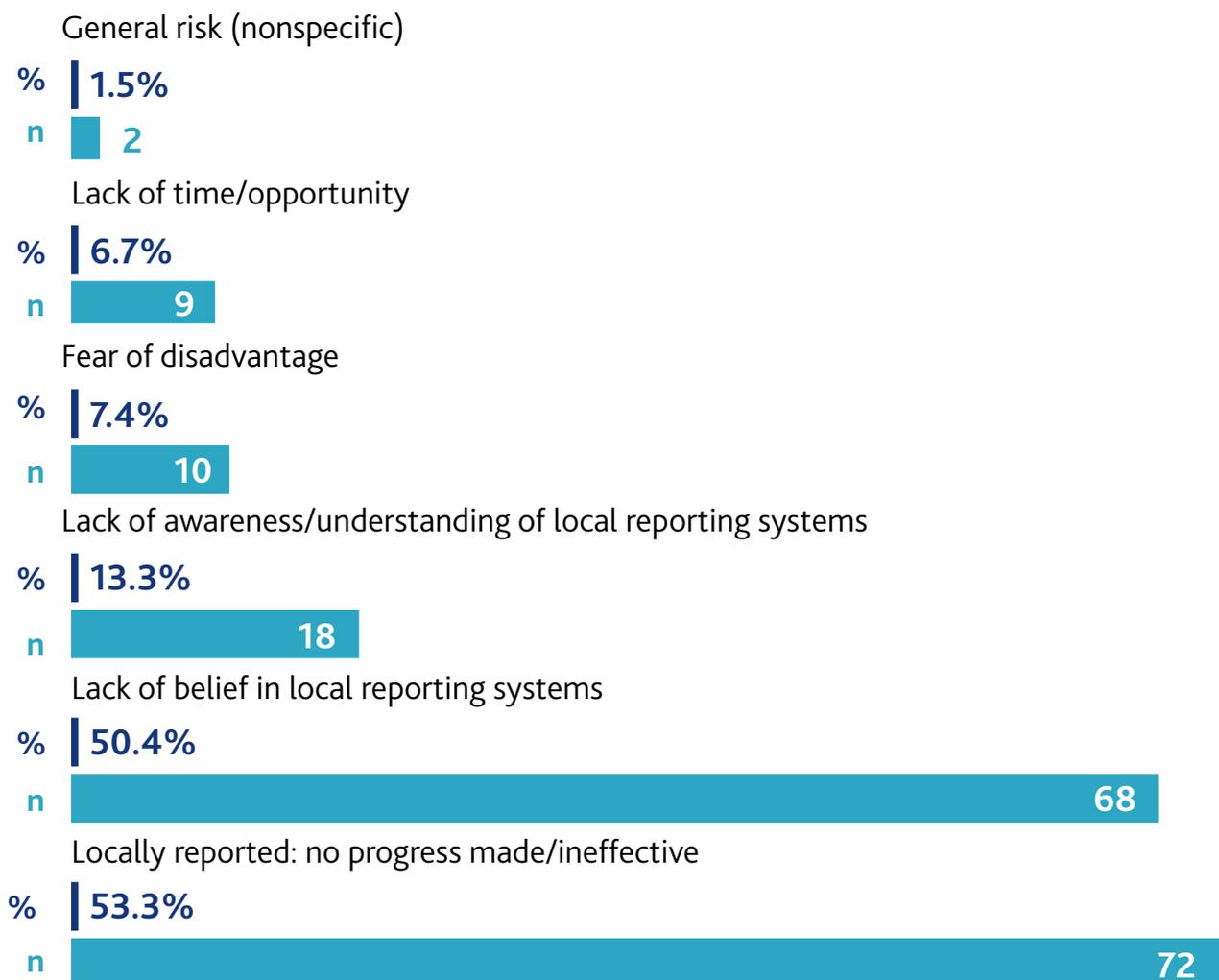
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**What are the  
experiences of  
doctors in training  
reporting concerns  
locally?**

In this year's survey, we asked those doctors in training who reported a concern to us but said they hadn't raised their concern locally, why this was the case (n=135). This was to help us find out more about why doctors in training use our survey rather than reporting a concern locally.

Over half of the doctors in training who chose to tell us more about this had indeed reported their concern locally, but were using the survey because they felt that little or no progress had been made with the matter, or they felt that mechanisms for reporting were ineffective or prohibitive.

**Figure 7: Answers to the question 'To help us understand more about local reporting systems, please comment on why you have not previously reported this concern', coded into themes**



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## Lack of a clear process and feedback

Underlying the majority of these responses was the complaint that when doctors in training raised an issue, they were then excluded from the process – of how the issue would be investigated or if it was resolved.

Doctors in training told us about the experience of moving through hospitals, each with different systems for reporting. For many, it was often unclear who to report to for what. Some doctors in training also told us about their experiences of using computerised reporting systems which could be unwieldy, restrictive and time consuming.

The lack of feedback on concerns that have been reported is an issue that has been noted in other research, such as the study carried out by Public Concern at Work. It found that 60.0% of whistleblowers received no feedback at all from management.\* It is a big problem, not only because it leads to disillusionment with the process, but also because it leads to duplication of reporting when doctors in training go on to report their concerns in the survey.

## Lack of belief in reporting processes

A clear theme that emerged from the analysis was that a subset of doctors in training suffer from a general lack of belief in the processes for reporting concerns. Respondents told us that they felt that raising concerns over certain issues seemed pointless when nothing (perceptibly) seemed to change.† These sorts of statements were often accompanied

by comments about budgetary pressures and management processes that the doctor in training feels powerless to impact upon.

Some doctors in training also felt disempowered in terms of not being taken seriously by more senior colleagues. Sometimes this was connected to the idea that they would be labelled as isolated or difficult if they raised concerns and would therefore harm their ability to function or progress in their place of work.

Some doctors in training told us that they were uncomfortable reporting locally because they feared that they would not be adequately supported through the process.

## 'Just the way things are'

More insidious is the sense that patient safety risks sometimes become normalised in the local environment. In survey responses, this was expressed most frequently in responses by using the phrase 'known concern'. Sir Robert Francis's description of doctors in training as the 'invaluable eyes and ears in a hospital setting' has often been quoted in discussions on this issue, but our findings here underline this assertion, so it bears repeating: 'They come without preconceptions, are not likely to be immediately infected by any unhealthy local culture, and are therefore perhaps more likely than established staff to perceive unacceptable practices.'‡

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\* Available at [www.pcaw.org.uk/files/Whistleblowing%20-%20the%20inside%20story%20FINAL.pdf](http://www.pcaw.org.uk/files/Whistleblowing%20-%20the%20inside%20story%20FINAL.pdf). See also the survey conducted by *Pulse* which found that up to a third of GPs who raised concerns regarding care of their patients in local hospitals were ignored, available at [www.pulsetoday.co.uk/your-practice/francis-inquiry/up-to-third-of-gps-raising-alarm-over-hospital-care-see-complaints-ignored/20002784.article#.VA2pF\\_ldV8E](http://www.pulsetoday.co.uk/your-practice/francis-inquiry/up-to-third-of-gps-raising-alarm-over-hospital-care-see-complaints-ignored/20002784.article#.VA2pF_ldV8E).

† The 2013 NHS staff survey found that although 85.0% of workers felt encouraged to report, only 62.0% believed that action taken by the organisation. See [www.nhsstaffsurveys.com/Page/1006/Latest-Results/2013-Results](http://www.nhsstaffsurveys.com/Page/1006/Latest-Results/2013-Results).

‡ Mid Staffordshire Foundation Trust Public Inquiry (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* volume 2, chapter 18, paragraph 228, available at: [www.midstaffspublicinquiry.com](http://www.midstaffspublicinquiry.com)

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Clearly the respondents who were telling us about these so-called known concerns still had the ability to perceive that something was wrong, and this is encouraging, but there is an underlying cultural problem here that needs addressing.

If doctors in training are the eyes and ears of the NHS, then our national training survey hopes to lend them a voice with which to speak. But when it comes to raising patient safety concerns, the survey should ideally only be used as a last resort. Regulators, LEPS, deaneries and LETBs all have a responsibility to encourage the widespread practice of routinely raising concerns and embedding a culture of daily lesson learning.

The case study *Doctors in training work closely with their deanery/LETB making improvements to training and patient safety* (on page 22), looks at an instance of doctors in training taking ownership of problems around handover processes in their region and working successfully with their seniors and the deanery/LETB to push for change. In this example, healthcare professionals at all levels were invited to think beyond the present, 'the way things are' and towards the future 'the way things might be'.

## Open and honest reporting cultures: a work in progress

A priority issue that is currently being debated across the UK healthcare sector, is how to understand more about the sorts of environments that encourage reporting, and the barriers that professionals face in raising concerns.\*

Here at the GMC, we have commissioned Sir Anthony Hooper to review our work in this area, so that we can be sure we have the right processes and guidance in place to help us encourage and better support doctors who raise concerns.† We also offer a number of other support services to doctors. For example, we run workshops on raising concerns across the UK, and we have interactive guidance and a decision making tool on our website.‡

What is needed, as a recent discussion paper by the British Medical Association pointed out, is 'a fundamental change in attitude towards reporting concerns and being honest about errors and poor care'.§ The creation of an open and honest reporting culture throughout the NHS is something that, since the scandals at Mid Staffordshire and elsewhere, all healthcare professionals aspire to, though it is recognised that there is much work to be done before this vision is realised fully.

In the meantime, there are some practical steps that we can take towards achieving this goal. The next section discusses how we propose to use the national training survey to gather information on local reporting systems in order to identify problems and make improvements.

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\* For example, see the independent review on whistleblowing in the NHS, led by Sir Robert Francis, which is due to report in November 2014, available at [www.gov.uk/government/groups/whistleblowing-in-the-nhs-independent-review](http://www.gov.uk/government/groups/whistleblowing-in-the-nhs-independent-review); the review of concerns handling process within NHS Wales, *Putting things right*, available at [www.wales.gov.uk/topics/health/publications/health/reports/complaints/?lang=en](http://www.wales.gov.uk/topics/health/publications/health/reports/complaints/?lang=en); and the excellent work done as part the Scottish Patient Safety programme, available at [www.scottishpatientsafetyprogramme.scot.nhs.uk](http://www.scottishpatientsafetyprogramme.scot.nhs.uk).

† See [www.gmc-uk.org/news/25306.asp](http://www.gmc-uk.org/news/25306.asp).

‡ See [www.gmc-uk.org/guidance/ethical\\_guidance/raising\\_concerns.asp](http://www.gmc-uk.org/guidance/ethical_guidance/raising_concerns.asp) and the work of our regional liaison service at [www.gmc-uk.org/rls](http://www.gmc-uk.org/rls).

§ Supporting doctors in raising concerns BMA discussion paper and member consultation, 2013, available at <http://bma.org.uk//media/files/pdfs/working%20for%20change/shaping%20healthcare/nhs%20culture/supportingdoctorsinraisingconcerns.pdf>.

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## CASE STUDY: Doctors in training work closely with their deanery/LETB making improvements to training and patient safety

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### Inspired by discussions at an acute medicine conference, two doctors in training decided to survey their peers to collect information about handover processes in their specialty.

The survey from the pair of doctors in training revealed a number of concerns about handover. Just as they were sharing their results, our national training survey revealed several red outliers\* for handover, while investigations into handover by the deanery/LETB corroborated their findings.

The doctors in training showed their findings to the deanery/LETB and were invited to join a task and finish group to review handover arrangements across several specialties and several trusts.

The task and finish group was set up through the school of medicine and involved around 30 professionals from a range of disciplines. It included consultants, nursing, primary care, educational and quality representatives, as well as doctors in training.

The group investigated differences in handover across the region and identified examples of best practice to help the deanery/LETB develop tools that could help improve processes across the region.

The initial results and recommendations from the doctors in training gave the task and finish group a very good starting point for its work. The meetings focused on sharing knowledge and ways to work together to find solutions. Each group member was encouraged to describe experiences from their organisation, both good and bad.

The group also reviewed a range of information, including national and local survey results for handover, which gave a focus for discussions.

*Continued>>*

\* A red outlier, or red flag, is a result where the score for a report is significantly below the national score in the benchmark group.

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## What changes did the findings lead to?

The recommendations from the group were followed up as part of the deanery/LETB annual quality meetings, to make sure that handover was discussed and recognised as an important area for improvement and monitoring. Through these annual quality meetings, the deanery/LETB found that the work of the task and finish group had led to:

- evidence of regular audits, which showed improvements in handover processes
- examples of working groups with involvement from doctors in training, which looked at handover processes, training and improvement initiatives
- changes to induction to make sure that handover is appropriately covered
- a redesigned handover sheet with clearer patient identification and escalation planning
- improved access to training, including monthly face-to-face handover training
- evidence of robust handover policies and a commitment to monitor them.

'It felt like we were being listened to and taken seriously at a senior level,' explained one of the doctors in training. 'It was really nice to have our work recognised, and then to see it being acted upon while being encouraged to remain involved in the project. It felt empowering to be making positive changes that really made a difference.'

'It was an excellent experience of working on a quality improvement project, and has opened up other opportunities to us. For example, we have both been sought out to work on further handover improvement initiatives at local and regional level, and the different LEPs we have rotated through have been keen to use the knowledge and experience we gained through the project.'

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# How can we identify and improve poor local reporting systems?

Reporting any concern locally, usually to the LEP, is important as it allows issues to be more quickly identified and dealt with. We encourage doctors in training to use this route wherever possible, rather than waiting for the national training survey. However, if we are to encourage them to use this route, we need to help by making sure that local systems are effective and that they are supported to raise concerns.

Whereas our data overall confirm that the majority of doctors in training did not have patient safety concerns in their posts, or if they did that these had been resolved locally, there are still too many who do not feel confident that local systems can resolve issues.

One in five responses to the question: 'To help us understand more about local reporting systems, please comment on why you have not previously reported this concern' cited a lack of understanding of how to report locally or a lack of opportunity to do so. This is especially worrying.

In our standards for postgraduate medical education and training, *The Trainee Doctor*, we state that: 'There must be clear procedures to address immediately any concerns about patient safety arising from the training of doctors'.\*

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\* See *The Trainee Doctor*, available at [www.gmc-uk.org/The\\_Trainee\\_Doctor\\_0414.pdf\\_56439508.pdf](http://www.gmc-uk.org/The_Trainee_Doctor_0414.pdf_56439508.pdf).

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## Reporting concerns: is there room for improvement?

It is clearly not acceptable that some doctors in training do not have the necessary knowledge or time to report concerns. Knowing how to and actually having the opportunity to report are basic and fundamental components of an effective system for reporting concerns. This is not only essential for training in safe environments, but also for patient safety.

Due to the small number of doctors in training who made a patient safety comment in this year's survey, we don't have a complete picture on how effective their local reporting systems are. The information we do have suggests that some LEPs are not doing enough to support doctors in training to raise concerns and that the culture in some training environments actively discourages reporting.

## Using the survey as a tool for change

In response to the issues that some doctors in training raised around raising concerns locally, we're looking at ways that we could use future surveys to collect information to help us better diagnose the extent of the problem.

Since the survey closed and the analysis of survey answers began, we've held a number of workshops with doctors in training, deaneries and LETBs to explore the main concerns raised in 2014 and gathered further feedback on these. As a result of this consultation, we're aiming to test some new questions in 2015 that would help us to investigate the effectiveness of local reporting mechanisms in every training post across the UK.

These test questions would be presented to everyone and therefore would not rely on doctors in training having to come forward with a specific concern. We know that this step is still unacceptably difficult for some doctors in training to make. We need to acknowledge this and use the resources we have to focus attention on systems that are failing and drive up standards for safer patient care and better training environments. Having more comprehensive information would enable deaneries and LETBs to engage with training providers to make sure the right mechanisms are in place to meet the standards that we set for clear, effective and swift reporting procedures.

With the help of quality teams, senior representatives of medical training, doctors in training, clinicians and others, we have begun designing questions that would capture information around the culture of concerns reporting in a post, in addition to the basic components of a working system, such as clear information and feedback.

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**What does this  
year's report show  
about the patient  
safety concerns of  
doctors in training?**

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Part of encouraging reporting is to show that issues reported are investigated and that action is taken. This applies to us as well as to LEPs. This report has demonstrated how we share and investigate each issue reported in the survey, and how we make sure that positive changes are made.

It has also explained, through a series of case studies, how survey data is used to a greater or lesser extent, in conjunction with other mechanisms for reporting, to resolve patient safety concerns in local contexts. By including these case studies, we aim to shine a light on these processes, and contribute to making them more transparent.

The report further explored the new information gathered from respondents in 2014 about their experiences of raising concerns locally, and tried to get to the heart of the motivations of doctors in training to report concerns to us. We are coming to understand that the majority of doctors in training who use our survey often do so because they are frustrated with the way that their concern has been handled locally. This is inappropriate and needs to change.

## **The national training survey and reporting concerns: understanding and influencing the bigger picture**

We have received far fewer patient safety comments this year than in previous years. This may largely be a result of our changed guidance to respondents, in which we ask for more detailed and actionable issues, and because we have encouraged doctors in training to use local reporting systems wherever possible. However, it is possible that the reduction in concerns raised is partially attributable to respondents fearing reprisal, as we have made the process for handling concerns clearer to them. We are not complacent about this. Our view is that all doctors should report concerns when they arise. There should also be no culture of fear.

By introducing test indicator questions into future surveys, we will be able to learn more about cultures of reporting across the UK rather than waiting for respondents to come forward when something has already gone wrong. As these will be multiple choice questions, respondents will be able to answer with confidence that their identity won't be shared and that their answers will contribute to a broader understanding of the culture within their department.

We know that the survey is a powerful tool for driving up standards. Using it to focus attention on the quality of reporting mechanisms in the training environment is something that we hope will be a positive step towards ensuring that these systems are working and that they are robust.

The ability to report concerns, to be listened to and the chance for everyone to learn and improve as a consequence is at the heart of good medical practice. This may seem easier said than done, but by developing future surveys in order to collect information around these vital features of the healthcare environment, we hope to take a practical step towards implementing the ideal of a truly open and honest reporting culture. The information gathered will help us understand more about the difficulties and successes of local systems, and keep the dialogue going.

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# What happens next?

## The process for handling patient safety concerns raised through the survey and our next steps

- Deaneries and LETBs reported new issues raised by the patient safety free text questions in the October deans' reports. We will continue to monitor their action plans and progress to make sure they are appropriate and that progress is being made.
- Issues where progress is not being made may be escalated to our enhanced monitoring process. Most of these issues are published on our website and are regularly updated to show progress made.
- We are working with doctors in training to understand more about the barriers they face in reporting patient safety issues. We will work with them to come up with solutions that we can implement, together with deaneries and LETBs.
- We are working with deaneries, LETBs, doctors in training and other groups to develop questions that will measure the quality of local reporting mechanisms, to be tested in future surveys.

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