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Foreword

Every day healthcare professionals go to extraordinary lengths to keep on delivering the best possible care to patients. In these challenging times it would be deeply concerning but perfectly understandable to see the quality of postgraduate training suffer. That we have not seen this is remarkable.

The results of our national training surveys for this year as in previous years show the quality of doctors’ training remains high. For that we all owe a huge debt of thanks to the 50,000 senior doctors who, in addition to their demanding roles, devote part of their time to training and inspiring the next generation of medical leaders.

It would be wrong to take their commitment for granted, yet in some places this is what appears to be happening.

This year nearly one in three trainers told us their job plans do not include enough time to fulfil their roles as educators. We must not assume these doctors will somehow ‘find the time’ to train. It’s vital their employers carve out the right amount of time for them to fulfil their roles as trainers properly. Valuing training, a cornerstone of any workforce strategy, starts with valuing trainers.

It is not only these doctors who say training is being squeezed. A worrying number of doctors in training continue to raise concerns about heavy workloads and shortness of sleep while on duty, with some missing educational opportunities because of these pressures. Both trainees and trainers also reported that poorly designed rotas negatively impact education.

This annual survey, of more than 100,000 doctors across the UK, provides us, postgraduate deans, other regulators and employers with a rich source of intelligence about where education and training is being delivered well and where it needs help. Our commitment on this matter is clear: we will step in to protect and improve both the quality of training – which is intrinsically linked to the quality and safety of patient care – as well as the health and wellbeing of doctors receiving training in those places which are struggling.

This report contains two examples of where we have acted in partnership with others to address serious concerns about postgraduate training – North Middlesex University Hospital NHS Trust and East Kent Hospitals University NHS Foundation Trust. These were challenging cases, raising important questions for us and the other national bodies involved. When there are education concerns it is vital that we act in partnership with others to address them quickly before they get worse and cause real harm to doctors in training, or patients. Next year we will be actively considering the ways in which we become more effective in this critical area of our work.

Charlie Massey,
Chief Executive and Registrar
Executive summary

The national training surveys give doctors in training and trainers across the four countries of the UK, an opportunity to give feedback on their training. This feedback forms a crucial part of the evidence we use to quality assure medical education and training. It gives us the information we need to identify good practice and pinpoint the places where training does not meet our standards.

We expect organisations responsible for education and training – including employers – to use these results, along with other sources of information, to improve how they manage and deliver their training programmes. We monitor their progress through regular reporting, analysis of survey results and trends, and visits and inspections. Where hospitals and other training providers struggle to meet our standards, we take action in partnership with others. Throughout this report you can see examples of how data from the surveys have been used to protect doctors and patients.

Our analysis of this year’s results suggests that many trainers are going above and beyond to make sure that the quality of medical education and training isn’t sacrificed for service provision.

While most doctors in training remain broadly satisfied with the training they receive, trainers told us they’re under pressure, with many saying they don’t have the time and support they need to carry out this vital role.

And in response to new survey questions on rota design, both trainees and trainers – particularly those working in acute specialities – also said that poorly designed or incomplete rotas are having a negative impact on education.

Key findings for 2017 include:

- Trainers are reporting high workloads – with almost 80% working beyond their rostered hours at least once a week – and this is having an impact on training: around a third say they don’t have enough time in their job plan (or equivalent) for education.

- While just over a half of trainers rated the support they receive from their trust or board in their role as an educator as good or very good, they also told us they need more support to balance service provision and training.

- Doctors in training continue to rate the quality of their education highly. Just over 75% of trainees would rate the quality of teaching in their post as ‘good’ or ‘very good’ and over 80% would rate the quality of experience as ‘excellent’ or ‘good’.

- Heavy workloads remain common – almost 25% of doctors in training feel short of sleep while at work on a daily or weekly basis. Just over 40% of trainees rated the intensity of their work by day as ‘heavy’ or ‘very heavy’.

- There is a strong correlation between bullying and undermining and the retention of doctors on training programmes.

- Less than full time trainees tend to be more positive about their training than their full time colleagues.
In these challenging and uncertain times, intelligence on training environments is more important than ever. The honest and comprehensive views provided by over 53,000 trainees and 24,000 trainers, allows us to shine a light on the pressures faced by doctors working, learning and teaching across the UK today. It helps us push for better rota design and job plans that take into account time for education. It also gives us, and those responsible for postgraduate medical education, information to challenge or support training environments in difficulty.

What do we do with data from the national training surveys?

Every year since 2013 approximately 98% of doctors in training across the UK have taken part in the survey. And since it was reintroduced last year, around 55% of named clinical and educational supervisors have responded to our survey of trainers.

The surveys ask doctors about their training experience and environment. They also ask how our Promoting excellence: standards for medical education and training are being delivered locally, to check whether high-quality educational experiences are being provided in safe, effective and appropriately supportive learning environments.

If responses from particular training sites indicate concerns, we work in partnership with the relevant postgraduate dean to put procedures in place – such as enhanced monitoring* – to resolve the problem.

The results can also identify areas of risk or good practice, which in turn can help us prioritise locations to visit during our national and regional reviews. You can see this in our recently published report of our Northern Ireland review.†

When a doctor in training uses the survey to report a patient safety or bullying or undermining concern, we share this with the relevant deanery or HEE local team who must tell us what action has been taken to address the issue.

Last but not least, we use the data to help us look for trends in postgraduate education and, where appropriate, lead or contribute to policy considerations, aimed at driving improvements in training.

* See www.gmc-uk.org/education/enhanced_monitoring.asp
† See www.gmc-uk.org/education/26812.asp
Dr Paul Baylis: Emergency Department Consultant

‘In 2015 we received some challenging feedback from our junior doctors via the GMC national training survey. The major issue highlighted was that our junior doctors felt that the level of senior support and supervision was not adequate.

It was both frustrating and disheartening to receive this feedback from our own staff, as I believe that achieving and maintaining a positive environment was central to managing the pressures of life in emergency medicine. Didn’t our juniors understand the efforts their consultant colleagues were making as we tried to maintain a safe service in the face of increased patient attendances, near permanent bed access issues and flat resource allocation? And now on top of all this our juniors were revolting!

Clearly in such a situation the key is not to shoot the messenger. Once my bruised “Trainer’s ego” had recovered, we set about redoubling our efforts to improve the support we were affording our trainees. We improved the utility of our current resources, rejigging senior rosters and revisiting our junior doctors training program whilst crucially lobbying for an increase in both senior and career middle grade staffing resources.

In recent years I have noticed that junior medical staff feel more empowered to ask for senior support. I don’t believe that this is because my own generation of trainees, from the 1980s, were in any way superior to the current cohort but instead it reflects the evolution of the patient safety culture in our NHS over the course of my career. The maxim of “see one, do one, teach one” has blessedly been consigned to the dustbin. When our trainees tell us that they do not feel adequately supported they are likely actually telling us that our patients’ safety is potentially at risk.

We had been aware for some time that our Emergency Department’s senior and middle grade staffing numbers were not adequate. So we integrated the feedback from the GMC national training survey into our ongoing staffing negotiations with our trust’s management and our local postgraduate medical deanship. We stressed the likely implications for patient safety, plus the risks to our department’s training accreditation.

We were subsequently allocated a significant increase in our senior and middle grade resources. This allowed us to make the radical changes to our rosters required to afford more appropriate direct clinical supervision of our junior doctors. These changes, along with refreshing our junior doctor training programme, resulted in much improved feedback from our juniors via the GMC national training surveys of 2016 and 2017.’
Dr Neil Corrigan – Director of Medical Education:

‘As the Director of Medical Education I shared much of this journey with the Emergency Department team. Learning to accept criticism and use negative feedback as a positive force for change is core to this story. It is essential to facilitate trainers to separate out issues that can be addressed within the team from those that require external change or resources. This joint approach allowed Paul and his team to successfully address complex training concerns and improve patient care.’
1 What did trainers across the UK tell us?

In addition to providing care and keeping our health services running in challenging times, trainers teach, mentor and inspire future generations of doctors. In turn, the trainees of today become the trainers of tomorrow.

We reintroduced our survey of trainers in 2016 to better understand their experiences and to seek more information about training environments across the UK. Since then we have spent a lot of time listening to those who took part, as well as organisations responsible for education and training, to identify potential improvements to the survey and the data we gather. As a result of what they told us, we made some changes to the 2017 survey to make it more comparable with the trainee survey. We also made it more straightforward for trainers to complete and easier for users to interpret the results.

High quality training is strongly dependent on consistent support from trainers; and the main findings in this report paint a picture of excellent training taking place in each of the four UK countries. But we can also see training taking place in environments under considerable workload pressure. Many trainers are telling us they aren’t able to support their trainees as much as they feel they should.

Our Promoting excellence standards say that employers must provide trainers with the support and resources they need to meet their education and training responsibilities. They should also protect time for training, and produce rotas which help deliver that goal. Where the survey shows this isn’t happening, we expect employers to take action to ensure their training environments do meet our standards. Data from both surveys should be used to identify local examples where training is working well, to help make improvements to other areas.

24,577 trainers completed the national training surveys this year. They answered a number of questions about every aspect of their educational role – from the learning environment and culture, to developing and implementing curricula and assessments.

Key findings

- Almost 30% of trainers disagreed or strongly disagreed that their job plan contains enough designated time for their role as an educator.
- Almost 70% said that their daytime workload was ‘heavy’ or ‘very heavy’.
- Just over 40% said they want more support in balancing education and service delivery.
- Almost 30% said they work beyond their rostered hours on a daily basis. Almost 50% said weekly.
- Just over 20% disagreed or strongly disagreed that there was enough staff at their trust/board to make sure patients are always treated by someone with an appropriate level of clinical experience.
It is important to note in the analysis that follows we cannot always directly compare results from 2016 and 2017, as we changed some of the questions in the trainer survey this year. And as headline results across the four countries of the UK are broadly similar, we have only chosen to show results by country where there are significant differences.

Promoting excellence: standards for medical education and training set out how trainers and educators should be supported in their role:

- **Standard S4.1**: Educators are selected, inducted, trained and appraised to reflect their education and training responsibilities.

- **Standard S4.2**: Educators receive the support, resources and time to meet their education and training responsibilities.

Trainers are reporting high workloads, particularly in emergency medicine and general practice, and this impacts on training

In 2017 for the first time we asked trainers questions about their workload and we can see that UK-wide they have reported heavier workloads than trainees.

69.9% (n=17,186) of trainers said that their daytime workload was ‘heavy’ or ‘very heavy’. With 29.5% (n=7,236) saying it was ‘about right’.

This is higher than the results for trainees with 40.8% (n=21,675) saying their daytime workload was ‘heavy’ or ‘very heavy’ and 54.8% (n=29,090) saying it was ‘about right’. See page 19 for more details.

Splitting the results by specialty group shows a high proportion of emergency medicine (43.7% n=446) and general practice trainers (36.7% n=1,328) saying that their day workloads are very heavy.
1. What did trainers across the UK tell us?

When asked about staffing in the place where they work, one in five (21.3%, n=5,225) trainers disagreed or strongly disagreed that there are enough staff at their trust or board to make sure patients are always treated by someone with an appropriate level of clinical experience.

By splitting this question by specialty, we can see that workload perceptions vary depending on which area respondents work in. Emergency medicine trainers had the highest proportion of ‘disagree’ or ‘strongly disagreed’ respondents (39.0%, n=398).

There was also a difference in responses to this question when split by country.

How would you rate the intensity of your work through the day?
Another measure of workload was to ask trainers how often they work beyond their rostered hours. 28.6% (n=7,031) of trainers said this happens on a daily basis, and 47.28% (n=11,616) answered ‘weekly’ to the same question.

When we separate the respondents by specialty, we can see that trainers in general practice are much more likely to report regularly working beyond their rostered hours – with 60.4% (n=2,185) saying they do so on a daily basis and 27.3% (n=985) saying it happens weekly.

This is in stark contrast to trainees’ responses on page 37 which shows general practice trainees reporting comparatively manageable workloads, compared to other specialties.

In a secondary care setting, anaesthetics and psychiatry trainers are less likely to report working beyond their rostered hours, suggesting that job planning in those specialties may be better than others.

In my trust/board there are enough staff to ensure that patients are always treated by someone with an appropriate level of clinical experience
How often (if at all) have you worked beyond your rostered hours?

<table>
<thead>
<tr>
<th>Specialty group</th>
<th>Monthly</th>
<th>Weekly</th>
<th>Daily</th>
<th>Less than once</th>
<th>Never</th>
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</thead>
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<tr>
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<td>1,690</td>
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<td>579</td>
<td>9</td>
<td>73</td>
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<td>398</td>
<td>17</td>
<td>11</td>
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<tr>
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<td>2,185</td>
<td>34</td>
<td>14</td>
<td>818</td>
</tr>
<tr>
<td>Obstetrics and Gynaecology</td>
<td>359</td>
<td>1,783</td>
<td>38</td>
<td>36</td>
<td>214</td>
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<tr>
<td>Occupational medicine</td>
<td>598</td>
<td>2,722</td>
<td>23</td>
<td>19</td>
<td>1,061</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>598</td>
<td>2,722</td>
<td>23</td>
<td>19</td>
<td>1,061</td>
</tr>
<tr>
<td>Paediatrics and child health</td>
<td>242</td>
<td>468</td>
<td>32</td>
<td>75</td>
<td>2,004</td>
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<td>Pathology</td>
<td>326</td>
<td>526</td>
<td>21</td>
<td>11</td>
<td>37</td>
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<tr>
<td>Psychiatry</td>
<td>167</td>
<td>200</td>
<td>9</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>Public health</td>
<td>14</td>
<td>181</td>
<td>134</td>
<td>19</td>
<td>1,500</td>
</tr>
<tr>
<td>Radiology</td>
<td>134</td>
<td>249</td>
<td>9</td>
<td>5</td>
<td>731</td>
</tr>
<tr>
<td>Surgery</td>
<td>134</td>
<td>249</td>
<td>9</td>
<td>5</td>
<td>731</td>
</tr>
</tbody>
</table>
Trainers told us they don’t have enough time to deliver the supervisor role

*Promoting excellence: standards for medical education and training* set out how time for training should be protected:

**Requirement R4.2:** Trainers must have enough time in job plans to meet their educational responsibilities so they can carry out their role in a way that promotes safe and effective care and a positive learning experience.

Almost a third (29.3%, n=7,204) of trainers disagreed or strongly disagreed with the statement ‘my job plan contains enough designated time for my role as an educator.’

There is some variation on this across specialties and greater satisfaction with designated educational time in anaesthetics, psychiatry and general practice. This may reflect that trainees and trainers are more likely to have a one-to-one relationship in these specialties.

The survey results show that high workloads can hinder trainers’ ability to deliver education. Simply finding time to dedicate to training is challenging. Almost a third (31.9%, n=7,828) of trainers disagreed or strongly disagreed with the statement ‘I am always able to use the time allocated to me in my role as an educator specifically for that purpose’.

There is some variation when we break down the results for this question by specialty group. Specifically, general practice trainers are more likely to say they are able to use their educational time for its intended purpose (63.3% n=2,288) compared with an average of 43.5% (n=10,694). Trainers in anaesthetics (54.7% n=1,756) and psychiatry (50.8% n=1,175) were also more likely to report higher than average responses to this question.

Just over a fifth (22.4%, n=4,437) of educational supervisors disagreed or strongly disagreed with the statement, ‘My job plan contains enough time to meet with my trainee(s) as frequently as they require’. We can see stronger degrees of satisfaction in anaesthetics, general practice and psychiatry. This may suggest more effective job planning processes and better trainee contact within these types of training environments; it is worth exploring this relationship further.

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* See the 2017 national training surveys summary report (www.gmc-uk.org/education/national_summary_reports.asp) for a breakdown of results by country.

† Clinical supervisors were removed from this analysis.
Trainers want more support in balancing education and service delivery

Promoting excellence: standards for medical education and training set out that trainers should be resourced

Requirement R4.3: Educators must have access to appropriately funded resources they need to meet the requirements of the training programme or curriculum.

The survey asked trainers to rate their access to learning and development opportunities, and to specify areas where they would benefit from more training in.

Less than 10% of trainers answered 'none of the above' indicating that there are few who feel they would not benefit from further training and support. The results are similar to those for the same survey question in 2016.

<table>
<thead>
<tr>
<th>Area of training (select all that apply)</th>
<th>Number of responses</th>
<th>% against number of trainers who answered the survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balancing the needs of service delivery with education</td>
<td>10,094</td>
<td>41.1</td>
</tr>
<tr>
<td>Writing effective supervisors reports</td>
<td>9,169</td>
<td>37.3</td>
</tr>
<tr>
<td>Identification, diagnosis and management of the trainee in difficulty</td>
<td>9,162</td>
<td>37.3</td>
</tr>
<tr>
<td>Curriculum coverage</td>
<td>8,726</td>
<td>35.5</td>
</tr>
<tr>
<td>Coaching and mentoring</td>
<td>8,551</td>
<td>34.8</td>
</tr>
<tr>
<td>Giving effective feedback as an educator</td>
<td>8,431</td>
<td>34.3</td>
</tr>
<tr>
<td>Annual Review of Competence Progression (ARCP) training</td>
<td>7,503</td>
<td>30.5</td>
</tr>
<tr>
<td>Unconscious bias</td>
<td>7,220</td>
<td>29.4</td>
</tr>
<tr>
<td>Leadership and management</td>
<td>6,066</td>
<td>24.7</td>
</tr>
<tr>
<td>None of the above</td>
<td>2,256</td>
<td>9.2</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>1,461</td>
<td>5.9</td>
</tr>
</tbody>
</table>

* It was possible to select more than one option.
Trainers are more confident in their support from their postgraduate dean than their trust or board

All organisations must demonstrate leadership of medical education and training through effective educational governance. Working together, they should integrate educational, clinical and medical governance to keep patients and learners safe and create an appropriate learning environment and organisational culture.

Promoting excellence: standards for medical education and training set out the role of governance:

52.2 The educational and clinical governance systems are integrated, allowing organisations to address concerns about patient safety, the standard of care, and the standard of education and training.

We asked trainers a range of questions on this aspect of the training environment, making the distinction between the support offered at different organisation levels. Overall, responses to a number of questions – across the four countries of the UK – trainers were more positive about their deanery or HEE local office than their trust or board.

While 76.6% (n=18,816) of trainers agreed or strongly agreed that they were confident that their deanery or local office would act effectively if concerns about education were raised, 63.3% (n=15,543) said the same thing about their trust or board.

55.7% (n=13,679) of trainers said that they agreed or strongly agreed with the statement that 'my deanery or local education and training board (LETB) works collaboratively with my trust/board to make sure trainees’ educational needs are balanced with service commitments’.

At a local level, 72.0% (n=17,694) of trainers rated the support they receive from their department or practice in their role as an educator as good or very good. 56.3% (n=13,834) said the same thing about their trust or board. And 60.5% (n=14,861) said the same thing about their deanery or LETB.

51.9% (n=12,745) of trainers said that their trust or board was effective or highly effective in making changes to help improve the provision of education.

Positively, 82.5% (n=20,262) of trainers agreed or strongly agreed that the educational responsibilities of their role are very clearly defined; only 5.6% (n=1,363) disagreed or strongly disagreed.

81.0% (n=19,893) of trainers agreed or strongly agreed that the resources in their trust or board allowed them to cover the part of the curriculum required by their trainees.
Many trainers with undergraduate responsibilities did not feel this part of their role is accounted for in their job plan

Of those trainers who said they also acted as an educator to undergraduate medical school students (total n=5,783) – 66.2% (n=3,828) rated the support they received from their medical school as good or very good. 71.1% (n=4,113) agreed or strongly agreed that their medical school values their work as an educator.

Only 49.8% (n=2,882) agreed or strongly agreed that their educational responsibilities in their undergraduate training role are clearly defined in their job plan. This suggests that boards and trusts need to work more closely with medical schools to make sure training time is adequately accounted for.
What did trainers across the UK tell us?

High quality training is essential to patient care. In recent years we have worked with Health Education England, NHS Education for Scotland, Northern Ireland Medical and Dental Training Agency, and the Wales Deanery, to recognise and promote the status of trainers, and the critical role they play in providing the next generations of the profession.

Since 2014 we have published a list of GP trainers practising in the UK. As of 31 July 2016, we required medical schools and postgraduate deans to recognise and support all trainers who act as:

- postgraduate named educational supervisors
- postgraduate named clinical supervisors
- lead coordinators for undergraduate education at each local education provider
- doctors who oversee medical students’ progress at each medical school.

In September 2017, we started publishing this information on the medical register to recognise these important roles.

FOCUS ON: Publication of trainer status on the medical register

In Scotland, deanery quality management and improvement is managed by eight specialty Quality Management Groups (sQMGs).

Each sQMG is accountable for the quality management of training in all posts and programmes within its scope across Scotland. At the start of each quality annual cycle, typically in August or September, each sQMG convenes Quality Review Panels (QRPs) with college, trainee and lay members to review all of the new data, information and intelligence available for all posts and programmes. Each QRP reviews data from a number of sources, including: national training surveys results from trainees and trainers; patient safety and bullying and undermining comments; Deans’ reports; enhanced monitoring details; Scottish Training Survey data; and requirements from recent deanery visits.

Reviewing all of this information allows the QRP panels to identify how training environments are performing. Supported by a ‘decision aid’ the panels will decide which posts or programmes need ‘triggered visits’ to gather more information.

The GMC’s trainer survey data is integral to the data, information and intelligence that is reviewed and discussed for each post at the QRPs. When the trainers’ survey shows several red or pink flags – despite the indications otherwise that the training environment is satisfactory – a Director of Medical Education enquiry is triggered (and the response would be considered by the sQMG). NHS Education for Scotland (NES) have also investigated sites that have green flags in the trainers’ survey to understand what good practice may be taking place.

CASE STUDY: Deanery quality management and improvement in Scotland

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* See www.scotlanddeanery.nhs.scot/trainer-information/quality-management/trainee-and-trainer-surveys/
† Red flags are survey results that are significantly lower than the average score. Pink flags are survey results that are negative but share a confidence interval with the national average. Green flags are survey results that are significantly higher than the average score.


**Conclusion**

The results presented in this section only represent a fraction of the trainer-specific data available in the national training surveys. We encourage trainers, doctors in training and those responsible for medical education to use our online reporting tool* to engage in local quality improvement work.

As we learn more from trainers about the training environments they work in and how they are supported in their education roles, it is increasingly clear that we all need to do more to make sure the vital educational work they do is not taken for granted.

We encourage employers to recognise the important role trainers have in preparing the next generation of clinicians for practice. Educational time needs protecting to achieve this. Our data suggest there are lessons that can be learned from some specialties about how this can best be delivered, and the importance of ensuring closer interactions between trainers and their trainees. This includes considerations of rota design to meet educational as well as service requirements.

In 2018, we’ll also review our work on trainer recognition and listen and learn from partner organisations to assess what has been achieved so far and what more we can do.

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* See www.gmc-uk.org/education/surveys.asp
2 What did doctors in training tell us?

We survey all doctors in foundation, core and higher specialty (including GP) training programmes who are currently in a training post.

There has been continuing debate over the appropriateness of the term ‘junior doctor’ to describe those who are in training programmes. As an organisation we mainly use the term, and derivatives of, ‘doctor in training’, as we think it better reflects the role, skills and experience of this highly qualified section of the UK’s medical workforce. Many ‘juniors’ have worked in our health services for a number of years, dealing with complex and challenging cases every day; these doctors in training are critical to the provision of care in both now and in the future.

2016 was a challenging year, with the contractual dispute in England and pressures on budget and services across the United Kingdom. Despite this, last year’s results showed that trainees recognised the support they received from their trainers and the overall quality of their training. This appreciation for trainers has continued into 2017, but trainees continue to tell us there are still a range of issues that affect their training. Overall, results across the four countries of the UK are broadly comparable although we have highlighted where there are significant differences.

53,335 doctors in training completed the national training survey this year. They gave us views about their day-to-day training experience, and the environments where they work.

Key findings

- **Just over 75%** of trainees rate the quality of teaching in their post as ‘good’ or ‘very good’ and over 80% rate the quality of experience as ‘excellent’ or ‘good’.
- **Just over 40%** rate the intensity of their work by day as ‘heavy’ or ‘very heavy’.
- **Fewer than 60%** rate the encouragement they received to take study leave as ‘good’ or ‘very good’.
- Those trainees who work on a less than full time basis are generally more positive about their training environments and experiences.

*Promoting excellence: standards for medical education and training* set how learners within postgraduate education should be supported.

**Standard S1.1:** The learning environment is safe for patients and supportive for learners and educators. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers and families.

**Standard S1.2:** The learning environment and organisations culture value and support education and training so that learners are able to demonstrate what is expected in Good medical practice and to achieve the learning outcomes required by their curriculum.
What did doctors in training tell us?

Standard S3.1: Learners receive educational and pastoral support to be able to demonstrate what is expected in Good medical practice and to achieve the learning outcomes required by their curriculum.

Trainees continue to rate the quality of their education highly despite workload pressures

Promoting excellence: standards for medical education and training set out how learning opportunities should be balanced with patient care.

Requirement R.1.7: Organisations must make sure there are enough staff members who are suitably qualified, so that learners have appropriate clinical supervision, working patterns and workload, for patients to receive care that is safe and of good standard, while creating the required learning opportunities.

76.4% (n=40,567) of doctors in training would rate the quality of their teaching as good or very good. 7.5% (n=3,966) had a negative ‘poor’ or ‘very poor’ impression.

And 81.8% (n=43,390) of trainees told us the quality of experience in their post was excellent or good. Although this shows a small decline in positive responses from last year (83.0%, n=44,514), it is too early to say whether this is the start of a trend.

As we reported in July*, overall, doctors in training are also reporting slightly improved workload intensity during the day, with 54.8% (n=29,090) saying they felt it was ‘about right’.

While there isn’t much variation between the four UK countries, trainees in England were slightly more likely to report that their workload is ‘heavy’ or ‘very heavy’.

* See www.gmc-uk.org/2017_national_training_surveys_summary_report__initial_results_on_doctors__training_and_progression.pdf_71003116.pdf
53.6% (n=28,425) of trainees said that they work beyond their rostered hours on a weekly or daily basis. Scotland has the highest proportion (30.6% n=1,524) of trainees who said they ‘never’ or ‘less than once a month’ worked beyond their rostered hours.

How would you rate the intensity of your work, by day in this post?

![Intensity of work chart]

Country

- England
  - Very light: 23,700
  - Light: 13,918
  - About right: 4,270
  - Very heavy: 56
  - Very heavy: 222

- Northern Ireland
  - Very light: 935
  - Light: 485
  - About right: 145
  - Very heavy: 22
  - Very heavy: 6

- Scotland
  - Very light: 2,900
  - Light: 1,491
  - About right: 350
  - Very heavy: 46
  - Very heavy: 7

- Wales
  - Very light: 1,304
  - Light: 657
  - About right: 1,491
  - Very heavy: 163
  - Very heavy: 7
What did doctors in training tell us?

22.4% (n=11,880) doctors in training also feel short of sleep at work on a daily or weekly basis.

It is too soon to see the impact of ‘guardian(s) of safe working hours’* and exception reporting † on the working lives of doctors in training in England, and other initiatives in Northern Ireland, Scotland and Wales, but we will continue to scrutinise country-specific national training surveys data to monitor conditions across the UK.

In this post, how often (if at all) have you worked beyond your rostered hours?

In this post, how often (if at all) did your working pattern leave you feeling short of sleep?

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* See www.nhsemployers.org/~/media/Employers/Documents/Need%20to%20know/jnr%20Dr%20 guardian%20of%20safe%20working%2030%2003.pdf
What did doctors in training tell us?

In 2012 and 2013, the GMC national training survey highlighted that the intensity of work was well above the national average at Craigavon Area Hospital. Trainees reported that they were consistently working beyond their rostered hours.

A deanery visit in October 2013 confirmed the findings of the 2012/13 red flag reports.* This led to an agreement between the Educational Supervisor and the trust HR department to produce a rota/shift pattern that would comply with the European Working Time Directive, and would make sure training needs could be better accommodated within the set hours.

Although there was some improvement in the reported figures in the 2014 national training survey, workload intensity remained a red-flagged issue. The Deanery School of Anaesthesia further reviewed the situation through the 2014 June ARCP processes. Although trainees reported that the workload was manageable, and repeatedly rated the quality of experience in this local education provider (LEP) as excellent or good, feedback supported the survey findings of continued high workload intensity.

The Deanery School of Anaesthesia discussed progress on this issue with the Educational Supervisor. As a consequence the trust agreed to initiate a review of five shift pattern change options to determine the clinical, educational and service-delivery feasibility of alterations to shift duration, and the impact of covering some of these shifts with alternate staffing models. The Educational Supervisor also agreed to re-audit out of hours working patterns. This included reviewing pager calls to trainees to determine the frequency, time pattern and source of disturbances; a review of the clinical caseload in theatres, maternity and emergency department to establish the out of hours clinical load accounted for by these areas.

In January 2016, the trust introduced a new rota with revised working hours for both first and second on-call trainees which, as shown by the 2016 and 2017 national training survey, has addressed the workload intensity issue.

From additional follow up – by local school review, and through the ARCP process – indications are that this trust continues to provide excellent training opportunities alongside reduced workloads. It was green flagged for its delivery of the curriculum in the 2017 survey.‘

CASE STUDY: Anaesthesics at Craigavon Area Hospital (CAH) – Northern Ireland

The Northern Ireland Medical & Dental Training Agency shared how they used survey results to identify and address a problem with a particular specialty at a hospital.

* Red flags are survey results that are significantly lower than the average score. Green flags are survey results that are significantly higher than the average score. Pink flags are survey results that are negative but share a confidence interval with the national average.
What did doctors in training tell us?

As this report shows, there are continued pressures on trainers and doctors in training. Our national training surveys allow us to identify these pressures, often providing the first warning signs that a training environment is experiencing difficulties. Sometimes these pressures become serious concerns requiring action to protect and improve the quality of training (which is intrinsically linked to the quality and safety of patient care), and to protect the health and wellbeing of individual doctors.

There are currently two education providers that are subject to conditions we have imposed through our enhanced monitoring process – North Middlesex University Hospital NHS Trust and East Kent Hospitals University NHS Foundation Trust.

We’ve told both organisations they must meet specific standards to retain our approval to deliver training. In each case, we have acted in close partnership with the national education body for England, Health Education England (HEE), to protect the safety of trainees who were being left to deal with situations beyond their competence because of an absence of senior supervising doctors – an issue caused by recruitment difficulties.

North Middlesex University Hospital NHS Trust

In March 2016, we carried out an inspection – again with HEE – of the emergency medicine department of North Middlesex University Hospital. Previous national training surveys showed very poor results for doctors in the second year of the Foundation Programme, general practice and specialty doctors in training at this department.

We worked closely with the trust, HEE, NHS England, NHS Improvement and the Care Quality Commission to closely monitor these concerns and to put measures in place to help improve the standard of training and patient safety in the department. Follow up visits in June and September 2016 revealed some improvements in the level of support and supervision that doctors in training were receiving. We saw echoes of this in the national training surveys results for the department in 2017. However we continue to work closely with all the organisations involved to keep the situation under close review to make sure that trainees are being properly supported.

East Kent Hospitals University NHS Foundation Trust

The Urgent Care Centre at East Kent’s Kent and Canterbury Hospital has been subject to our enhanced monitoring processes following concerns raised with us by doctors in training, through our national training surveys.

In March 2017, we carried out an urgent inspection of the Urgent Care Centre with HEE and found the quality of education and training received by doctors in training to be seriously below the standards we require. Poor levels of clinical supervision made this an unsafe and unsupportive environment for doctors in training, and we were concerned that left unchecked, this could impact on patient safety.

The trust agreed with HEE that trainees should be moved from some medicine specialties at the site to other sites within the trust. This resulted in some services also moving to the other sites to maintain patient safety. A further visit is planned to the trust shortly, to assess whether the medicine trainees’ experience has improved since their relocation to other sites. At that stage we will review whether the trust should stay in enhanced monitoring.

CASE STUDIES: Our work at the Urgent Care Centre – Kent and Canterbury Hospital, and at the Emergency Medicine Department – North Middlesex University Hospital

As this report shows, there are continued pressures on trainers and doctors in training. Our national training surveys allow us to identify these pressures, often providing the first warning signs that a training environment is experiencing difficulties. Sometimes these pressures become serious concerns requiring action to protect and improve the quality of training (which is intrinsically linked to the quality and safety of patient care), and to protect the health and wellbeing of individual doctors.

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**Implications for our future work**

These cases raise questions for us about the effectiveness of the action we can take in situations such as these – situations that are likely to stem from pressures in the wider healthcare environment, which can make sustainable solutions hard to find.

When there are education concerns it is vital that we act in partnership with others to address them quickly before they get worse and cause real harm to doctors in training or patients. Next year we will be actively considering the ways in which we can become more effective in this critical area of our work.

This will include strengthening our understanding of organisations that find themselves in difficulty because of the impact their environments can have – on the education and training of doctors; on a doctor’s ability to meet our professional standards; and on the morale, mental health and wellbeing of doctors and other professionals.

Knowing the root causes and characteristics of environments that are in these positions could enable us to predict and intervene in problems at an earlier stage.

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In this post, how often (if ever) do you feel forced to cope with clinical problems beyond your competence or experience?

![Chart showing the frequency of clinical problems beyond competence by training level.](chart.png)
### I am confident that concerns are effectively dealt with

<table>
<thead>
<tr>
<th>Training level</th>
<th>% of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>F1</td>
<td>851</td>
</tr>
<tr>
<td>F2</td>
<td>1,360</td>
</tr>
<tr>
<td>CT1/ST1</td>
<td>1,229</td>
</tr>
<tr>
<td>CT2/ST2</td>
<td>1,375</td>
</tr>
<tr>
<td>CT3/ST3</td>
<td>2,143</td>
</tr>
<tr>
<td>ST4</td>
<td>780</td>
</tr>
<tr>
<td>ST5</td>
<td>774</td>
</tr>
<tr>
<td>ST6</td>
<td>686</td>
</tr>
<tr>
<td>ST7</td>
<td>487</td>
</tr>
<tr>
<td>ST8</td>
<td>161</td>
</tr>
</tbody>
</table>

- **Strongly agree**
- **Agree**
- **Neither agree nor disagree**
- **Disagree**
- **Strongly disagree**
- **N/A (not aware of any concerns being raised)**
Doctors feel more confident as they progress through the training pathway

6.3% (n=3,327) of doctors in training said that they felt forced to cope with clinical problems beyond their competence or experience on at least a weekly basis.

Perhaps not surprisingly, trainees at the beginning of their postgraduate careers are more likely to report feeling forced to cope with clinical problems beyond their competence on a regular basis.

Patient safety concerns

5.0% (n=2,652) of trainees disagreed or strongly disagreed that patient safety concerns are effectively dealt with – a slight decrease from 5.7% in 2016.

747 doctors in training reported a patient safety concern through the national training surveys in 2017. This is a fall from 838 in 2016. As soon as these are submitted we immediately share them with the relevant postgraduate dean for investigation, and we follow up with the deanery/HEE local team to ensure we are satisfied with the outcome of that investigation.

FOCUS ON: Doctors attitudes to consent and shared decision making

We are currently reviewing our guidance on consent. As part of this process, we commissioned some research* which interviewed doctors from across the UK from a range of specialties and at different stages in their careers.

That research found that younger doctors were more likely to show natural support for shared decision making; doctors further along in their careers also commented that their younger counterparts were better educated in consent and shared decision making.

This year’s survey results seem to corroborate these findings, and the effectiveness of undergraduate and postgraduate education and teaching in this area, with only 1.1% (n=560) of trainees across the UK feeling that they were expected to obtain consent for procedures where they do not understand the proposed intervention and its risks on a daily or weekly basis.

* See www.gmc-uk.org/about/research/31343.asp
More could be done to support trainees to take study leave

58.3% (n=26,737) of trainees (excluding those in the first year of the Foundation Programme) would rate the encouragement they received to take study leave as good or very good.

Doctors at the beginning of their training are less likely to report that they have received encouragement to take study leave – this may be down to greater challenges in supporting foundation, core and ST1/2 trainees. This number increases as they progress through training, with those who rate their encouragement to take study leave as ‘very good’ or ‘good’ rising – although around 30% continue to consider the encouragement they receive in a neutral or negative light even at ST8.

67.9% (n=1,507) of doctors in training in Wales agreed or strongly agreed that they had enough protected time to attend all the local/departmental teaching they needed to in their post. In Scotland that figure is 61.3% (n=3,046) and for England and Northern Ireland it was around 65%.

In this post, please rate the encouragement you receive to take study leave

<table>
<thead>
<tr>
<th>Training level</th>
<th>% of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>F2</td>
<td></td>
</tr>
<tr>
<td>CT1/ST1</td>
<td></td>
</tr>
<tr>
<td>CT2/ST2</td>
<td></td>
</tr>
<tr>
<td>CT3/ST3</td>
<td></td>
</tr>
<tr>
<td>ST4</td>
<td></td>
</tr>
<tr>
<td>ST5</td>
<td></td>
</tr>
<tr>
<td>ST6</td>
<td></td>
</tr>
<tr>
<td>ST7</td>
<td></td>
</tr>
<tr>
<td>ST8</td>
<td></td>
</tr>
<tr>
<td>Very good</td>
<td>1,120 1,096 1,428</td>
</tr>
<tr>
<td>Good</td>
<td>1,929 2,601 2,743</td>
</tr>
<tr>
<td>Neither good nor poor</td>
<td>3,352 1,804 1,680</td>
</tr>
<tr>
<td>Poor</td>
<td>1,097 355 2,168</td>
</tr>
<tr>
<td>Very Poor</td>
<td>511 597 873</td>
</tr>
<tr>
<td>% of Respondents</td>
<td>100 90 80 70 60 50 40 30 20 10 0</td>
</tr>
</tbody>
</table>
The Wales Deanery has recently introduced an Education Contract, between the doctor in training, Local Education Provider (LEP) and deanery. It documents specialty specific expectations in terms of sessions trainees must attend, and key education and training opportunities.

The deanery mapped these criteria and metrics against our approved curricula and royal college training standards. Our *Promoting excellence* standards form the basis against which we and the deanery will monitor the delivery of training across Wales. And a number of those standards and requirements are detailed within the Education Contract.

Accountability for meeting the responsibilities set out in the contracts lies with the trainee, LEP, and the deanery. To make sure issues are identified quickly, the deanery reviews progress against the contract at agreed intervals through existing processes, such as the Annual Review of Competence Progression reviews for trainees; trainee end of placement evaluation feedback processes; real-time monitoring systems and self-reporting for LEPs. Where issues have been identified, an action plan with timeframes and deliverables are agreed. By signing this contract, all parties are demonstrating their commitment and support to developing a culture across NHS Wales which supports learning, education and training.
Doctors training less than full time

We want to make sure medical education and training is responsive to the evolving and changing needs of patients and doctors. As part of this year’s analysis we compared responses to some survey questions between trainees who told us they trained on a full time basis, with those who said they trained on a less than full time basis.

Key points

- 10.7% (n=5,642) of trainees told us they worked on a less than full time basis. Less than full time trainees are more common in some specialties than others.

- 91.2% (n=5,145) of less than full time trainees are female.

- The vast majority of those trainees say that they chose less than full time training due to childcare commitments, disability, illness or health conditions.

- Doctors in training who work on a less than full time basis are generally more positive about their training environments.

Less than full time training is more common in some specialties than others, with surgery (3% n=257), emergency medicine (6.2% n=212), and medicine (6.9% n=1,031) having the lowest proportions.

Are you formally working on a Less Than Full Time (LTFT) basis, which has been approved by your deanery/LETB?
79.2% (n=4,466) doctors training on a part time basis rated the quality of formal teaching in their post as 'good' or 'very good'. 72.0% (n=33,944) of full time trainees said the same thing. When asked about informal teaching, 76.7% (n=4,326) of part time trainees rated it as 'good' or 'very good', compared with 71.7% (n=33,807) of those training full time.

86.0% (n=4,840) part time trainees 'agreed' or 'strongly agreed' that the working environment is a fully supportive one. 82.3% (n=38,760) of full time trainees responded in the same way. 77.0% (n=4,343) part time trainees 'agreed' or 'strongly agreed' that their working environment fully supports the confidence building of doctors in training. 73.1% (n=34,435) of full time trainees said the same thing.

78.0% (n=4,389) part time trainees agreed or strongly agreed that staff, including doctors in training, are always treated fairly. 72.9% (n=34,365) of full time trainees thought the same thing.

92.6% (n=5,224) of part time trainees 'agreed' or 'strongly agreed' that their post will be useful in their future career. 88.56% (n=41,737) of full time trainees said the same thing.

In examples where it might be expected that part time doctors may be disadvantaged – for example, induction, supervisor contact time and encouragement to take study leave – the 2017 surveys show that part time trainees are either equally or more positive than their full time colleagues.
What did doctors in training tell us?

51.4% (n=24,207) of doctors in training who reported that they work on a full time basis rated the encouragement they receive to take study leave as good or very good compared with 62.7% (n=3,537) who answered the same way and said they worked on a less than full time basis.

4.7% (n=266) of less than full time doctors in training said that they had been a victim of or witnessed bullying and harassment in their post but did not want to report it in the national training surveys. 0.3% (n=15) did report it through the national training surveys. Of the doctors in training who report working full time, 5.18% (n=2,443) said they did not want to report a bullying or undermining event they experienced via the national training surveys, and 0.4% (n=171) did report a concern.

23.5% (n=1,323) of doctors in training who reported that they work on a part time basis said that they only received informal feedback on their performance from senior colleagues less than once a month or never. Full time colleagues were slightly more likely to report higher levels of contact, with 21.6% (n=10,186) answering that question in the same way.

The reasons given by trainees for choosing less than full time training are overwhelmingly reported to be related to childcare, disability, illness or health conditions. Opportunities for personal or professional development, extraordinary responsibility, religious commitments, or non-medical professional development are much less common.
We don’t collect data on unsuccessful applications to less than full time training, so we can’t determine whether there are strong additional demands to train on a part time basis because of these factors, that aren’t being approved.

<table>
<thead>
<tr>
<th>Reason for training on a less than full time basis</th>
<th>Number of responses</th>
<th>% number of trainers who answered the survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability, illness or health condition related reasons</td>
<td>1,199</td>
<td>21.3</td>
</tr>
<tr>
<td>Childcare</td>
<td>4,346</td>
<td>77.0</td>
</tr>
<tr>
<td>Caring for an adult (eg a parent, family member or friend)</td>
<td>178</td>
<td>3.2</td>
</tr>
<tr>
<td>Other work commitment (eg professional development opportunities)</td>
<td>218</td>
<td>3.9</td>
</tr>
<tr>
<td>Other external commitments (eg leisure, religious or community commitments)</td>
<td>153</td>
<td>2.7</td>
</tr>
</tbody>
</table>
In the 2017 trainee survey we also added some questions on attitudes to accessing less than full time training. 43.5% (n=22,971) of trainees agreed or strongly agreed that their deanery/local HEE team would be supportive if they requested to formally work on a long-term less than full time basis. However it’s important that we note that 35.0% (n=18,461) answered this question as ‘Not sure (have not considered working on a less than full time basis)’.

Overall, trainees felt that their supervisor would be more likely than their deanery or HEE local office to be supportive of requests to work on a long-term less than full time basis – with 51.5% (n=27,183) agreeing or strongly agreeing that their supervisor would be supportive.
Were I to request to work on a Less Than Full Time (LTFT) basis, I believe my supervisor(s) would be supportive

The same overall number of trainees thought that their colleagues would be as supportive as their supervisor. 51.5% (n=27,057) trainees said they ‘agreed’ or ‘strongly agreed’ that they would be supportive to a request to work on a long-term less than full time basis.

54.9% (n=28,964) of trainees agreed or strongly agreed that their specialty is supportive of trainees who wish to work on a less than full time basis. 25.6% (n=13,493) said they were not sure.

There do appear to be material differences in the responses to this question by specialty, with surgery trainees much less likely to believe that their specialty is supporting of less than full time trainees.
I feel that my specialty is supportive of trainees who wish to work on a Less Than Full Time basis

<table>
<thead>
<tr>
<th>Specialty group</th>
<th>% of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaesthetics</td>
<td>863</td>
</tr>
<tr>
<td>Emergency medicine</td>
<td>1,142</td>
</tr>
<tr>
<td>General practice</td>
<td>1,142</td>
</tr>
<tr>
<td>Medicine</td>
<td>1,142</td>
</tr>
<tr>
<td>Obstetrics and gynaecology</td>
<td>1,142</td>
</tr>
<tr>
<td>Occupational medicine</td>
<td>1,142</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>1,142</td>
</tr>
<tr>
<td>Paediatrics and child health</td>
<td>1,142</td>
</tr>
<tr>
<td>Pathology</td>
<td>1,142</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>1,142</td>
</tr>
<tr>
<td>Public health</td>
<td>1,142</td>
</tr>
<tr>
<td>Radiology</td>
<td>1,142</td>
</tr>
<tr>
<td>Surgery</td>
<td>1,142</td>
</tr>
</tbody>
</table>
Conclusion

As we reported last year, the national training surveys present a complex picture of how postgraduate trainees experience their training environments. Most trainees are satisfied with the training they receive, but acknowledge that high and pressurised workloads affect time available for training.

While workload scores have improved slightly this year, and satisfaction with the quality of teaching remains high, it has fallen by a similar proportion across the four countries of the UK. It is too early to say whether this represents a trend, but we will review these results in the light of the 2018 survey results.

FOCUS ON: Updating our position on less than full time training

In March 2017 we published a seven point plan* to set out how we’re working to improve the flexibility of postgraduate medical training. The plan included our commitment to revise our policy on less than full time (LTFT) training.

We want doctors to be able to adapt their training to reflect their own personal circumstances; and we want to provide clearer and more consistent guidance to help postgraduate deans, colleges and employers consider requests to train more flexibly. On 2 November 2017 we published our updated position statement on LTFT training.

The statement clarifies the role we have in maintaining the quality of UK training and it sets out how the conditions for LTFT training should ensure that doctors maintain current competences, and continue to develop capabilities to progress, maintain an appropriate presence in the training environment, and cover the required aspects of the curriculum.

It also explains that all placements must have the approval of the Postgraduate Dean or their deputy, and that the ability of training programmes and training environments to support doctors to train LTFT will depend on local arrangements.

While it is not part of our role to determine the practical or operational arrangements for those wishing to train at LTFT, or to set requirements for what they may or may not do outside of their programme hours, we want to make sure that those responsible for delivering medical education and training have the information they need to help doctors to train more flexibly. We’re therefore joining with key partners, including the conference of postgraduate medical deans (COPMeD), to update the Gold Guide, ready for publication next year.

* See www.gmc-uk.org/education/30540.asp
3 Variation in responses by specialty

While there are expected and appropriate differences in experience, the national training surveys highlight some interesting findings when we compare the responses of trainees and trainers by specialty.

There is variation in training experiences across different specialties – with emergency medicine, medicine, obstetrics and gynaecology, and surgery often having less favourable responses overall.

The reasons for these differences are likely to be numerous and multi-factorial. For example, they may be down to the operational realities of working in acute and non-acute settings, or specialty-specific cultures and processes.

But we believe there is scope for local education providers (LEPs) to learn from the good practice taking place in their own units and departments – and apply it to areas where surveys’ results indicate improvements are needed. The information required to identify areas of good and poor practice is publicly available on our website, in our online reporting tool*.

Likewise, 44.6% (n=3,847) of doctors in surgical training rated their encouragement to take study leave as ‘very good’ or ‘good’, compared with 66.8% (n=4,323) of those in general practice.

13.4% (n=1,158) of doctors in training within surgery specialties reported that they had to leave a teaching session to answer a clinical call either once a session or multiple times each session. It is of note that only 3.1% (n=80) of those in emergency medicine reported having to do the same thing. This may suggest more effective processes are in place in emergency units to deal with trainee cover during training sessions.

One of the highest variations in experience by specialty relates to workload. As an example, 73.0% (n=2,490) of doctors in training emergency medicine report the intensity of their work during the day as ‘heavy’ or ‘very heavy’ compared with 36.6% (n=2,368) of doctors in general practice and 45.1% (n=1,273) of those in obstetrics and gynaecology.

68.0% (n=5,855) of doctors training in surgical specialties rated the quality of their teaching as ‘very good’ or ‘good’, compared to 90.3% (n=5,846) of those in a general practice programme.

* See www.gmc-uk.org/education/surveys.asp
In this post, please rate the encouragement to take study leave

Trainees: how would you rate the intensity of your work, by day in this post?

However, there are also differences between trainers and doctors in training – while only 36.6% (n=2,368) of doctors training in general practice reported ‘heavy’ or ‘very heavy’ workloads, 84.5% (n=3,054) of general practice trainers reported the same – this striking difference would benefit from further exploration.
Although it may be difficult to identify differences in workplace culture between specialties, it is worth noting that 12.4% (n=1,069) of surgical doctors in training disagreed or strongly disagreed with the statement that the working environment is one that fully supports the confidence building of doctors in training. In comparison, only 4.9% (n=83) of radiology doctors in training said the same thing.

Similarly, while 86.4% (n=5,589) of general practice doctors in training agreed or strongly agreed that if they disagreed with a senior colleague, that colleague would be open to their opinion, 64.9% (n=1,832) of obstetrics and gynaecology doctors in training felt the same way.

Focus on: general practice and primary and secondary placements

The care setting in which general practice training takes place in, affects trainees’ overall satisfaction.

In some cases, it’s important to look beyond splitting results by specialty. For example, trainees can undergo general practice training in primary and secondary care posts, so it’s worth looking in this differentiation in more detail. Across a number of different questions, trainees in primary care settings report better educational experiences than those in secondary care.
Please rate the quality of teaching (informal and bedside teaching as well as formal and organised sessions) in this post

For example, this graph shows responses to the quality of teaching question based on training setting.

While 91.4% (n=4,689) of general practice trainees in primary care posts would rate the quality of their education as good or very good, 72.9% (3,321) of those in secondary care posts would say the same thing.

Similarly, when we look at the question on quality of experience, 93.6% (n=4,800) of primary care trainees would rate theirs as excellent or good, while 75.87% (n=3,455) of secondary care trainees answered the same way.

Looking at questions on patient safety concerns, 3.9% (n=199) of general practice doctors training in primary care said they feel forced to cope with clinical problems beyond their competence or experience. 9.4% (n=430) of those in secondary care responded the same way.
4 The quality of rotas and the impact on postgraduate medical education

Trainees and trainees believe poor rotas have a negative impact on education

Responses to our new questions on rota design show that doctors in training and trainers strongly believe poor and incomplete rotas frequently have a detrimental impact on medical education, with around one third saying that rota gaps impact on available training opportunities.

*Promoting excellence: standards for medical education and training* set out that rotas should provide appropriate educational opportunities.

- **Requirement R.1.12**: Organisations must design rotas to:
  - make sure doctors in training have appropriate clinical supervision
  - support doctors in training to develop the professional values, knowledge, skills and behaviours required of all doctors working in the UK
  - provide learning opportunities that allow doctors in training to meet the requirements of their curriculum and training programme
  - give doctors in training access to educational supervisors
  - minimise the adverse effects of fatigue and workload.

There is some variation in responses to rota gap questions by specialty, with stronger concerns being reported in acute specialties. A comparison between the responses of doctors in training and trainers suggests a commonality of experience within specialties.

45.9% (n=1,273) of obstetrics and gynaecology doctors in training disagreed or strongly disagreed that educational and training opportunities are rarely lost due to gaps in the rota. 28.5% (n=943) of emergency medicine doctors in training responded the same way to the same question. Similarly, 44.2% (n=528) of trainers in obstetrics and gynaecology and 28.0% (n=285) of trainers in emergency medicine said the same thing.

33.4% (n=4,735) of doctors training in a medicine specialty agreed or strongly agreed that gaps in the rota are dealt with appropriately to make sure their education and training is not adversely affected. 62.3% (n=2,794) of doctors training in anaesthetics said the same thing. 39.2% (n= 1,965) of trainers in medicine agreed or strongly agreed when the same question was put to them regarding their trainees; for anaesthetic trainers that figure was 52.1% (n=1,652).

Trainees in some specialties are more likely to report that rota design in their post helps optimise education and development for doctors in training. For example, 40.3% (n=3,459) of surgical specialty trainees agreed or strongly agreed with that sentiment, while 75.0% (n=462) of pathology specialty doctors responded in the same way. While the same pattern can be found in trainers’ responses to these questions, they were more likely than doctors in training to agree that rota design had been optimised. For example, 57.2% (n=1,996) of surgical trainers versus 86.5% (n=474) of pathology trainers.
The quality of rotas and the impact on postgraduate medical education

The rota design in my current post helps optimise trainee doctors' education and development

The rota design in my department/practice helps optimise trainee doctors' education and development
5 Trainees and reported bullying and undermining

Bullying and undermining appears to have an impact on retention

Instances of reported bullying and undermining via the national training surveys have fallen over several years. But our analysis shows that a victim or witness to bullying and undermining behaviour is 10% more likely to state that they will not be continuing in their current training programme in a year’s time.*

Bullying and undermining are completely unacceptable behaviours. Beyond the serious impact of bullying and undermining on those who bear the brunt of it, our analysis suggests it could also affect retention and workloads – potentially making already toxic educational environments worse.

* Chi-squared p<0.05.

How many trainees reported bullying and undermining?

The national training surveys provide an opportunity for trainees to report bullying and undermining concerns when local procedures have not been effective.

In 2017, 187 (0.4%) doctors in training reported being a victim of, or witnessing, bullying and undermining in their post and wanted to report it via the surveys; while 2,721 (5.1%) said they had been a victim or witness but did not want to report it. This represents a slight decline from 2016 when the number of responses was 590 and 2,818 respectively – although 541 of the 2016 comments referenced the contract dispute in England. As a result it isn’t possible to directly compare data.

The greatest number of bullying and undermining reports came from doctors in training within the specialties of medicine (69 reported, 808 indicated but not formally reported); surgery (23 reported, 643 indicated but not formally reported); and obstetrics and gynaecology (26 reported, 290 indicated but not formally reported).

Promoting excellence: standards for medical education and training set out how those at all stages of training should be treated.

Requirement R3.3: Learners must not be subjected to, or subject others to, behaviour that undermines their professional confidence, performance or self-esteem.
Have you been the victim of, or witnessed, any bullying or harassment in this post?

![Chart](chart.png)

Person doing the bullying or undermining | Number of responses in national training surveys 2017
--- | ---
Consultant/GP (within my post) | 83
Consultant/GP (outside my post) | 29
Nurse/midwife | 28
Other doctor | 31
Other trainee | 15
Management | 20
Patient/relative | 11
Other | 29
We understand that a large number of trainees do not feel comfortable in reporting bullying and undermining concerns to their regulator. By design, because we expect deaneries/HEE local teams to investigate reports and report back to us on how they’ve been resolved, the process is not completely anonymous.

And we know from talking to doctors that they have concerns that complaints may be held against them later in their career by us or their employer. That fear of adverse consequences shows itself in the data table above, alongside the worrying continued belief that reporting bullying and undermining will fail to have any effect.

We appreciate how some trainees may feel, but for our part we handle complaints of bullying and undermining – as well as patient safety concerns – sensitively. And we expect employers, deaneries and HEE local teams to investigate fairly and move to protect complainants from reprisal.

We use our position as regulator to maintain supportive and fair educational environments.

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* It was possible to select more than one response.
CASE STUDY: The Royal College of Surgeons of Edinburgh – working to tackle bullying in the specialty

The Royal College of Surgeons of Edinburgh (RCSEd) has developed a comprehensive strategy to prevent undermining and bullying behaviour in surgery. This followed publication of data from the 2014 national training survey suggesting this behaviour was more prevalent in surgery than in almost all other specialties.

The link between bullying and undermining behaviour and patient safety is now clear. Evidence that this kind of behaviour has a negative impact on the workings of a team is getting bigger each year. The extent of bullying and undermining throughout healthcare is well documented, and surgery in particular is often reported as being a specialty where it is particularly prevalent.

In the 2014 national training survey results, surgical specialties had the second highest reported incidence of bullying. RCSEd conducted its own survey of members and fellows. This found that nearly 40% of respondents reported they had been victims of such behaviour, with the same proportion reporting that they had witnessed it.

It has been estimated that bullying and undermining behaviour costs organisations in the UK £13.75 billion annually*. And healthcare professionals have attributed disruptive behaviour in the perioperative area alone to 67% of adverse events, 71% of medical errors, and 27% of perioperative deaths. In addition, the Mid Staffordshire NHS Foundation Trust Public Inquiry† (the ‘Francis Report’) concluded that bullying and undermining of staff contributed to the culture of poor patient care at Stafford Hospital.

In response, the President and Council of RCSEd established a Bullying and Undermining Behaviour Working Group, charged with leading a culture change not only in surgery, but in all other specialties. The RCSEd is working closely with the GMC, and the BMA, the Royal College of Obstetricians and Gynaecology, the Royal College of Midwives, the Royal Australasian College of Surgeons, the Foundation Schools and the Intercollegiate Surgical Curriculum Programme to develop a set of resources to help doctors who may experience or observe bullying, or who may identify negative behaviours in their own practice. The RCSEd have also collaborated with Wellbeing at the Bar (who aim to protect and improve psychological health among barristers) and the Ben Cohen Foundation (a charity who campaign against bullying) to draw experiences from non-medical experts.

Since the inception of the group, it has:

- developed a freely-available set of web resources defining the law, the relevant literature, the effect on patient care, strategies for self-reflection, and strategies for reporting bullying and undermining behaviour safely
- produced freely available ten and 30 minute presentations that can be delivered at local hospital grand rounds or departmental teaching
- developed a continuing professional development-accredited eLearning module

* See www.acas.org.uk/index.aspx?articleid=5543
† See webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/
launched a successful poster and social media campaign called #LetsRemoveIt
- begun to design a professional development course for surgeons and dentists, aiming to optimise workplace behaviour.

RCSEd believes that achieving culture change takes time, and so is fully committed to this work in the long term. The college will look to future results of the national training surveys as one marker of success, and will continue to refine its approach as the data emerges. RCSEd will always have a zero tolerance approach to bullying, undermining and harassment, and categorically condemns this in all circumstances.
6 What happens next?

Supporting trainers as the backbone of medical education

It is clear that many trainers are going above and beyond to deliver training to trainees who continue to rate it highly. Findings here and elsewhere raise questions on how sustainable the current delivery systems remain and what the long-term impact will be on the quality of education doctors’ receive. We urge everyone responsible for medical education to use the findings in this report and work with trainers to make improvements where necessary.

Our role is to protect and enhance the status of trainers, by recognising the critical role they play. Over the past few years, we’ve concentrated on recognising trainers, and came to the end of our planned implementation plan in September 2017 when we published the status of undergraduate and postgraduate trainers on the medical register.

Next year we’ll evaluate the work we’ve done in this area and investigate what more we can do ourselves and with others to continue to support trainers.

The pressure on educational environments

Last year we reported on pressures on the system and challenged employers to protect training. We acknowledge that pressures on health services across the UK are very real, and there are some welcome signs of small improvements for trainees.

Now we’ve adapted the questions put to trainers, we can more clearly see that trainers are also experiencing those same pressures; raising further concerns and difficult questions on how to strike the right balance between education and training; service delivery and patient safety in the short and long term.

It is clear that trainers and trainees are working hard to deliver services. With no immediate indication that those pressures are going to ease, there is a danger that education is not seen as a priority. We do not believe that service provision and medical training are necessarily a zero-sum game. Both are inextricably linked. A lack of training opportunities, mixed with busy working conditions has obvious patient safety implications. Safe training environments are usually safe places to work and safe places to be treated.

Using the surveys to identify and intervene in poorly performing training environments protects trainees and trainers and raises standards. While we understand the realities of survey fatigue on busy professionals, results are taken seriously by trusts, boards, deaneries, HEE local teams, colleges and faculties and we individually and collectively take action when required – examples of this are presented throughout this report.

We strongly encourage trainers and trainees to continue to provide honest feedback on their training environments through the national training surveys.
Developing the national training surveys

Each year, we carry out a process of continuous improvement to the national training surveys, to make sure they remain fit for purpose as quality assurance tools. This involves working with training organisations, and conducting focus groups with doctors in training across the UK. We test changes to survey questions and indicators and explore new topic areas; we also commission independent research into the statistical validity of the survey.

Rota design

In 2017, we tested new questions on rota design in both the trainee and trainer surveys, to see if this would enhance our view of training environments. We shared test data with seven deanery/HEE local offices to check how the results compared with other local intelligence sources.

Feedback was positive, suggesting NTS data on rota design could be used to help triangulate the training environments where rota gaps are having an adverse impact, as well as places where good rota design is working well. Consequently, we are planning to include questions in the 2018 survey, with results for the indicator publicly available in the online reporting tool next year.

Health and wellbeing

Another important area we have been exploring is doctor health and wellbeing. In recent years there have been growing concerns about the impact of working conditions on doctors’ personal lives, with fears that pressures could lead to burnout, and have a negative impact on mental health.

In the last twelve months we have worked with groups of doctors in training, including representatives from the British Medical Association, to test whether survey questions on this topic would be appropriate, and what they might look like. Doctors told us that questions that focus on mental health could be viewed as problematic, as some respondents may have concerns about sharing personal data with a regulatory body. As a result, we decided not to include these questions in the 2017 trainee while we looked into these complex issues further.

Since then we have continued to engage doctors and their representatives to explore how we can sensitively collect data in this area. We are now planning to develop new questions in advance of the 2018 survey to help us measure wellbeing in a way we hope survey respondents will feel comfortable with. We hope the resulting information and data will help us produce an analysis of where issues like burnout are having a negative impact on the training environment, and on doctors’ wellbeing.

Increasing flexibility

We are committed to making sure education and training are responsive to the evolving and changing needs of patients and doctors.

This year we published, *Adapting for the future: a plan for improving the flexibility of UK postgraduate medical training,* which aims to improve training paths for doctors by offering more flexibility for trainees and patients with doctors who can care for multiple health conditions.

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* See www.gmc-uk.org/news/30721.asp
As the first step to implementing that plan we also published, *Excellence by design: standards for postgraduate curricula*, which asks medical colleges and faculties to update all existing postgraduate medical curricula by 2020 against new standards designed to support greater flexibility in postgraduate training.*

We have recently updated our position on less than full time training for doctors working towards a Certificate of Completion of Training (CCT)† – setting out our conditions to make sure that the duration, level and quality of less than full time training is not less than that of continuous training. The statement also clarifies that we don’t set requirements for what a doctor may or may not do outside of their training programme hours – including part-time work.

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* See www.gmc-uk.org/news/29707.asp
† See www.gmc-uk.org/education/postgraduate/27071.asp
What did doctors in training tell us?