



General
Medical
Council

National training survey 2016

Key findings

Working with doctors Working for patients

Contents

| | |
|---|----|
| Foreword | 01 |
| Introduction | 03 |
| What did doctors in training across the UK tell us? | 05 |
| What did trainers across the UK tell us? | 18 |
| Variations between England, Northern Ireland, Scotland and Wales | 25 |
| How we use the national training survey to improve medical training | 29 |
| National training survey in action across the UK – using the data outside of the GMC | 31 |
| What happens next? | 34 |
| | |
| Appendix A – Who answered the survey? | 35 |
| Appendix B – Using the national training survey reporting tool | 39 |

Foreword

That there are pressures on health services across the UK will surprise no one. In October, when we published our annual report – *The state of medical education and practice in the UK* – we warned of a ‘state of unease’ that exists within the medical profession, and evidence in our national training survey reinforces that important message.

Doctors in training are the next generation of consultants and GPs, and they are telling us, in significant numbers, that current workloads threaten the time they need to train. Poor-quality training, whether it’s to a low standard, rushed or interrupted, correlates with a higher likelihood of patient safety concerns, and with working environments that are not conducive to doctors raising concerns.

Trainers are also struggling under the strain. They tell us they enjoy the role when they get time to do it, but almost one in three say they simply don’t have enough time.

All this can have serious consequences for patients and doctors alike.

Concerns around heavy workloads for doctors in training

Overall, around four in ten doctors in training told us their workload was heavy or very heavy. But the figures were worse, and more worrying, in those specialties that we know are struggling to cope with the rise in demand from patients. In surgery, emergency medicine, and obstetrics and gynaecology, many doctors told us they routinely have to work beyond their rostered hours.

In raising concerns about patient safety, doctors in training highlighted rota gaps – which is why, in next year’s national training survey, we will test new questions about rota gaps that can help us better pinpoint the problems.

These questions will be particularly important because overworked doctors had twice as many patient safety concerns – demonstrating that doctors in under-resourced placements are more likely to come face-to-face with poor practice. They were also six times more likely to feel forced to cope with clinical problems beyond their competence.

Doctors with heavy workloads were also more likely to have to leave teaching sessions to answer clinical calls. Training time is essential for doctors to gain the knowledge, skills and experience they need.

That’s not to say the picture is entirely bleak.

Training is held in high regard, despite wider pressures

The survey findings highlight a tremendous amount of high-quality training that’s taking place across the UK. Overall satisfaction with training provision is relatively high, and remains stable. For that we must acknowledge – and indeed celebrate – the excellent work done by so many senior doctors, often in difficult circumstances, in their roles as trainers of highly-motivated trainees.

The high regard that doctors have for their training, and those who provide it, is clear, and it must be borne in mind that our survey focuses on training, and not on any wider concerns postgraduate doctors in training may have about working in the UK health services.

This year’s survey was run at the height of the dispute between the British Medical Association and the Department of Health (England) over the contract for doctors in training. Yet while the dispute was in England, the survey results were strikingly similar in each of the four home nations. Doctors in training are working in systems that are under significant and growing pressure, and for a host of reasons

(many of them non-contractual) they feel undervalued. It is vital that we address this crisis affecting the next generation of medical leaders – indeed we have started to do so by looking at the current inflexible nature of postgraduate training.

We're very grateful for the professionalism of those who completed the survey, which gives us a uniquely detailed insight into training environments at individual locations right across the UK.

However, insight alone is not enough, and there is a need for vigilance and action, nationally as well as locally, to ensure the quality of medical education and training is protected in what are very difficult times. The GMC, and those responsible for managing training, will work with trusts and boards and take prompt action to address concerns identified by doctors in training and their trainers.

Charlie Massey, Chief Executive and Registrar

Introduction

What is the national training survey?

We run an annual UK survey of two groups of doctors:

- doctors in postgraduate training – all those in foundation, core and higher specialty (including GP) training programmes.
- trainers – named clinical and educational supervisors.

The trainer survey was originally developed by the Postgraduate Medical Education and Training Board (PMETB) in 2007, alongside their existing survey of doctors in training. When PMETB merged with the General Medical Council (GMC) in 2010, we continued this work, running both surveys side by side until 2011, when we paused the survey of trainers to work on a framework for recognising and approving trainers.*

Following a pilot with five deaneries and local and educational training boards (LETBs) in 2014, we reintroduced the national survey of trainers to make sure we gathered the views of clinical and educational supervisors about how they are supported in their training roles.

The UK response rate for the survey of doctors in training has been approximately 98% since 2013 (98.7% in 2016). This year the trainer survey response rate was 53.3%.

The national training survey is a powerful monitoring tool that provides intelligence about training posts across the UK. It gives all of us involved in medical education and training – including our visits teams, postgraduate deans, and National Health Service

(NHS) and Health and Social Care in Northern Ireland (HSC) trusts and boards – the information we need to take action and resolve issues at a local level.

It also gives doctors in training and trainers an opportunity to give confidential feedback on their perceptions of their local training posts and programmes. This feedback forms a crucial part of the evidence we use to quality assure medical education and training, by enabling us to identify good practice and pinpoint the places where training does not meet our standards.

What standards do medical education and training providers work to?

Our standards, *Promoting excellence: standards for medical education and training*,[†] came into effect in January this year. They require organisations responsible for medical education and training to provide high-quality educational experiences in safe, effective and appropriately-supported learning environments. We expect those organisations – including employers – to use the results of the national training survey, along with other sources of information, to review and improve how they manage and deliver their training programmes and posts.

We monitor and check their progress through regular reporting, analysis of survey results and trends, and visits and inspections. Where hospitals and other training providers don't meet our standards, we will take action. This report contains several case studies that show real examples of this process in action.

* See www.gmc-uk.org/education/10264.asp.

† See www.gmc-uk.org/education/standards.asp.

There were no major differences between the four UK nations

Our results in 2016 show no major difference in indicators between England, Northern Ireland, Scotland and Wales.*

Results from this year's survey indicate high levels of satisfaction with training posts across the four countries of the UK from doctors in training and trainers.

Despite this, we know that there is a large amount of concern within the health services due to increasing workloads and stretched budgets, as well as uncertainty linked to the postgraduate doctor in training contract issue in England.

Respondents made comments about patient safety, bullying and the contract dispute in England

The national training survey does not seek views on wider political, professional or industrial issues, and is not designed to measure workplace satisfaction within the NHS/HSC as a whole – other surveys do this.

However, this year 541 doctors in training used this as an opportunity to comment on the postgraduate doctor in training contract dispute in England. You can read a summary of the comments we received in this year's survey on pages 16 and 17.

* We have not given a full analysis of every question compared across the four countries of the UK. But you can use the national training survey reporting tool to compare questions. You can find a summary of four-country findings on pages 25–28.

What did doctors in training across the UK tell us?*

- Doctors reported decreasing satisfaction with workloads (44.5% average score in 2016, compared with 46% in 2014).
- Compared with 2012, 2.3% more respondents – over 1,200 doctors – rate their workloads as heavy or very heavy during the day, and 3.4% more respondents – over 1,800 doctors – report feeling short of sleep on a 'daily' or 'weekly' basis, in 2016.
- Doctors with the highest workloads are more likely to report patient safety concerns, especially in acute care.
- Doctors continue to report concerns that, in some training environments, patient safety risks are not being addressed locally – with 1.8% of respondents [n=979], stating that this is the case.
- Satisfaction with training posts remains high. UK-wide average scores for the majority of survey questions remained unchanged from 2015 – despite the ever-increasing pressures of working within the four health systems of the UK.
- We spoke to a sample of doctors in training from across the UK to try to understand the apparent paradox of positive national training survey scores and obvious dissatisfaction. They told us that they view the national training survey as being an opportunity to reflect on how they feel about their training posts and not how they feel as an NHS/HSC employee.
- A number of doctors we talked to also acknowledged the high-quality work done by trainers and others involved in providing training under increasing workplace pressures.
- Some doctors still feel they cannot speak up about bullying and undermining in the workplace. 5% [n=2,818] of doctors who said they experienced or saw bullying and undermining behaviour in their current post said they would not report it in the national training survey.
- This year, 541 doctors shared concerns about the new contractual arrangements in England. Their concerns related to the potential negative impact on patients from proposed rotas, low morale and mental health issues. They also had longer-term patient safety concerns relating to an expected increase in doctors leaving training in the UK.

Increasing pressures and low morale

As we highlighted in *The state of medical education and practice in the UK 2016*,[†] there are rising levels of workplace pressure and levels of dissatisfaction within UK health services.

NHS Providers has warned that the NHS in England is 'under the greatest pressure in generations'.[‡] Audit Scotland has warned about declining standards of care due to budget cuts and the 22% increase in the amount spent on locum services in Scotland between 2013–14 and 2014–15 indicates problems with recruitment.[§]

* 53,835 doctors in training completed the survey out of the 54,563 who were eligible – giving a response rate of 98.7%.

† See www.gmc-uk.org/somep2016.

‡ See www.theguardian.com/society/2016/sep/10/hospitals-on-brink-of-collapse-say-health-chiefs.

§ See www.audit-scotland.gov.uk/uploads/docs/report/2015/nr_151022_nhs_overview.pdf.

The most high-profile recent example of workplace dissatisfaction has been the doctor contract dispute in England. But there are other indications that NHS and HSC staff across the UK are increasingly likely to suffer from low morale. A survey by the British Medical Association (BMA) in 2014 found that just one in five of doctors who joined the BMA's online research panel were satisfied with their career,^{*} while the 2015 National GP Worklife Survey found that GPs' job satisfaction was the lowest and their stress levels highest since the surveys began in 2001.[†] And there are indications that an increasing number of doctors are considering working outside the UK.[‡]

The paradox of high levels of satisfaction with training

Against this UK picture, the national training survey shows that doctors continue to feel positive about their training environment – despite some local areas of clear concern, overall satisfaction with training provision at a national and regional level is relatively high and has remained stable over recent years.

97.1% [n=52,097] of doctors in training rated the quality of clinical supervision in their post as excellent, good or fair. 96.3% [n=51,642] rated the quality of experience in their post on the same scale. 93.8% [n=50,301] would describe the post to a friend who was thinking about applying to it as excellent, good or fair.

Reasons for this paradox are likely to be complex. But when talking to groups of doctors in training from across the UK about the survey, they told us that this is largely due to the national training survey being viewed as an avenue through which to report on current training placements, rather than on wider experiences of being an NHS or HSC employee. We recognise that high levels of training satisfaction against such a difficult backdrop is a testament to the professionalism and dedication of trainers and those responsible for quality managing training programmes across the UK.

Survey results highlight some worrying trends

That is not to say that there are no areas of concern within the national training survey results. A number of indicators highlight worrying trends in relation to workload, patient safety and disparity between specialties – especially in acute care.

Doctors in training feel their workload is increasing and so are concerns about patient safety

Doctors in training reported decreasing satisfaction with workloads (44.5% average satisfaction score in 2016, compared with 46% in 2014). The survey demonstrates that doctors working under significant workload pressures are far more likely to report patient safety concerns.

We asked doctors in training to report their daytime workload on a five-point scale:

- very light (0.5% of respondents) [n=267]
- light (3.5%) [n=1,882]
- about right (52.8%) [n=28,261]
- heavy (32.5%) [n=17,368]
- very heavy (10.7%) [n=5,743].

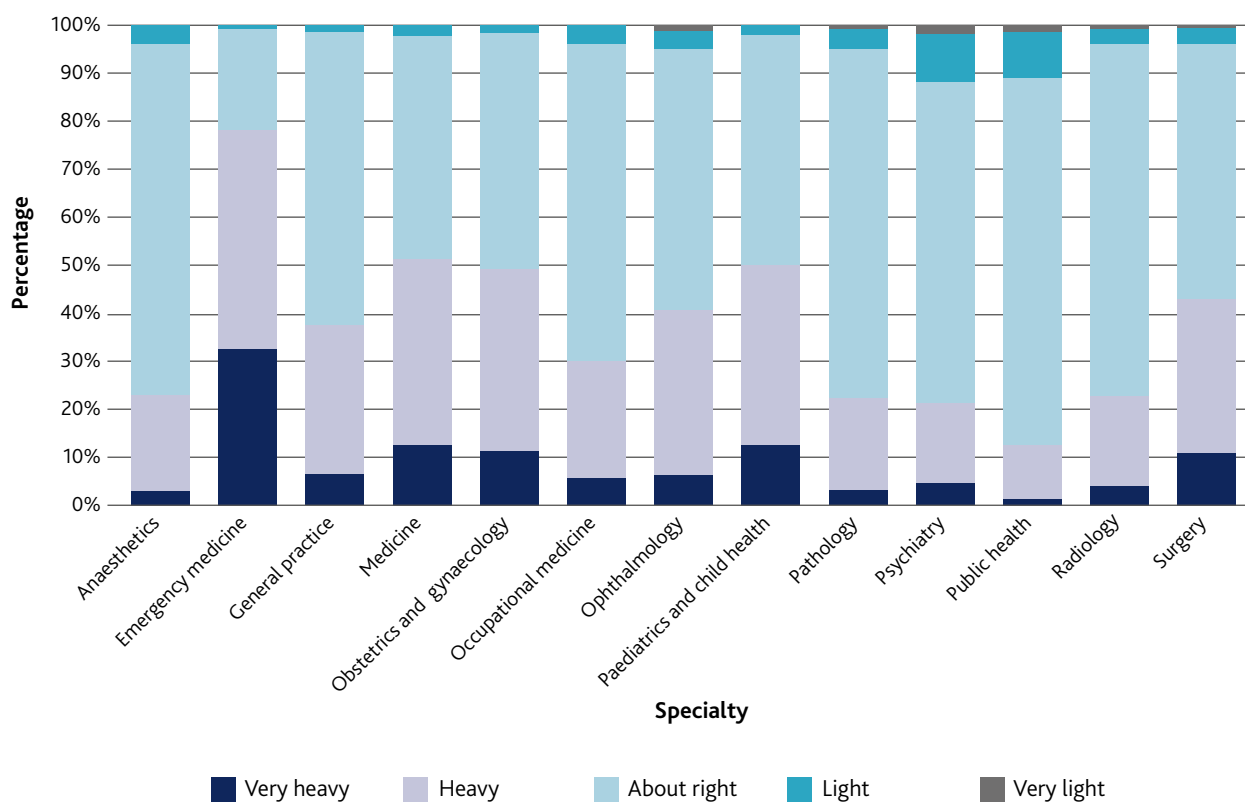
The graph on the following page provides a percentage breakdown of workloads with post specialty group. Doctors in training in acute specialties were more likely to report that their workloads were heavy or very heavy.

^{*} British Medical Association (2016) *Morale decline: workforce survey shows plummeting satisfaction* available at www.bma.org.uk/news-views-analysis/news/2014/december/morale-decline-workforce-survey-shows-plummeting-satisfaction (accessed 26 August 2016).

[†] Gibson J, Checkland K, Coleman A, Hann M, McCall R, Spooner S and Sutton M (2015) *Eighth National GP Worklife Survey* available at www.population-health.manchester.ac.uk/healthconomics/research/Reports/EighthNationalGPWorklifeSurveyreport/EighthNationalGPWorklifeSurveyreport.pdf (accessed 26 August 2016).

[‡] See www.bma.org.uk/collective-voice/policy-and-research/education-training-and-workforce/cohort-study.

Day workload by specialty



Across all specialties when compared with doctors in training who said their workload was about right [52.8%, n=28,261] those who said their daytime workload was very heavy [10.7%, n=5,743]:

- had **twice as many** concerns about patient safety in their post (21.1% to 8.7% [n=1,210 to n=2,465]). This is obviously concerning, as it demonstrates that doctors in training within under-resourced placements are more likely to come face-to-face with poor practice
- were **six times more likely** to feel forced to cope with clinical problems beyond their competence or experience on a daily or weekly basis (15.5% to 2.4% [n=890 to 691]). This has worrying implications for the safety of patients, doctors in training, and public confidence. Our standards are clear that doctors in training should not be expected to find themselves in such a situation:

Requirement R1.9 of *Promoting excellence* says:

Learners' responsibilities for patient care must be appropriate for their stage of education and training. Supervisors must determine a learner's level of competence, confidence and experience and provide an appropriately graded level of clinical supervision.

When compared with doctors in training who said their daytime workload was about right (52.8% [n=28,261]), those who said their daytime workload was heavy or very heavy (43.2% [n=23,111]):

- were **three times more likely** have to leave a local teaching session to answer a clinical call once or multiple times each session (12.7% to 4.4% [n=2,927 to 1,246]). While we acknowledge that treatment in busy environments is an occupational inevitability, training time should be protected as much as possible

- were **one-and-a-half times more likely** to disagree or strongly disagree that appropriate members of the multidisciplinary team were included in handover (16.5% to 11.2% [n=3,256 to 2,461]).

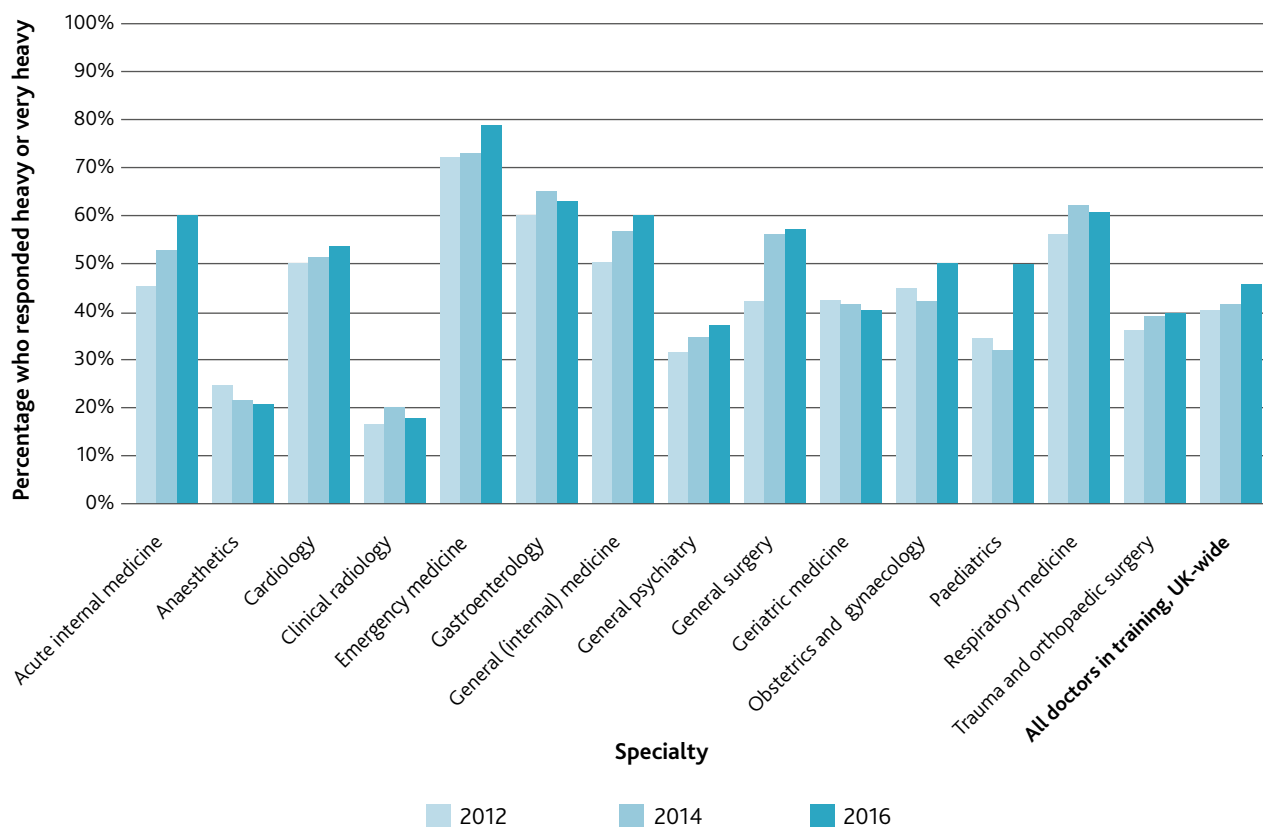
The data also suggest that doctors in training who report insufficient time for training are more likely to give poorer scores to questions related to satisfaction with clinical supervision in and out of hours.

Over the last few years, we can see that more doctors in training are reporting heavy or very

heavy workloads. The graph below shows increasing proportions of doctors reporting heavy or very heavy daytime workloads across many of the larger specialties (n>1,000) over the period 2012 to 2016.

These workload and time pressures are only likely to increase in the short and medium term.*† We consider the protection of training time to be essential to give doctors the knowledge, skills and experience they need.

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



* See <http://qmr.kingsfund.org.uk/2016>.

† See www.hsj.co.uk/topics/workforce/revealed-nhs-trusts-to-lose-millions-in-training-funding/7010145.article.

Table of key workload and clinical supervision satisfaction scores across the four countries of the UK

| | England | Northern Ireland | Scotland | Wales |
|--|---------|------------------|----------|-------|
| Workload | | | | |
| About right | 52% | 58% | 56.7% | 55.3% |
| Light or very light | 3.9% | 4% | 4.9% | 4.3% |
| Heavy or very heavy | 44% | 38% | 38.3% | 40.4% |
| Daily or weekly feeling short of sleep during work | 25% | 19.6% | 21.3% | 22% |
| Daily or weekly worked beyond their rostered hours | 59.7% | 53.8% | 50.3% | 57.4% |
| Clinical supervision | | | | |
| Excellent or good | 84.2% | 87.7% | 86.3% | 86.6% |
| Fair | 12.8% | 10.5% | 11.1% | 11.3% |
| Poor or very poor | 2.9% | 1.8% | 2.6% | 2.1% |

We have increased our resources around our enhanced monitoring processes* and we intelligently target areas where doctors in training report significant concerns. In talking to doctors in training

who filled out the national training survey, there is some awareness that the survey helps to drive local improvements.

* See www.gmc-uk.org/education/enhanced_monitoring.asp.

FOCUS ON: Training, the workplace and links to patient safety

Vincent et al (1998)* present a framework for understanding risk and safety in clinical medicine. A key concept within their framework is that there are latent failures which negatively influence staff performance, and provide the working conditions for unsafe acts to occur.

Those conditions include:

- heavy workloads
- inadequate knowledge or experience
- inadequate supervision
- a stressful environment
- rapid change within an organisation
- incompatible goals (for example, conflict between finance and clinical need)
- inadequate systems of communication
- inadequate maintenance of equipment and buildings.

(Vincent et al, 1998:1155)

Specific questions within the national training survey are used to explore:

- the workloads of doctors in training and trainers (for example, 'How would you rate the intensity of your work, by day in this post?')
- the quality of supervision (for example, 'In this post how often, if ever, were you supervised by someone who you felt wasn't competent to do so?')
- whether doctors in training are being asked to perform tasks without adequate knowledge or experience (for example, 'In this post how often have you been expected to obtain consent for procedures where you feel you do not understand the proposed interventions and its risks?').

It is possible to look at problems within the training environment as being a precursor or a sign of wider problems within medical environments and we therefore think that the national training survey has value in identifying systemic failings. That is why we use national training survey data before a regulatory visit.

* Vincent, C., Taylor-Adams, S. and Stanhope, N. (1998) Framework for analysing risk and safety in clinical medicine. *British Medical Journal*, Vol 316, pp. 1154–1157.

CASE STUDY: North Middlesex Hospital

In July 2015, we – alongside Health Education England (HEE) – visited the emergency medicine department of North Middlesex Hospital. Previous national training survey results showed very poor results for doctors in the second year of the Foundation Programme, general practice and specialty doctors in training at this department. HEE had previously received reports from doctors in training of undermining, a lack of focus on education and unmanageable workloads. The trust undertook work to address these issues, but service pressures, staffing issues, and management challenges meant that a follow up visit in March 2016 alongside HEE identified additional serious concerns. These were around clinical supervision, workload and the supportive environment. The 2016 national training survey results also reflected these issues within the emergency department.

We proceeded to work 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 reported some improvements in the level of support and supervision the doctors in training are receiving.

We've undertaken significant effort to support doctors at North Middlesex Hospital throughout 2016. We ran sessions with foundation doctors to look at how and where to raise concerns, as well as helping them to develop their leadership skills. We worked closely with medical management at the trust to make sure doctors feel supported and that any concerns raised are dealt with effectively. And we ran sessions with doctors in training, to look at a range of issues, including better care towards the end of life, effective patient-doctor decision making together, and leadership and management techniques.

We continue to work closely with HEE, the trust, NHS England, and other healthcare regulators to collaboratively monitor and ensure patients and doctors in training are safe at North Middlesex Hospital. The national training survey data will be a key tool in that process.

Satisfaction with training in acute care environments remains low and there are significant concerns around patient safety

Doctors in training within acute care environments reported significant pressures that may impact patient safety and limit time available for training.

- **One in five** doctors in training (19.0%) [n=221] in **emergency medicine** posts had a concern about patient safety.*
- 748 doctors in training (8.4%) in **surgery** posts, 1,030 doctors in training (6.7%) in **medicine** posts, and 181 doctors in training (5.4%) in **emergency medicine** posts felt forced to cope with clinical problems beyond their competence or experience on a daily or weekly basis.
- If we average the scores of all national training survey questions, related to satisfaction and rank them by specialty, then **surgery, emergency medicine, medicine, and obstetrics and gynaecology** rank the lowest. This means that these specialties also score lower in key risk areas, such as clinical supervision and patient safety.
- **Surgery posts** – as a specialty and as part of the Foundation Programme – is in the bottom three (out of thirteen) ranked specialty groups in 85 of 106 questions.†
- 748 doctors in training (8.4%) in **surgery** posts, 1,030 doctors in training (6.7%) in **medicine** posts, and 181 doctors in training (5.4%) in **emergency medicine** posts felt forced to cope with clinical problems beyond their competence or experience on a daily or weekly basis.

- Overall, **obstetrics and gynaecology** doctors in training and trainers score the support they receive in their environment the lowest of all specialty groups.
- Doctors in training in both **geriatric medicine** and **endocrinology and diabetes mellitus posts** rated the quality of their clinical supervision out of hours as poorer than the national average.

Worryingly, the number of doctors in training who reported that they feel short of sleep at work on a daily or weekly basis is increasing with a pronounced upward trend in the data since 2012. The graph on the next page shows increasing proportions of doctors reporting feeling short of sleep on a daily or weekly basis across many of the larger specialties (n>1,000) over the period 2012 to 2016.

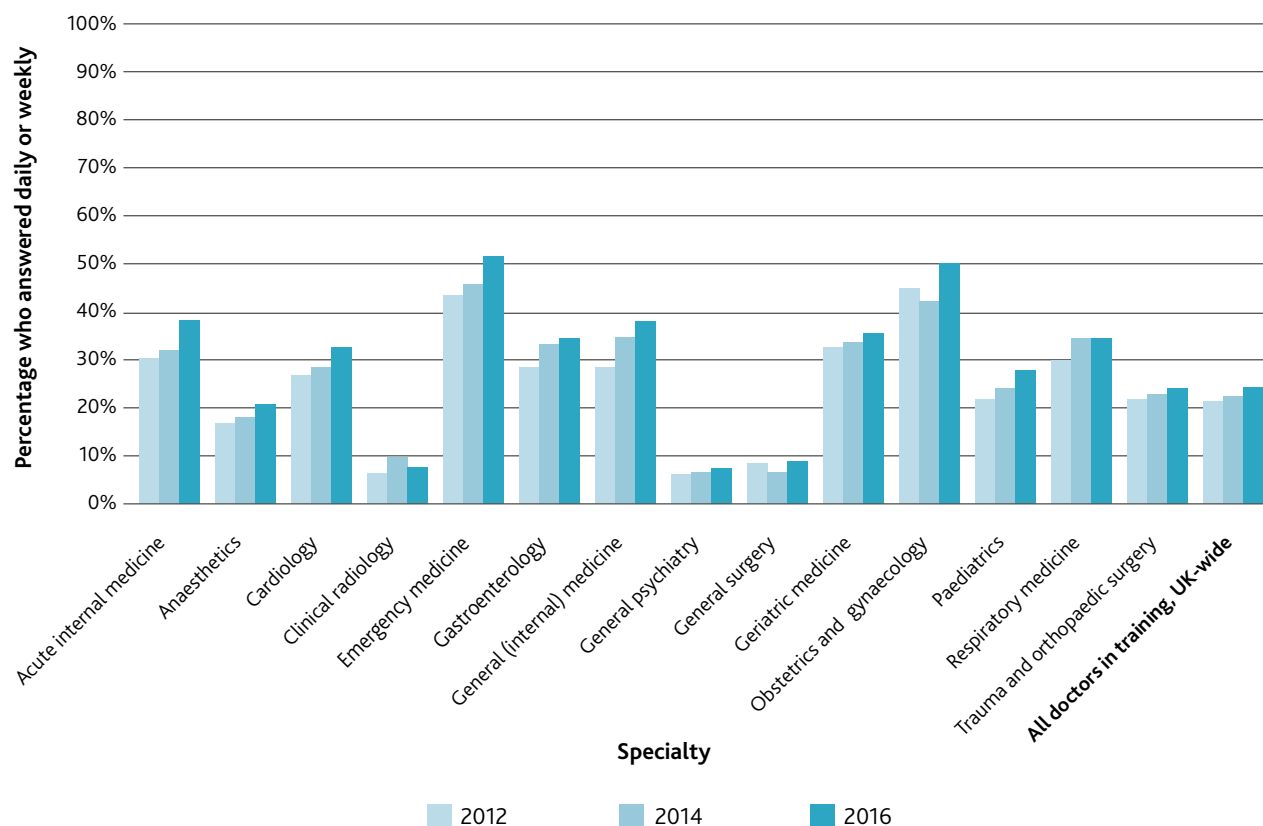
Following concerns – particularly around doctors in training working unsupervised at night – in 2012/13 we reviewed training in seven emergency medicine departments in England and Jersey and produced a report with recommendations titled *Medical education's front line: A review of training in seven emergency medicine departments*.[§] We remain concerned about the experiences of patients and doctors in training in emergency medicine environments.

* Rankings exclude Public Health and Occupational Medicine responses due to low 'n's for these specialty groups (Public Health n:155 trainer, 252 doctor in training; Occupational Medicine n:trainer 43, doctor in training 70).

† See previous footnote.

§ See www.gmc-uk.org/Medical_Education_s_Frontline__A_review_of_training_in_seven_emergency_medicine_departments.pdf_52637479.pdf_60861833.pdf.

In this post, how often did your working pattern leave you feeling short of sleep when at work?



FOCUS ON: Using the national training survey to report concerns

There are two opportunities in the national training survey for doctors in training to leave free-text comments. These sections are designed to give respondents an opportunity to report both bullying and undermining and patient safety concerns at their current post.

While the national training survey presents an opportunity for doctors in training to report their concerns to us and their deanery or LETB, if possible, concerns should be reported and dealt with at a local department or practice level. And doctors in training should raise their concerns as soon as practically possible after an incident happens or the concern becomes apparent.

In 2016, 1,574 doctors in training left comments – representing around 3% of all respondents. 984 of those comments were left in the patient safety section of the survey and 590 in the bullying and undermining section.

We should note that some doctors used the opportunity to highlight positive support given by trainers and colleagues. This was a sentiment echoed by doctors in training we talked to when reviewing 2016 results and developing questions for the 2017 survey.

Patient safety comments [n=838]

| | Doctor performance problems | Lack of staffing/resources | Problem with processes of care | Problems with management processes | Problems with patient management | Problems with supervision | Problems with work expected of doctor in training | Problems with working culture | Unable to code |
|------------------------|-----------------------------|----------------------------|--------------------------------|------------------------------------|----------------------------------|---------------------------|---|-------------------------------|----------------|
| Number of times raised | 72 | 522 | 225 | 202 | 275 | 95 | 129 | 81 | 31 |
| Percentage | 8.59% | 62.29% | 26.85% | 24.11% | 32.82% | 11.34% | 15.39% | 9.67% | 3.70% |

In total, 838 doctors in training used the national training survey to report a local* patient safety issue. Worryingly, this is a significant increase from the 404 who reported concern in 2014.

The majority of patient safety concerns were related to a lack of staffing or resources (62.3%), problems with patient management (32.8%) and problems with processes of care (26.85%).

We require that all concerns reported in the national training survey be investigated by the relevant deanery or LETB, and we must be satisfied with the outcome of that investigation.

We also believe there is a link between national training survey questions related to confidence in local reporting system, and patient safety. In sites such as North Middlesex Hospital – where we have already identified patient safety concerns (see page 11) – 10 out of 17 specialties had red indicators (a negative outlier when compared with UK averages) against reporting system indicators.

Our guidance *Raising and acting on concerns about patient safety*[†] is accompanied by an interactive decision support tool that guides doctors through the stages of the process, with illustrative case studies. Our Regional Liaison Service and devolved offices hold regular sessions with medical students and doctors to make them aware of the guidance, to explore the issues that may be involved in raising concerns, and to provide support. Doctors who are worried about patient safety can also contact our confidential helpline on 0161 923 6399. This is open Monday to Friday, 9 am to 5 pm.

If something goes wrong in a patient's care, we expect doctors to be open and honest with the patient and those close to them, apologising for what has gone wrong and doing what they can to put matters right. We also expect them to take action to report safety issues and ensure lessons can be learned from them. In 2015, we launched joint guidance with the Nursing and Midwifery Council on the professional duty of candour,[‡] which provides more-detailed advice on these issues.

* The remaining patient safety comments were related in the contract dispute in England.

[†] See www.gmc-uk.org/guidance/ethical_guidance/raising_concerns.asp.

[‡] See www.gmc-uk.org/guidance/ethical_guidance/27233.asp.

Bullying and undermining comments

Around 1% of respondents – the same percentage as in 2014 – used the bullying and undermining section to report being a victim of, or witnessing bullying or harassment in their current post.

Worryingly, **1 in 20** [n=2,818] doctors in training said* they had a bullying or undermining concern, but did not want to report it within the national training survey. Reasons given for not using this route to report incidents of bullying and undermining were:

- I don't think reporting will make a difference 36% [n=1,027]
- Fear of adverse consequences 29% [n=823]
- I don't think the issue is serious enough to report 24% [n=679].

More positive reasons for not reporting using the national training survey were:

- The issue has already been resolved locally 25% [n=764].
- I have raised it, or intend to raise the issues locally instead 25% [n=699].

Standard S1.1 of *Promoting excellence* is clear: *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.*

Requirement R1.1:

Organisations must demonstrate a culture that allows learners and educators to raise concerns about patient safety, and the standard of care or of education and training, openly and safely without fear of adverse consequences.

Requirement R3.3:

Learners must not be subjected to, or subject others to, behaviour that undermines their professional confidence, performance or self-esteem.

It is concerning that a number of respondents do not have faith that their concerns will be dealt with fairly, if at all.

* Respondents were able to select more than one reason.

FOCUS ON: Whistleblowing

Following the Freedom to Speak Up review,^{*} Health Education England, NHS Employers, the Department of Health and the BMA have come to an agreement to extend whistle-blowing protection for doctors in training in England.[†]

By 1 October 2016, NHS trusts appointed Freedom to Speak Up guardians and NHS England has become a 'prescribed person,' which means NHS whistleblowers who work in all fields can raise concerns with the same employment rights as if they make the disclosure directly to their employer.[‡]

In Northern Ireland, the Regulation and Quality Improvement Authority (RQIA) has guidance[§] to help health and social care staff who want to make a protected disclosure. You can get further information from the Department of Health (Northern Ireland) and the Northern Ireland Social Care Council. The RQIA published a whistleblowing review in September 2016 with 11 recommendations to improve whistleblowing arrangements within HSC organisations.

NHS Scotland has set up the National Confidential Alert Line (NCAL) to provide support to staff, should they need support in raising a concern or have exhausted other procedures in place. Alongside the announcement of a new independent national whistleblowing officer, non-executive whistleblowing champions have also been introduced in each NHS Scotland board to provide localised scrutiny. The

NHS Scotland PIN policy^{††} sets out overarching standards which Scottish boards' local employment police must either meet or exceed. You can get additional guidance from the Care Inspectorate, Health Improvement Scotland, and Scotland Social Services Council.

NHS Wales has an All Wales Raising Concerns (Whistleblowing) Policy.^{**} You can get additional guidance from Health Inspectorate Wales, the Department for Health and Social Services; and the Care Council for Wales.

Sir Anthony Hooper recently led an independent review of our whistleblowing procedures. You can read the full report as well as our action plan for implementing its recommendations on our website.^{§§}

* See <http://freedomtospeakup.org.uk/the-report/>.

† See www.gmc-uk.org/news/26380.asp.

‡ See www.england.nhs.uk/2016/04/neil-churchill-5/.

§ See www.rqia.org.uk/contact/complaints-feedback/whistleblowing/.

** See www.rqia.org.uk/news/2016/rqia-publishes-review-of-whistleblowing-arrangemen/.

†† See www.gov.scot/Publications/2011/12/06141807/10.

‡‡ See www.wales.nhs.uk/document/240483/info/.

§§ See www.gmc-uk.org/concerns/28464.asp.

FOCUS ON: Comments relating to the postgraduate doctor in training dispute in England

541 doctors in training – roughly 1% of respondents – used the opportunity provided by the free text box to leave comments related to the postgraduate doctor in training industrial dispute in England. We've broken these comments down into 15 different categories.

- The imposition of the new contract being an example of bullying and undermining was mentioned 340 times.
- A lack of engagement with postgraduate doctors in training or the BMA was mentioned 286 times.
- The contract having a negative impact on safety was mentioned 280 times.
- Poorer morale as a result of the dispute and the new contract was mentioned 205 times.
- Future recruitment and retention concerns were mentioned 149 times.
- Staffing and rota concerns were mentioned 145 times.
- The new contract being discriminatory was mentioned 136 times.
- A belief that misinformation had been spread by various bodies about the dispute was mentioned 114 times.
- The idea that there should be increased action from the GMC in supporting doctors in training in relation to the dispute was mentioned 112 times.
- The related, but separate, belief of media manipulation was mentioned 111 times.
- The new contract having a negative impact on the mental health of doctors was mentioned 106 times.
- Disillusionment with what was viewed as an inappropriate action from education organisers was mentioned 92 times.
- The new contract potentially resulting in poorer training conditions was mentioned 75 times.
- Positive support from a variety of different sources (for example, consultants, multidisciplinary team members, members of the public etc.) was mentioned 69 times.
- The new contract negatively affecting doctors' work-life balance was mentioned 39 times.

We have provided the Department of Health in England with an overview of these comments grouped into these themes. In line with the survey's confidentiality statement and data privacy policy, we have not shared the verbatim comments – or the personal details of respondents – with the department.

While the national training survey does not seek views on wider political, professional or industrial issues, this dispute has highlighted a series of deep-seated issues, such as gaps in rotas and the inflexible nature of the way doctors are trained. These issues require urgent attention – not just by governments across the UK, but also by the profession itself and by all of us who exist to safeguard doctors' education and training.

We're leading a review on making training pathways more flexible by making it easier to change specialties and transferring relevant competencies from one area of specialism to another. We're working with input and support from medical royal colleges, and will work closely with doctors in training across the UK as well as with Health Education England, NHS Education for Scotland, the Wales Deanery and the Northern Ireland Medical and Dental Training Agency as we develop our proposals.

What did trainers across the UK tell us?*

- Trainers enjoy their job, when they get the time to do it.
- Many spend more time working as a trainer than accounted for in their job plans or equivalent.
- **One in ten** trainers felt that:
 - the educational responsibilities expected of them were not clearly defined
 - the support they receive from their trust or board as educators is poor or very poor
 - their trust or board is ineffective or highly ineffective in making changes to help improve the provision of education.
- Trainers want more training opportunities for themselves.

Recognising the value of trainers

We – and the medical profession in general – are hugely reliant on the often-uncredited role that trainers play in developing and educating our doctors. Historically, the trainer role has often been carried out in an informal capacity.

With workload pressures increasing, it is more important than ever to safeguard educational activities. Our aim is to protect and enhance the status of trainers, by recognising the valuable role they play in medical education. We're supporting this aim by providing a structure to formally recognise

and approve trainers across all specialties[†] in our *Recognition and approval of trainers framework*.

The framework, published in 2012, established definitions for two postgraduate trainer roles:[‡]

A named **clinical supervisor**:

- *oversees the clinical work of a specified doctor in training throughout a placement*
- *provides constructive feedback during that placement*
- *leads on providing a review of the practice of the doctor in training throughout the placement that will contribute to the educational supervisor's report on whether they should progress to the next stage of their training.*

A named **educational supervisor**:

- *is responsible for the overall supervision and management of the educational progress of a doctor in training during a placement or series of placements*
- *helps the doctor in training to plan their training and achieve agreed learning outcomes*
- *is responsible for the educational agreement*
- *brings together all relevant evidence to form a summative judgement at the end of the placement or series of placements.*

* 53.3% of trainers who were invited to complete the survey did so.

† Approval of GP trainers has been in place for several years.

‡ See www.gmc-uk.org/static/documents/content/Approving_trainers_implementation_plan_Aug_12_v2.pdf.

Some training schemes appoint a named educational supervisor for each placement. The roles of clinical and educational supervisor may then be merged.

Named educational supervisors and named clinical supervisors must be recognised by their LETB or deanery. Each LETB or deanery sets criteria for recognition in light of the GMC's standards, specialty expectations and other guidance.

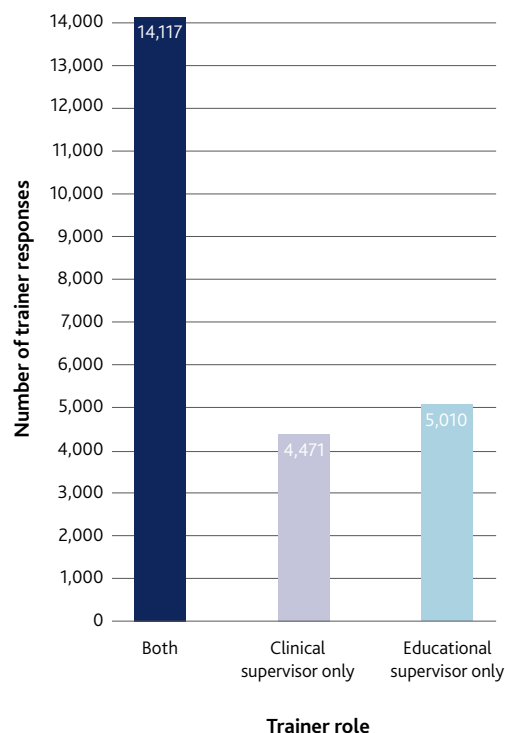
Training is provided by many doctors who are neither named educational supervisors nor named clinical supervisors. For example, a sessional supervisor:

- *oversees the work of doctors in training in a particular session, perhaps at night or in a very specialised aspect of practice*

- *need not be a named clinical supervisor or a named educational supervisor*
- *will be properly trained and appropriately managed and supported.*

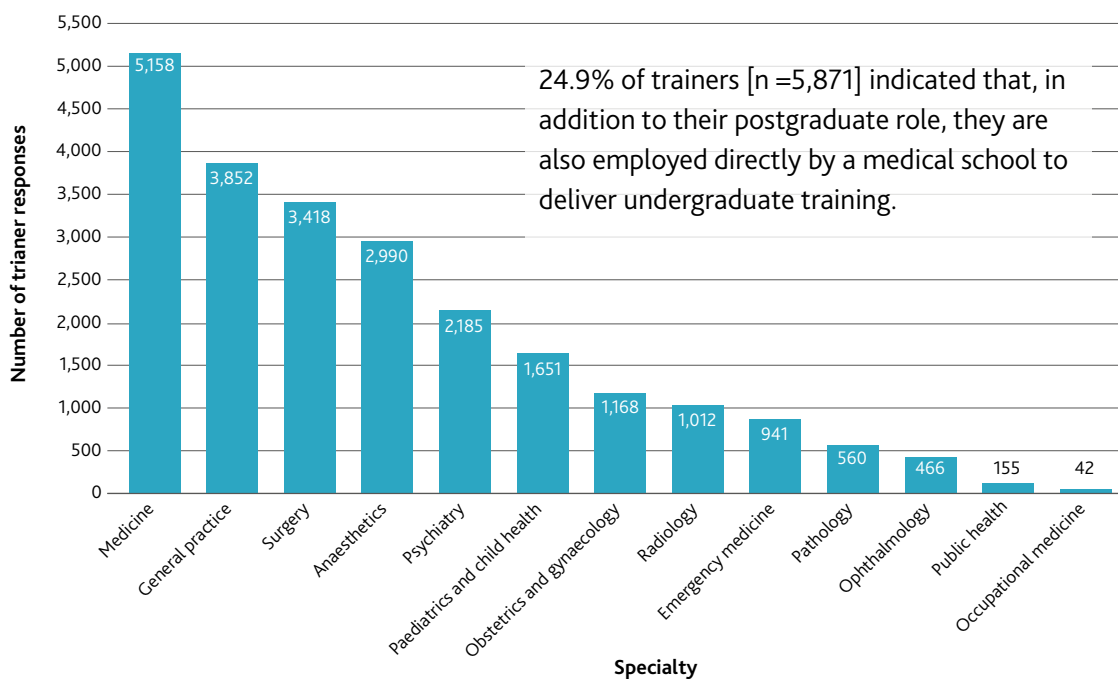
We designed the new trainer survey around these roles, and used the lists of recognised trainers from deaneries and LETBs as the survey population. The vast majority of trainers surveyed across the UK fulfilled dual roles as clinical and educational supervisors.

Number and percentage of trainer responses to the national training survey by role



We asked trainers which medical specialty they primarily practised in, presented below.

Number of trainers who responded to the national training survey by specialty



Attitudes on training

Overall, across the UK, trainers reported a generally positive view of their role. 92.8% [n=21,891] of respondents said that they strongly agreed or agreed with the statement, 'Overall, I enjoy my role as an educator'. Similarly, 93.6% [n=22,056] either strongly agreed or agreed with the statement, 'My department/practice demonstrates that it values the education of doctors in training'.

However, while they appear to enjoy the role, almost **one in three** said that they did not have enough time to actually do it.

Requirement R4.2 of *Promoting excellence* says:

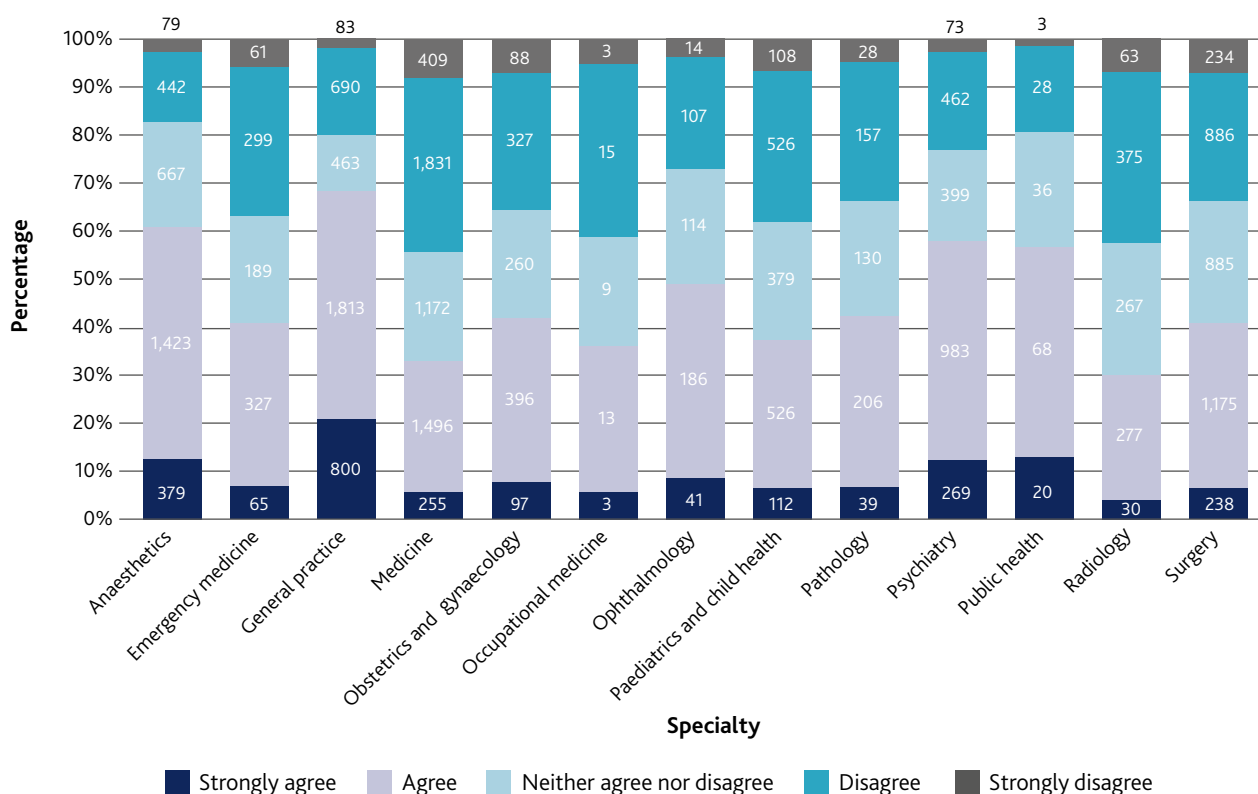
Trainers must have enough time in job plans to meet their educational responsibilities so that they can carry out their role in a way that promotes safe and effective care and a positive learning experience.

When asked to rate their agreement with the statement, 'My job plan contains enough designated time for my role as an educator' 53.3% [n=12,577] 'strongly agreed' or 'agreed'; 29.2% [n=6,895] 'disagreed' or 'strongly disagreed'. 14.3% [n=3,374] 'neither agreed or disagreed' and 3.2% [n=752] said the question was 'not applicable (I do not have a job plan)'.

Against the question, 'I am always able to use the time allocated to me in my role as an educator specifically for that purpose', 47.6% [n=11,237] 'strongly agreed' or 'agreed'; while 31.3% [n=7,391] said that they 'disagreed' or 'strongly disagreed'. 21.1% [n=4,970] 'neither agreed nor disagreed'.

It is perhaps unsurprising – but worth noting – that trainers in clinical posts report they are less able to use the time allocated to them for training for its intended purpose.

Trainer time by specialty

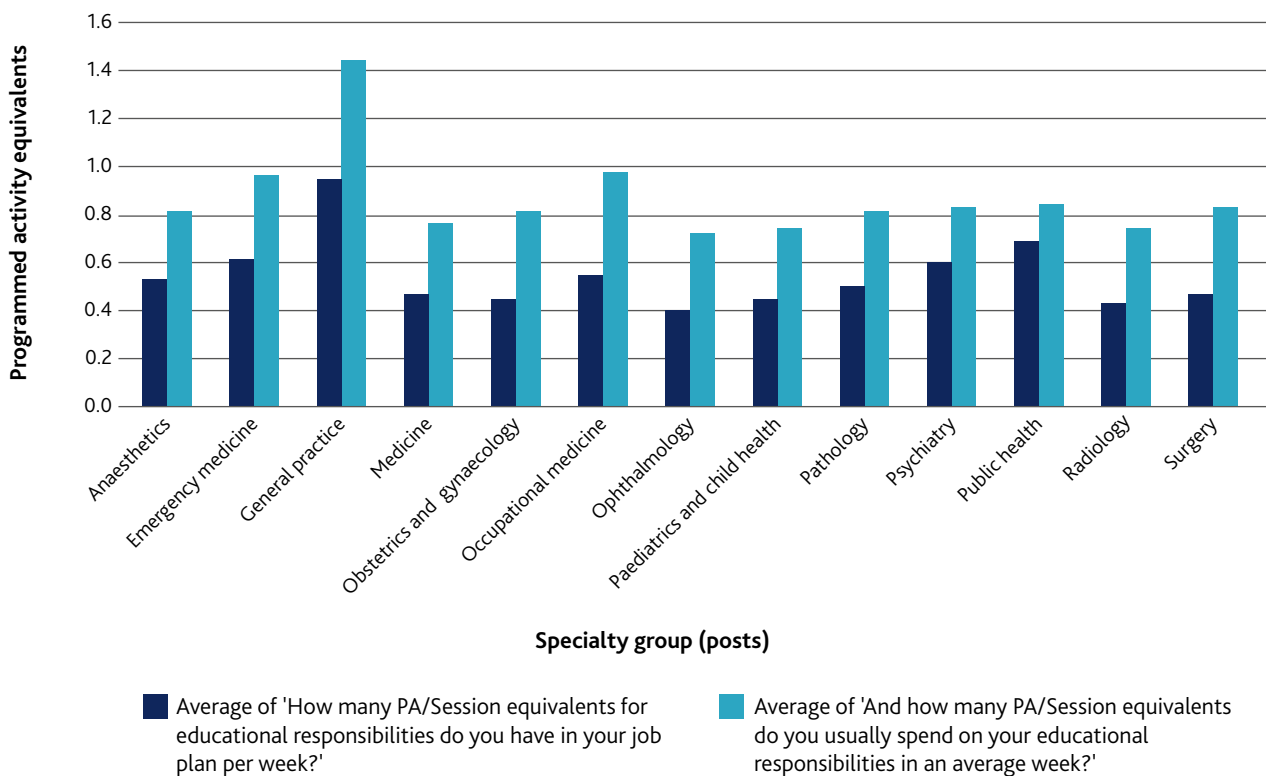


When asked to agree or disagree with the statement, 'As an educational supervisor, my job plan contains enough time to meet with my doctors in training as frequently as they require', 57.9% [n=12,142] 'strongly agreed' or 'agreed', while 25.2% [n=5,277] 'strongly disagreed' or 'disagreed'.

Overall, trainers reported that they spent almost twice as much time meeting educational responsibilities than is reflected in their job plan or equivalent. There was variance between specialties, as shown in the figure below.

We also asked trainers to tell us how much time in an average week (in programmed activities* or equivalent) they had in their job plan – or equivalent – for educational responsibilities, and how much time they actually spent on them.

Time spent on educational responsibilities



While we acknowledge the current pressures creating challenges in balancing patient care with training responsibilities – national, regional and local training environments must protect time for education and training and value the importance of being a trainer.

While the majority of trainers view their role in a positive light, roughly 10% of trainers consistently view their role and access to training time and resources negatively. In real terms, more than two thousand trainers (of the 23,598 who answered the survey) are dissatisfied. Given the fact that trainers on average supervise multiple doctors in training, the knock on effect of this dissatisfaction will likely be felt far wider.

* One programmed activity is a four-hour unit of time (a half day) dedicated to direct clinical care.

Requirement R4.1 of *Promoting excellence* says: *Educators must be selected against suitable criteria and receive an appropriate induction to their role, access to appropriately funded professional development and training for their role, and an appraisal against their educational responsibilities.*

Trainers also viewed the support they received from their trust or board more negatively (11.3% [n=2,662] 'poor' or 'very poor') than that received from their department or practice (5.1% [n=1,133] 'poor' or 'very poor') or deanery or local education and training board (LETB) (6.8% [n=1,598] 'poor' or 'very poor').

On a related note, only 65.5% [n=15,453] of trainers reported having a positive 'highly effective' or 'effective' education appraisal within the previous 12 months; with the remaining 34.5% [n=8,145]

either reporting that they have not had one, or that they viewed it in an ambivalent or negative light.

One in ten trainers [n=2,309] felt that the educational responsibilities expected of them were not clearly defined. A similar number [n=2,662] felt that the support they received from their trust or board as educators was poor or very poor. One in ten trainers [n=2,397] also said that their trust or board was ineffective (8.4%) or highly ineffective (1.8%) in making changes to help improve the provision of education.

We are clear in *Promoting excellence* that local education providers – specifically at board level or equivalent – are responsible for providing and reviewing the learning environment and culture in a way that meets our standards. This includes clarifying and protecting the essential role of the trainer.

FOCUS ON: Recognition and approval of trainers

We have been working with education organisers since 2012 on a programme to recognise and, eventually, approve trainers in four specific roles:

- postgraduate named educational supervisors
- postgraduate named clinical supervisors
- lead coordinators of undergraduate training at each local education provider
- doctors responsible for overseeing students' educational progress for each medical school.

We recognise that high-quality training is essential to patient care and have been working in partnership with Health Education England, NHS Education for Scotland, the Northern Ireland Medical and Dental Training Agency, and the Wales Deanery to make sure education and training is valued and protected.

We have now passed the final milestone in the recognition project: since 31 July 2016, education

organisers have had to confirm to us that all trainers in those four roles are fully recognised – ie they have met the education organiser's criteria without the use of interim concessions.

Benefits to trainers to recognition include:

- having support for training in job plans, or equivalent
- help with appraisal and revalidation
- CPD points through training as a trainer
- career development
- a stronger case for professional awards.

We have authority to approve GP trainers* and are seeking legal authority to approve all other medical trainers as we believe it is important to recognise this very important part of a doctor's role.

* See www.gmc-uk.org/education/approval_trainers.asp.

Trainers want more training

46.6% of trainers [n=11,000] felt that they would benefit from more training* on balancing the needs of service delivery with education. 39.3% [n=9,283] with training on writing effective supervisors reports, and 39% [n=9,211] on the identification, diagnosis and management of doctors in training who are in difficulty.

Requirement R4.3 of *Promoting excellence* says:

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

And requirement R4.6 says:

Trainers in the four specific roles must be developed and supported, as set out in our requirements for recognising and approving trainers.

* The categories in these questions were developed through focus groups with trainers, test questionnaires and scrutiny by medical education and survey experts.

Variations between England, Northern Ireland, Scotland and Wales

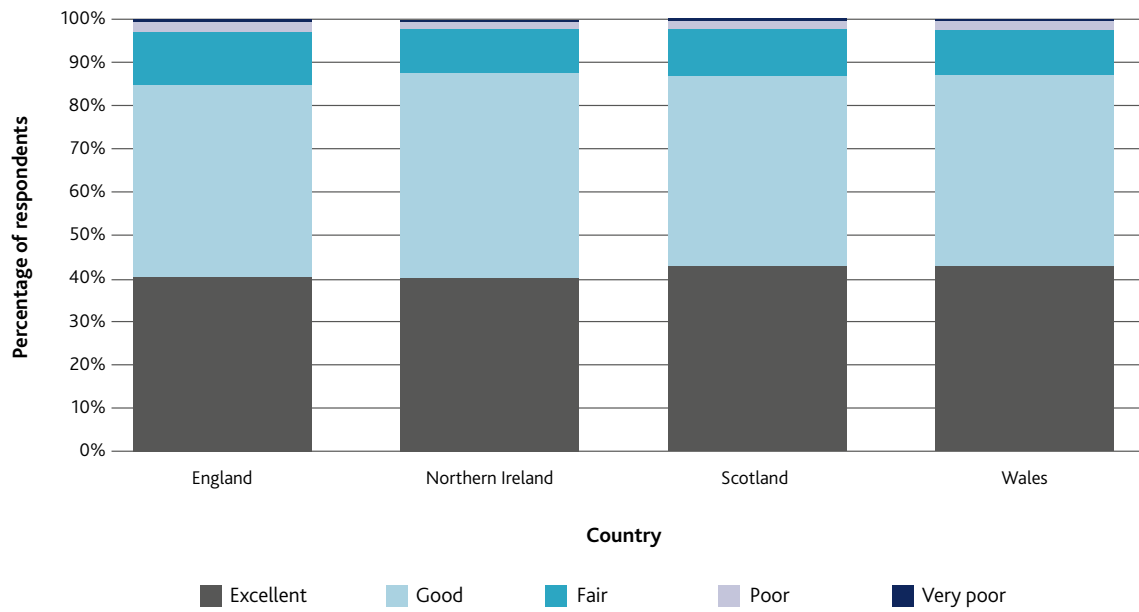
As well as giving us a view of the quality of education and training at a UK-level, we are able to reflect on findings from a country level. Using the online reporting tool, data from the national training survey can be broken down in a number of ways. Deaneries, LETBs, local education providers (LEPs) and other employers analyse local data, compared with UK averages, to find out which aspects of the training posts in their area work well or can be improved.

Medical royal colleges and faculties can also use the results of the specialty-specific questions to inform how they develop and deliver their curricula.

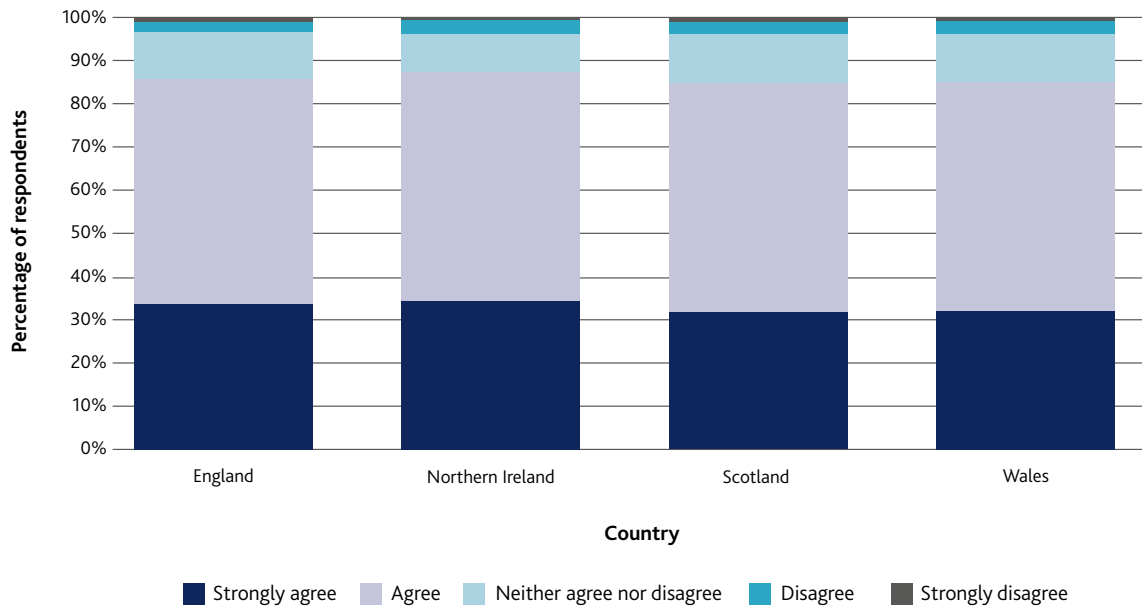
We have looked for major differences in responses between the four countries of the UK.

Our analysis showed very little variation. For example, on the following page are responses from two questions, broken down by country; the first for doctors in training, the second for trainers.

How would you rate the quality of clinical supervision in this post?



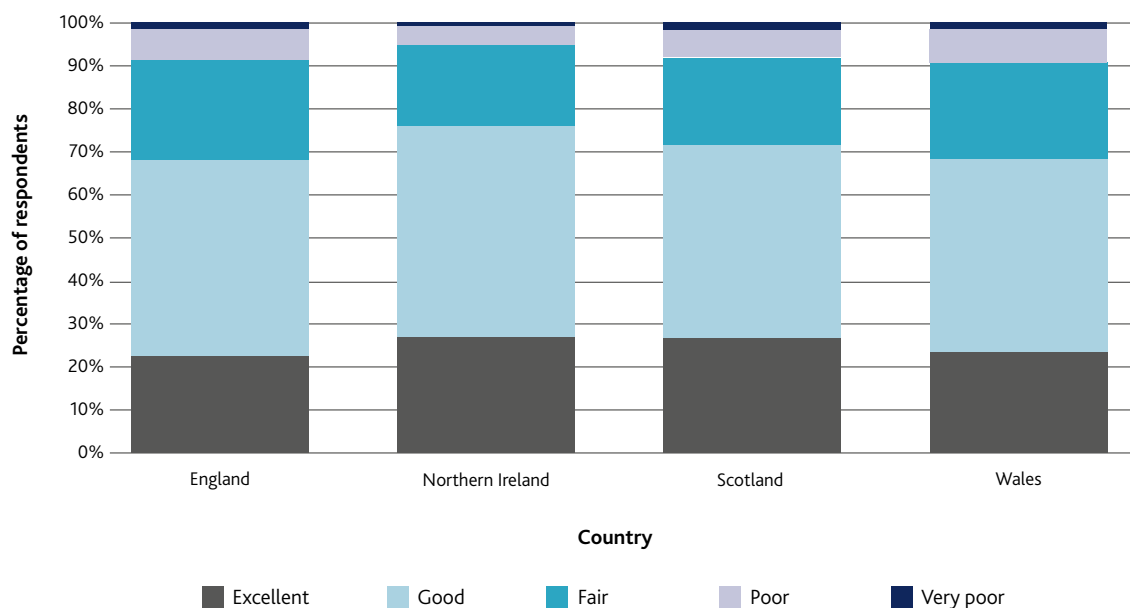
I'm confident that my deanery or LETB would act effectively if concerns about education were raised.



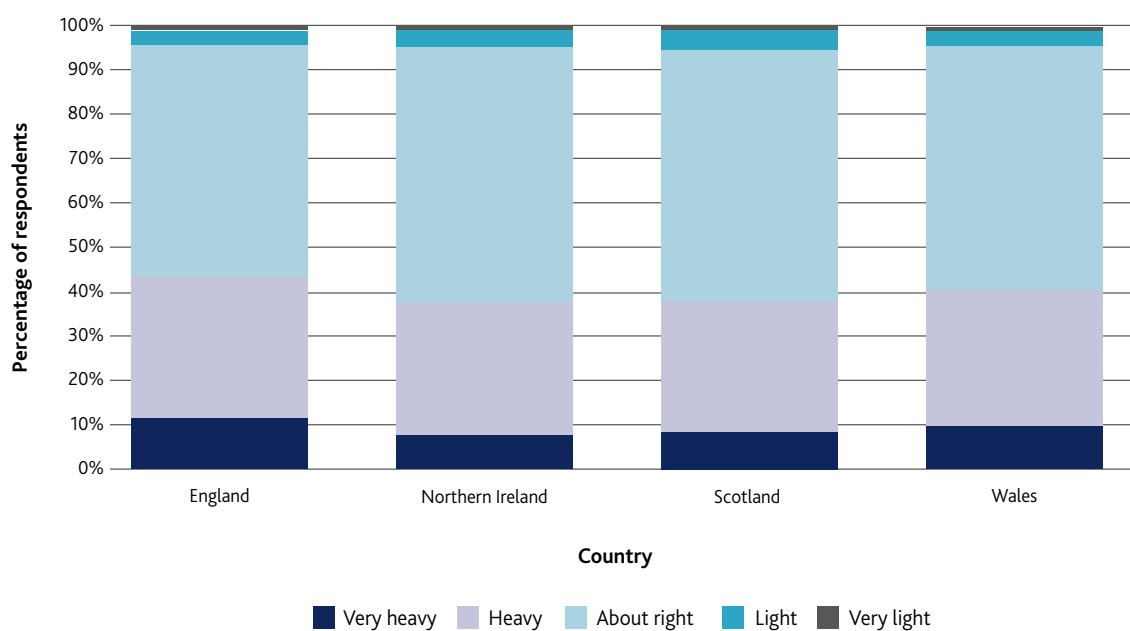
Similarly, if we break down responses to key questions by country of the UK, we can see that there is limited variation in satisfaction across a number of questions.

Doctors in training key indicators

How would you rate the quality of induction in this post?



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



FOCUS ON: The national training survey and four country policy

In October 2016, the Northern Ireland Health Minister, Michelle O'Neill MLA, announced a ten-year plan to transform the health and social care system. This includes the potential to redesign the delivery of healthcare provision and includes a significant increase in the number of GP training places in Northern Ireland. Alongside this the Department of Health (Northern Ireland) and Northern Ireland Medical Dental Medical Agency are working to develop a strategy for the recruitment and retention of doctors in training for Northern Ireland.

In Wales, the Welsh Government and the Royal College of General Practitioners (RCGP) Wales have recently launched the #TrainWorkLive campaign, which aims to address recruitment issues. Alongside this, the Wales Deanery's unique Education Contract – between the deanery, LEP and doctors in training – safeguards training and development opportunities for doctors in training in their day-to-day roles. The Wales Deanery uses the national training survey to monitor implementation of the contract. Future national training survey results may illustrate how this issue manifests itself in the attitudes and experiences of doctors in training and trainers.

The issue of recruitment and retention to GP training places and GPs to remote and rural areas is particularly pertinent to service provision in Scotland. Future national training survey results

may usefully illustrate how this issue manifests itself in the attitudes and experiences of doctors in training and trainers. Results may also indicate the impact of various policies and schemes created to address the issue, such as the Scottish Government-funded Scottish Rural Medicine Collaborative to coordinate recruitment of and support for rural GPs.

More broadly, Healthcare Improvement Scotland and NHS Education for Scotland will continue to use national training survey results to improve the quality of service, and training environments, respectively, in this and other areas.

As the healthcare systems in the UK continue to diverge as a result of devolution and other factors, we will continue to monitor national training survey data for country-wide trends and emerging issues. We have offices in Belfast, Cardiff and Edinburgh,* as well as a team of regional liaison advisors in England,† to make sure we truly have a whole UK-based approach to quality assurance of education and training, as well as policy and guidance development.

We have included case studies of training organisations in each of the four countries of the UK using national training survey data to highlight problems and drive improvement on pages 31 and 32.

* See www.gmc-uk.org/about/devolved_offices.asp.

† See www.gmc-uk.org/about/22348.asp.

How we use the national training survey to improve medical training

The national training survey gives us a comprehensive and statistically-significant snapshot of the experiences and concerns of doctors in training. It therefore gives us, and bodies responsible for medical training, an important tool to use for quality assurance purposes.

We also work closely with other regulators and organisations responsible for scrutinising, assuring and improving the quality and safety of healthcare to make sure the survey findings are used in their work to assure the quality and safety of healthcare. This includes the Care Quality Commission in England, Health Improvement Scotland, the Regulation and Quality Improvement Authority in Northern Ireland (RQIA), and Healthcare Inspectorate Wales.

Our online reporting tool* (see page 39) allows anyone to analyse the results in a variety of useful ways. It is also possible to compare data from previous surveys to identify trends.

However, the national training survey is just one source of information about the quality of medical education and training, and should be considered alongside other evidence. In many cases, local organisations will follow up survey results with a detailed investigation, examples of which can be found on pages 31 and 32.

Providing evidence for our quality assurance activities

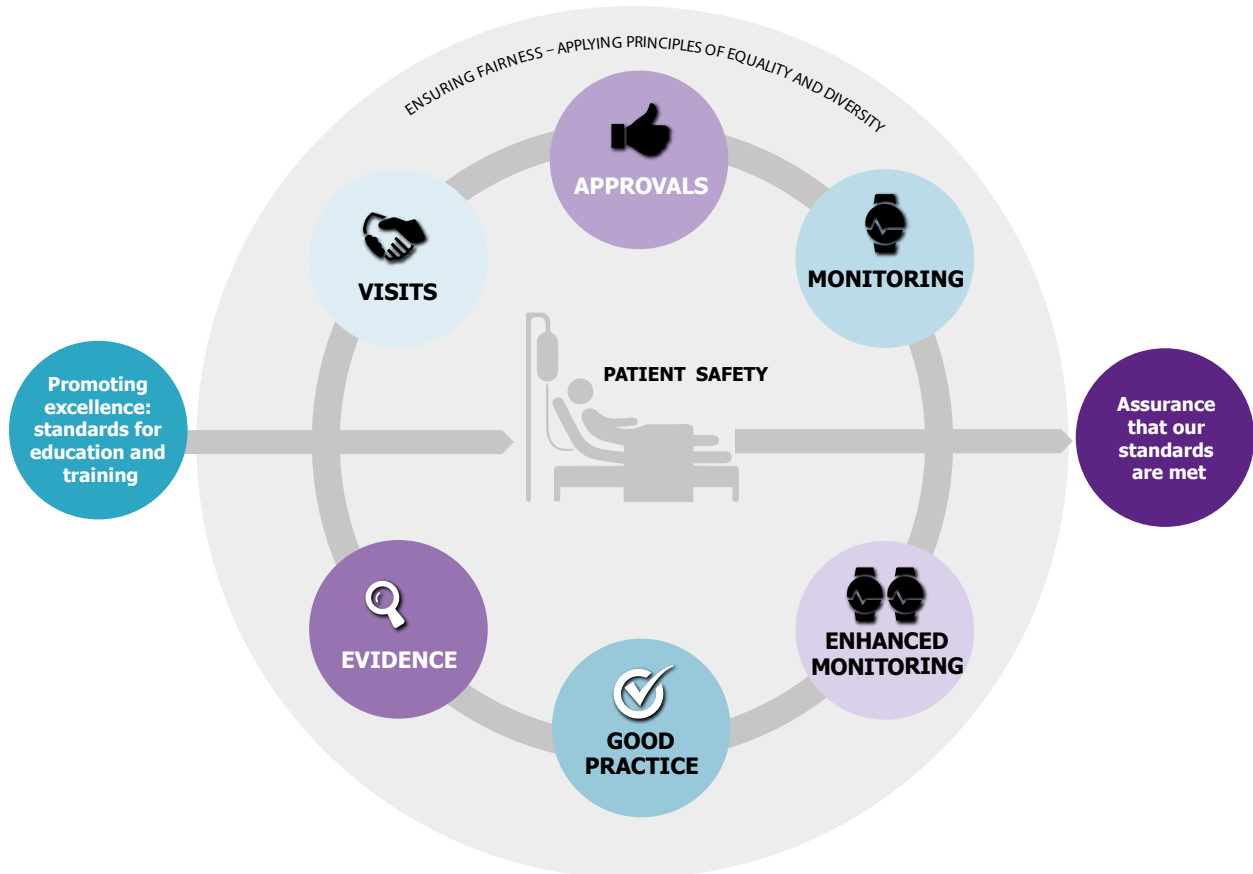
The primary purpose of the national training survey is to provide a cornerstone to the evidence base of our quality assurance activities. The diagram below gives an overview of our quality assurance framework. The questions that make up the survey are directly linked to our mandatory standards and requirements, outlined in *Promoting excellence*.

Where responses from doctors in a particular training location are significantly more negative than the UK average, we work with the relevant deaneries and LETBs to put into place enhanced monitoring procedures to resolve the problem. We also look at areas that have scores well above the UK average to attempt to highlight examples of best practice – you can find examples of these in this report and on our website.

We use data from the national training survey to identify areas of risk to prioritise locations to visit during our national and regional reviews. If issues are verified through a visit, then we work with deaneries and LETBs to drive improvements and monitor progress.

* See www.gmc-uk.org/education/surveys.asp.

Quality assurance framework



On a more immediate level, the national training survey provides an opportunity for doctors to directly raise patient safety or bullying or harassment concerns, if they have not already been addressed by

other means. The doctor in training can leave free-text comments detailing their concerns, which we share with the relevant deanery or LETB, who then reports back to us on any actions taken.

National training survey in action across the UK – using the data outside of the GMC

The following case studies are positive examples of national training survey findings being used by LETBs, deaneries, trusts, and individual departments to help improve training environments.

CASE STUDY: Cardiff and Vale University Health Board

Results from the 2015 survey identified a significant fall in doctors' training feedback scores within the core psychiatry cohort overseen by the Cardiff and Vale University Health Board. At the time, the board was in the process of introducing a revised rota. A fall in indicator scores and free text comments suggested that the dissatisfaction stemmed from how the changes were communicated.

The board set up regular meetings for doctors in training and trainers to discuss the issues and identify areas for improvement. In addition, workshop sessions for doctors in training were established to identify possible solutions to the concerns raised through the national training survey results. To address the challenges with induction, doctors in training gathered feedback

from previous cohorts to suggest improvements to the induction programme. This led to a new three-day induction programme and a policy of taking key doctors in training off the rota during induction to ensure consistency and quality.

A visit by the deanery found that the regular meetings have meant that doctors in training have an additional and early opportunity to raise concerns about their training. These and other changes appear to have helped change the culture within the programme, with doctors in training now feeling like a valued part of the team. The health board has continued to make sure the regular meetings with doctors in training and trainers are held, so that doctors in training always have an opportunity to raise any concerns.

CASE STUDY: Musgrave Park Hospital, Belfast Trust

Handover in rheumatology had shown negative (red) outliers in the 2015 national training survey. Doctors in training were located in multiple sites making face-to-face handover difficult. The LEP introduced a number of measures, including a working group with doctors in training to review the handover arrangements.

Changes made by the hospital include a daily formal virtual handover, which works via a shared

database. Each doctor who reviews the patients' and outcome data updates the database every day. Each week, a report of the outcome data is produced for consultants to review.

Because of these changes, handover changed to a positive (green) outlier in the 2016 national training survey results.

CASE STUDY: Aberdeen Royal Infirmary

Results from our 2014 national training survey highlighted concerns about patient safety in the A&E department at Aberdeen Royal Infirmary, NHS Grampian. The Scotland Deanery escalated the department to our enhanced monitoring process in August 2014. A Healthcare Improvement Scotland review of the Infirmary, published in December 2014, also identified concerns in a number of departments across the infirmary.

In January 2015 there was a GMC visit to the site which met with representatives from a number of clinical areas – care of the elderly, emergency medicine, paediatrics, and obstetrics and gynaecology. This was followed up by a GMC-supported deanery visit to the emergency department in May 2015 where it was clear that significant progress had been made in addressing the concerns identified in the 2014 survey. This progress was reflected in the 2015 survey results.

A deanery re-visit took place in May 2016, and the 2016 national training survey results provided further evidence that progress had been sustained, with multiple green outliers. In June 2016, following a deanery request, this unit was removed from the enhanced monitoring process.

There have been many areas of change that have contributed to improvement in the emergency department including changes to rotas, consultant availability and presence, improvements in clinical supervision, protected teaching time, and implementation of the 'push policy' which has aided patient flow out of the department.

CASE STUDY: Emergency medicine at Hull Royal Infirmary

The 2015 national training survey showed multiple negative (red) outliers for doctors in the second year of the Foundation Programme (F2) working in emergency medicine at Hull Royal Infirmary – specifically in relation to handover, workload, access to educational resources and overall satisfaction.

When Health Education England (HEE) visited in April 2015, the foundation doctors in training said that the newly opened emergency department has improved patient care provision, but it was no different from the old department as a learning environment – being extremely busy with no additional staff being appointed. There were concerns about F2 doctors in training regularly being expected to stay well beyond their shift finish time and they were unable to consistently access educational opportunities due to work intensity.

The trust named one senior trainer and gave them dedicated supporting professional activities time to promote training delivery within the department and to supervise the educational programme. The trust also began to have some success in recruiting additional senior staff.

When HEE visited again in July 2016, doctors in training reported that, although it remains a very busy department, additional staff appointments and improved working practices have meant that workloads have become more manageable.

Average indicator scores in the department's 2016 national training survey results improved significantly. For example, the mean score for handover increased from 40.39% to 70.24%. More changes are being implemented to improve the experience still further and will be monitored using survey results and other sources of quality information.

How will we develop and improve the national training survey?

We're committed to a process of continuous improvement in everything we do – including the national training survey.

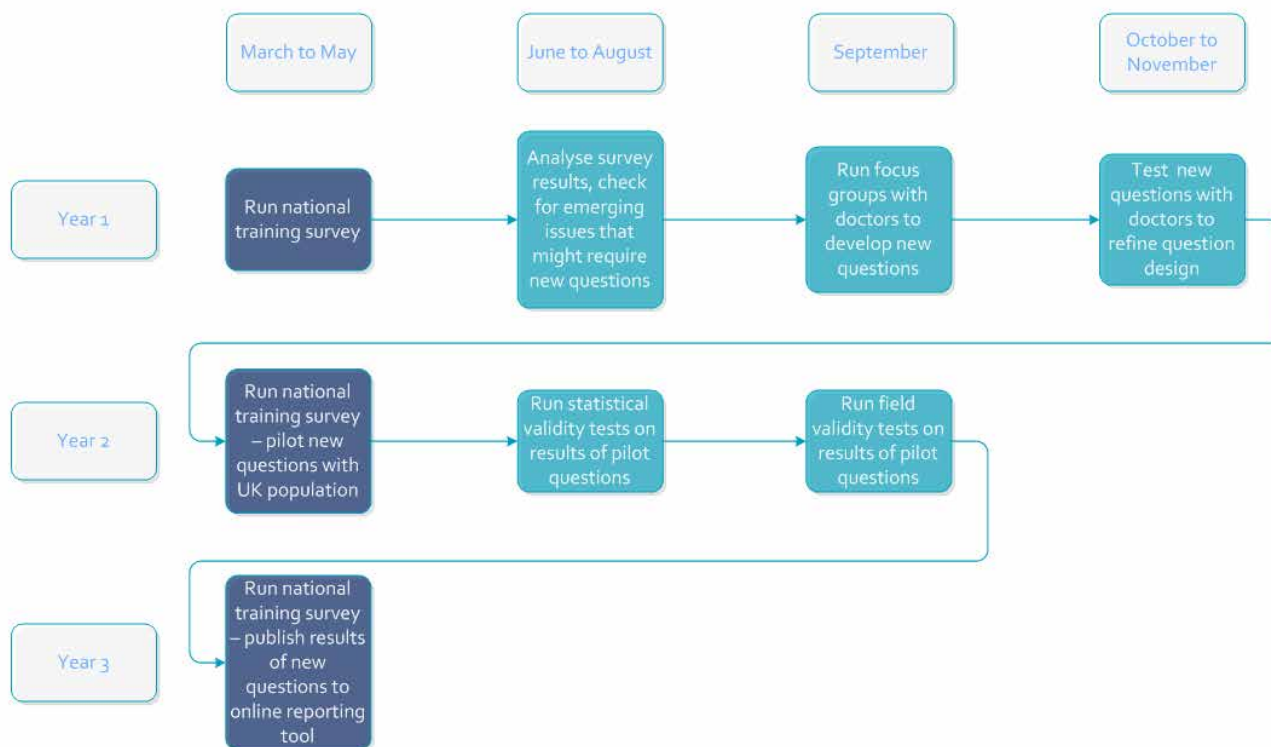
The diagram below gives an overview of how we develop new questions and indicators. This involves talking with training organisations and conducting focus groups with doctors in training and trainers across the UK to test changes. We also commission independent research into the statistical validity of the survey to make sure it remains fit for purpose as a quality assurance tool.

To be an effective quality assurance tool, we have to make sure the national training survey remains focused on helping us monitor the quality of medical education and training in the UK. That's why we try to make sure the questions remain as stable as possible, and we rigorously test and scrutinise new or changed questions before we include them in the survey.

But we acknowledge that the national training survey, in its current form, does not capture data on a number of issues that are directly linked to patient care, or the positive experiences of doctors in training.

To get a better picture of training environments, we're testing questions about the identification of rota gaps and the support networks available to doctors in training. We are clear in our standards within *Promoting excellence* that doctors in training must have access to resources to support their health and wellbeing, and they must be able to work within a well-designed rota (requirements R3.2 and R1.12).

We hope that by enhancing our knowledge in these areas, we can help create better workplaces, enhance doctors' wellbeing and improve patient care.



What happens next?

Steps to improve the experience of doctors in training

- 1 We will continue to prioritise the investigation of training environments that doctors have highlighted to us are of particular concern. This year, over 80 cases* have been subject to our enhanced scrutiny processes.
- 2 We will work with LEPs, deaneries and LETBs to improve feedback mechanisms to highlight where national training survey data have led to local and national/regional changes and improvements.
- 3 We know that acute medicine environments are the focus of the majority of our advanced monitoring cases. We're working closely with deaneries and LETBs to encourage improvement.
- 4 We are leading a review on making training pathways more flexible to respond to significant concerns raised by doctors in training.
- 5 We are testing national training survey questions to gauge the effect of rota gaps on training environments as well as questions on the general wellbeing of doctors in training.

Steps to improve the experience of trainers

- 1 We will use data from the national training survey to investigate where trainers have identified problems with the training environment.
- 2 We are seeking legislative change to allow us to approve all other medical trainers, as we believe in recognising this very important part of a doctor's role. From next year, we'll begin to recognise all trainers on our register, not just GP trainers as we do currently.
- 3 During our quality assurance visits, we'll ask trainers about their experiences of their role and work to identify and highlight areas where they are not being supported.
- 4 We will continue to work with deaneries, LETBs and trainers to develop and validate the questions used in the trainer survey.

* As of the end of September 2016 81 training sites are being scrutinised by our enhanced monitoring processes, See www.gmc-uk.org/education/enhanced_monitoring.asp.

Appendix A – Who answered the survey?

53,835 doctors in training completed the survey out of the 54,563 who were eligible – giving a response rate of 98.7%.*,†

23,598 trainers completed the survey out of 44,291 who were invited. This gave us a trainer response rate of 53.3%, which compares very favourably with other work-based surveys.‡ We will seek to improve that rate in the future by working with deaneries, LETBs, training bodies and trainers to communicate the importance of giving feedback.

Gender

Doctors in training

55.8% [n=30,033] of respondents were female and 44.2% [n=23,802] were male. Given the 98.7% response rate, this is an accurate reflection of the doctor in training gender breakdown.

Trainers

36.5% [n=8,613] of respondents were female and 63.5% [n=14,985] were male. Despite the comparatively low response rate, this figure is in line with the breakdown of gender of the trainers who were invited to complete the survey.

Health and disability

Of those doctors in training reporting a health problem or disability that limited their activities, 162 said that they need adjustments to be able to carry out their work. 18 of those who need adjustments said that adjustments they need have not been made.

Requirement R3.2 of *Promoting excellence* says:
Organisations must make reasonable adjustments for disabled learners, in line with the Equality Act 2010. Organisations must make sure learners have access to information about reasonable adjustments, with named contacts.

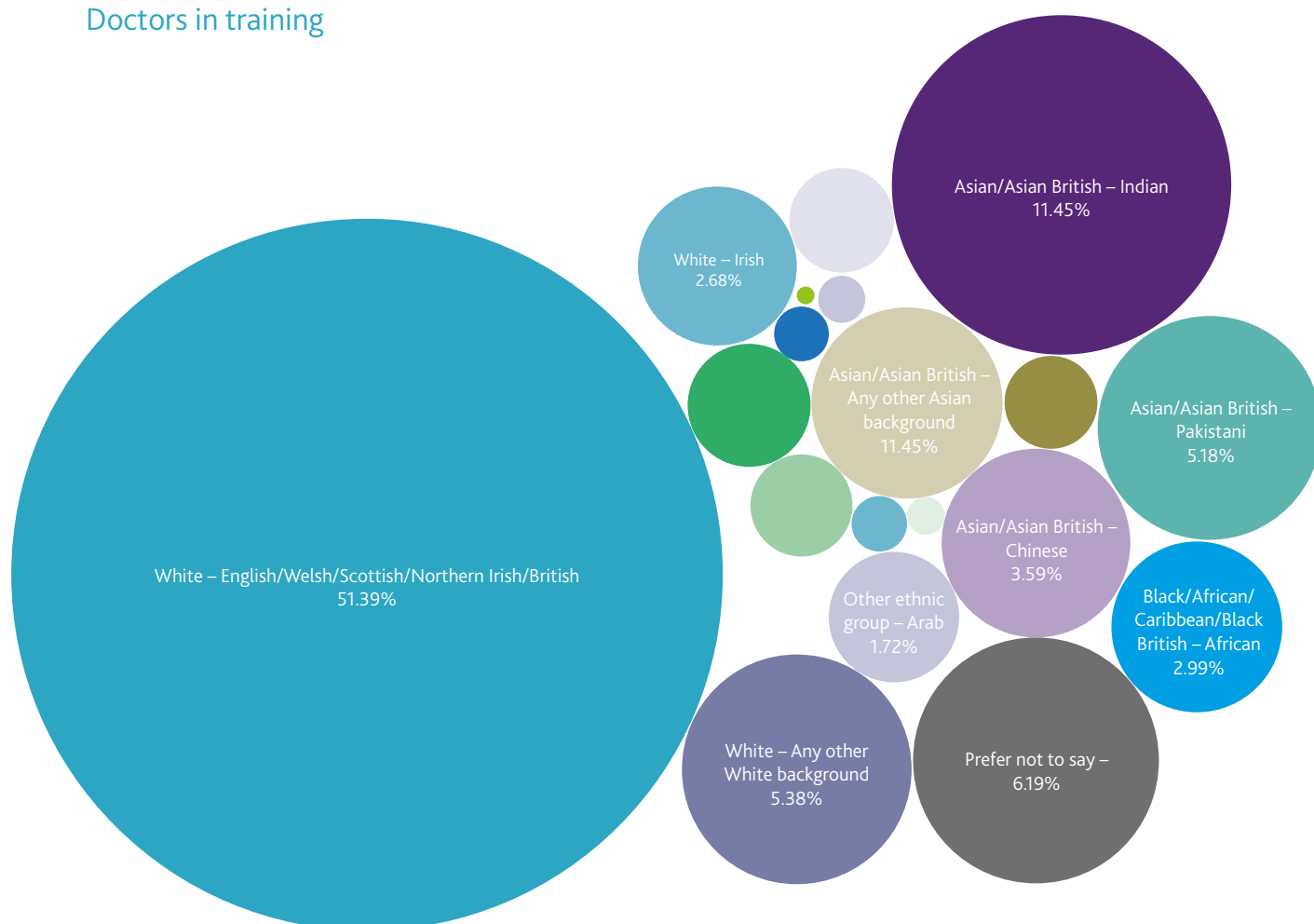
* The survey was open from 22 March 2016 to 11 May 2016. Doctors in training were asked about the post they were in on 22 March 2016.

† UK-wide scores are the overall score for each indicator, across all specialties and stages of training.

‡ For example, the 2015 NHS staff survey in England at 41%. Or the NHS Scotland 2015 staff survey at 38%.

Ethnicity

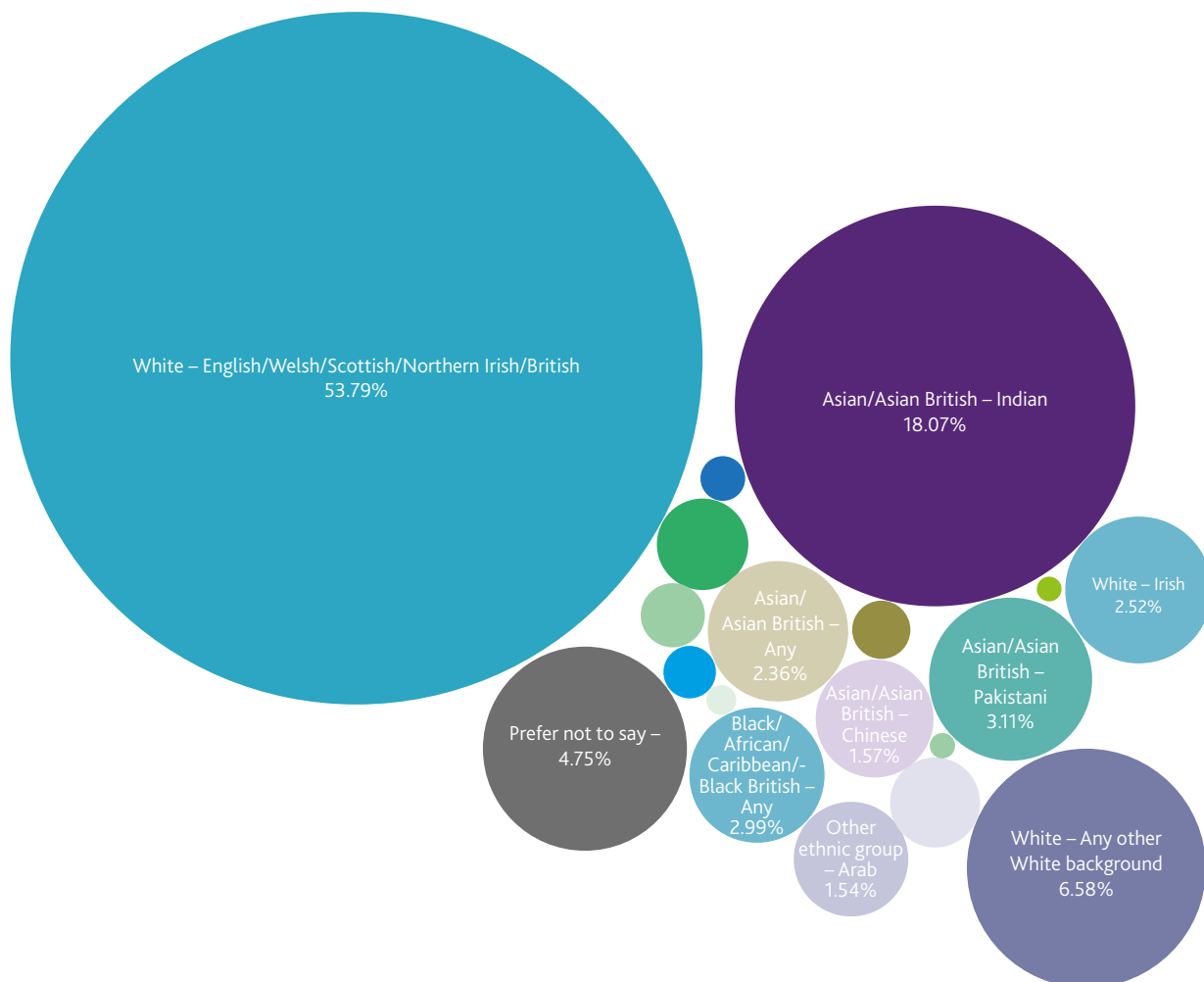
Doctors in training



- White – Irish
- White – Gypsy or Irish Traveller
- White – English/Welsh/Scottish/Northern Irish/British
- White – Any other White background
- Prefer not to say
- Other ethnic group – Arab
- Other ethnic group – Any other ethnic group
- Mixed/Multiple ethnic groups – White and Black Caribbean
- Mixed/Multiple ethnic groups – White and Black African
- Mixed/Multiple ethnic groups – White and Asian
- Mixed/Multiple ethnic groups – Any other Mixed/Multiple ethnic background
- Black/African/Caribbean/Black British – Caribbean
- Black/African/Caribbean/Black British – Any other Black/African/Caribbean background
- Black/African/Caribbean/Black British – African
- Asian/Asian British – Pakistani
- Asian/Asian British – Indian
- Asian/Asian British – Chinese
- Asian/Asian British – Bangladeshi
- Asian/Asian British – Any other Asian background

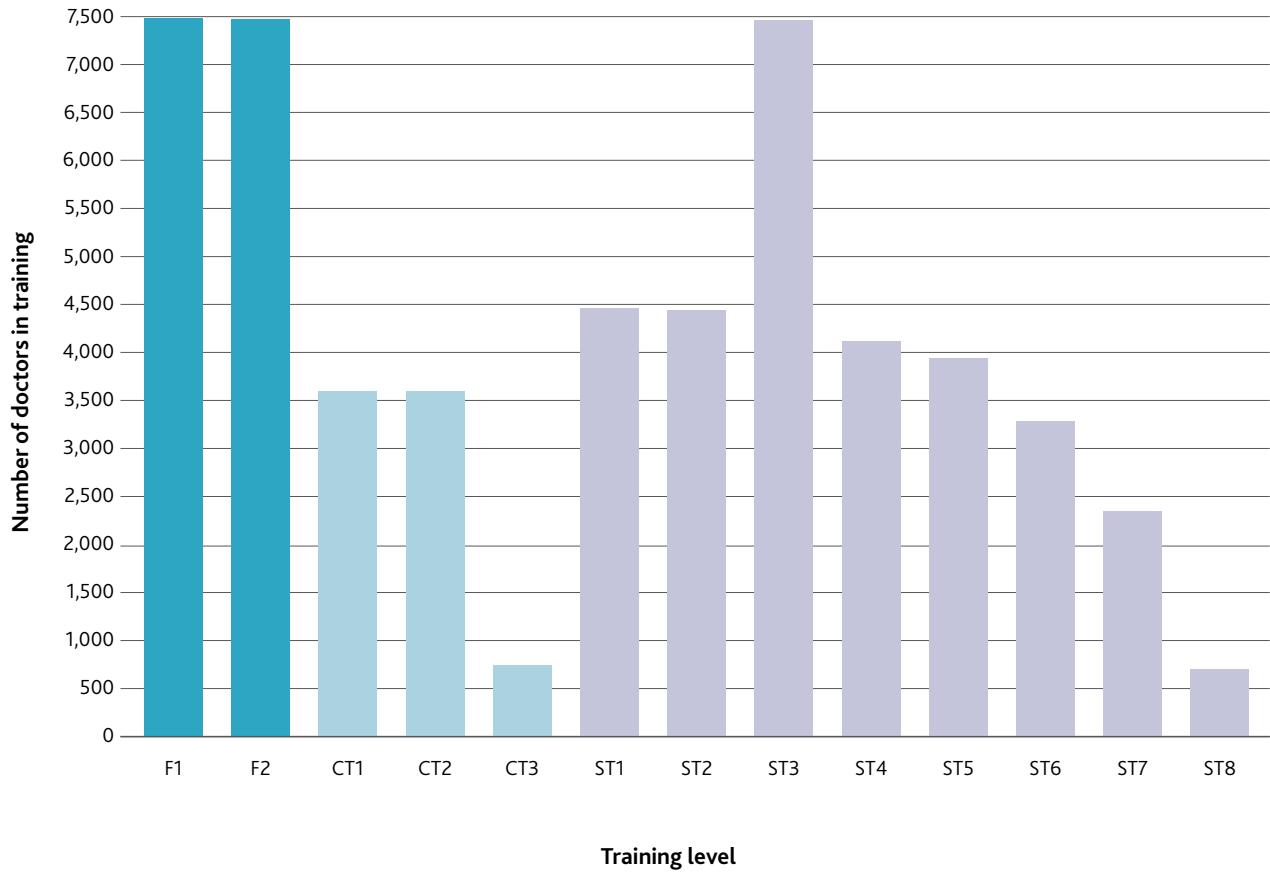
Ethnicity

Trainers



- White – Irish
- White – Gypsy or Irish Traveller
- White – English/Welsh/Scottish/Northern Irish/British
- White – Any other White background
- Prefer not to say
- Other ethnic group – Arab
- Other ethnic group – Any other ethnic group
- Mixed/Multiple ethnic groups – White and Black Caribbean
- Mixed/Multiple ethnic groups – White and Black African
- Mixed/Multiple ethnic groups – White and Asian
- Mixed/Multiple ethnic groups – Any other Mixed/Multiple ethnic background
- Black/African/Caribbean/Black British – Caribbean
- Black/African/Caribbean/Black British – Any other Black/African/Caribbean background
- Black/African/Caribbean/Black British – African
- Asian/Asian British – Pakistani
- Asian/Asian British – Indian
- Asian/Asian British – Chinese
- Asian/Asian British – Bangladeshi
- Asian/Asian British – Any other Asian background

Doctors in training by training level



Email: gmc@gmc-uk.org
Website: www.gmc-uk.org
Telephone: **0161 923 6602**

General Medical Council, 3 Hardman Street, Manchester M3 3AW

Textphone: **please dial the prefix 18001** then
0161 923 6602 to use the Text Relay service

Join the conversation

 [@gmcuk](https://twitter.com/gmcuk)

 facebook.com/gmcuk

 linkd.in/gmcuk

 youtube.com/gmcuktv

To ask for this publication in Welsh, or in another format or language, please call us on **0161 923 6602** or email us at publications@gmc-uk.org.

Published December 2016

© 2016 General Medical Council

The text of this document may be reproduced free of charge in any format or medium providing it is reproduced accurately and not in a misleading context. The material must be acknowledged as GMC copyright and the document title specified.

The GMC is a charity registered in England and Wales (1089278) and Scotland (SC037750)

Code: GMC/NTS2016KF/1216

General
Medical
Council