General Medical Council

Training environments 2018:

Key findings from the national training surveys

Contents

Foreword

It's no secret that our health services ask a lot of those who work on the medical frontline. Every day, doctors in training and doctors working as trainers come together to deliver care for patients, while at the same time fulfilling their training commitments.

In pressured working environments, their skill and dedication has helped make sure the standard of training across the UK remains high. Despite this, it's clear there are some areas where competing demands and pressures are taking a toll. Where they appear, the warning signs must be heeded.

Generally, the results of our national training surveys this year show the continuing high quality of postgraduate medical education and training. There are some very positive findings, especially around trainees' satisfaction with their teaching, clinical supervision and overall experience. Trainers are delivering education and mentoring to a very high standard in challenging circumstances. It is testament to their hard work that they continue to support the next generation of doctors while managing competing demands on their time and energy.

But the competing demands and pressures take a toll and, where they appear, the warning signs that all is not well must not be ignored.

Where handovers, inductions and rotas are well managed, we tend to find well-run hospitals with supportive environments that provide good quality training. That's not to say there aren't still pressures that can make it a challenge.

But where the working and learning environment is less supportive, more doctors are overstretched, and more trainees feel forced to work beyond their level of clinical competence.

This year we asked about signs of burnout for the first time. A quarter of doctors in training and a fifth of trainers told us they feel burnt out to a high or very high degree. Those in emergency medicine and trainees in their second year of postgraduate training are feeling it most.

The burnout questions were new, so we can't compare the results to previous years, but our analysis suggests that heavy workloads, rota gaps and an unsupportive environment are key factors in burnout.

This year's findings make it clear that employers must not underestimate the implications of an unsupportive working environment - for patient safety, as well as for the wellbeing of their workforce. To maintain the enviable international reputation that UK medical care has, employers must meet their obligations to protect time for high quality training. They must also support the health and wellbeing of their trainees and trainers.

The findings also give an indication of where we can work with doctors and employers to mitigate burnout and its impact. We have already commissioned Dame Denise Coia and Professor Michael West to co-chair a *UK-wide review* into the factors that lead to poor wellbeing in doctors and medical students. Their findings will enable us to work together with organisations across the UK to agree priority areas for collaborative action.

Overall, this year's surveys do show signs of small improvements in key areas, such as the impact of rota gaps and how often doctors in training work beyond their rostered hours. Doctors in training and trainers were positive about the support they receive in their roles, and about the processes for raising educational and patient safety concerns. It's important that we continue to work with doctors to promote this positive culture of speaking up, and that employers and training providers act on those concerns.

Over 70,000 doctors answered our surveys this year. Being able to collate the responses of so many doctors, both trainees and trainers, gives a uniquely detailed insight into training environments across all four UK nations.

The responses provide us, postgraduate deans, other regulators and employers with a rich source of intelligence about where education and training is being delivered well and where changes are needed to raise standards. It is important that those bodies which organise and deliver medical education use the data, and the tools we provide, to identify any warning signs and act on them.

Charlie Massey,
Chief Executive and Registrar

Executive summary

The national training surveys provide detailed perspectives of the UK postgraduate medical education and training environment. We use the data they generate to work closely with those responsible for managing and delivering training to identify good practice, and to pinpoint the places where training does not meet our standards and needs to be improved.

As in previous years' surveys, the 2018 results show that the majority of doctors in training are receiving high quality teaching, clinical supervision and training experience.

Trainers continue to deliver education and mentoring to a very high standard. They overwhelmingly enjoy their role and the opportunities it provides. These findings are testament to the ability, hard work and dedication of doctors working in training environments.

However, the survey results also show that doctors face many challenges – both trainees and trainers reported intense workloads, regularly working beyond their rostered/contracted hours, and a lack of time to train due to clinical demands and system pressures. Where these issues exist, they can impact on the standard of patient care and the health and wellbeing of doctors in training and trainers.

Our findings suggest that high quality handovers and inductions help to make sure postgraduate medical training and patient care is safe and effective. But where these processes aren't functioning as they should, it may be a sign of wider issues with training, teamwork and patient care.

This year, we introduced new questions on burnout, a state of prolonged physical and psychological exhaustion which is perceived as related to the person's work[1]. As we are trialling these questions, organisation-level results on burnout are not included in the 2018 *online reporting tool* – although some data has been shared with postgraduate deans in all four countries of the UK. As the burnout data is not available in the reporting tool, we have provided a *four country breakdown of these results online*. However, this report provides an opportunity for us to explore high level findings.

The responses show that many trainers and trainees feel physically tired and emotionally exhausted. As well as affecting doctors' health and wellbeing, burnout can impact on trainees' professional development and their learning experience; the standard and quality of medical education; and patient safety.

Burnout in trainers and trainees is associated with intense workloads, and the lack of a supportive working environment. Trainees who felt training time was better protected, and that they were supported and respected by colleagues, reported lower levels of burnout.

1 According to the definition provided in the *Copenhagen Burnout Inventory.*

The analysis in this year's report highlights the risks of unsupportive working environments, for training and patient care. The data we have suggests these risks can be reduced if employers protect time for training, make sure rota gaps do not interfere with training and by creating a supportive culture.

Key findings for 2018 include:

- The majority of doctors in training are satisfied with the standard of teaching and clinical supervision they receive. And most of the trainers we surveyed told us that they enjoy their role and the opportunities it brings.
- Many doctors in training and trainers are satisfied with the support they receive in their role. Around a quarter of trainees told us their working environment fully supports the confidence building of doctors in training.
- Trainers and doctors in training told us that heavy, intense workloads disrupt training and can lead to some trainees working beyond their clinical competence or experience.
- Many GPs are working under pressure; over half of all GP trainers work beyond their normal working hours on a daily basis. This can impact on the delivery of GP training, as well as trainers' health and wellbeing.
- A quarter of doctors in training and a fifth of trainers told us they feel burnt out. Our analysis suggests burnout may be associated with high workloads, the impact of rota gaps, and the lack of a supportive working environment.
- Trainers and trainees in emergency medicine, and trainees in their second foundation year, reported the highest levels of burnout.
- Getting enough time for training and good rota design remain important issues for both trainees and trainers. This includes trainees receiving sufficient notice of their roster, ahead of starting their post – many told us this was not the case.
- The majority of doctors rated handovers and inductions positively – but where they are poor, this may be a signal of wider issues with training, teamwork and patient care.

Report structure

This report breaks down the survey analysis into six thematic chapters, each of which ends with a short conclusion that discusses our findings in light of the work we are doing. These chapters look at: trainees' perspectives, trainers' and then GP trainers' views*; burnout; speaking up; and trainee career intentions. The final section, Taking action, sets out what we are doing and what we expect others to do based on these findings.

* We have reported on GP trainers separately as they answered a tailored set of questions this year (see introduction to Chapter 3). We have not done the same for GP trainees, as they were not as much of a consistent outlier (compared to other trainee specialties) as trainers in GP posts were (compared to other trainer specialties).

There were no major differences between the four UK countries.

Our results in 2018 show no major difference in indicators between England, Northern Ireland, Scotland and Wales. As this report is intended to present a high level picture of the training environment, we have not given a full analysis of every question by country. But you can use the *national training survey online reporting tool* to compare questions by country, trust/board, and by training site. We will also be providing a brief summary for each of the four countries.

1: What did doctors in training tell us?

1: What did doctors in training tell us?

Chapter summary

- The majority of doctors in training are satisfied with the standard of teaching, clinical supervision and experience they receive.
- Heavy, intense workloads can disrupt training, and sometimes lead to doctors in training working beyond their competence or experience.
- Poor handovers and inductions can have a negative impact on trainees' education and development, and can lead to issues with continuity of care for patients.
- The erosion of time to train concerns many doctors in training.

We survey all doctors in foundation, core and higher specialty (including GP) training programmes who are currently in a training post. 51,956 trainees took part in the survey this year, giving us their views about their day-to-day training experience, and the environments in which they work. We use their responses to identify where training environments aren't meeting our standards, so we can work with their employer to bring standards back in line with our guidance.

As in previous years' surveys, doctors in training recognise the overall high quality of their teaching, clinical supervision and training experience. These positive findings are testament to the ability, hard work and dedication of trainers, as well as to the role played by employers, training providers and postgraduate deans in maintaining successful and supportive training environments.

However, they also told us about a number of issues that can affect or impede their training. Many of these issues stem from the pressures of working in healthcare systems under considerable strain; two in five experience heavy workloads and almost half regularly work beyond their rostered/contracted hours on at least a weekly basis. They also told us that heavy workloads can erode time to train and sometimes lead them to work beyond their clinical competence. It's also clear that heavy workloads can negatively impact on satisfaction with training.

Many doctors in training reported concerns about the quality of handovers and the impact of rota gaps. Our analysis shows that these issues often have a negative effect on trainees' education and development. Problems with handovers and rotas can also lead to issues with continuity of care for patients. Three quarters of trainees rated their induction as good or very good – but where poor inductions were reported, a greater proportion of doctors felt unsupported or raised concerns about patient care.

Most doctors in training are very positive about the quality of their teaching, clinical supervision and experience.

The majority of doctors in training told us they are satisfied with the standard of teaching that they receive. Around three quarters [73.3%] rate overall teaching (informal and bedside teaching, as well as formal and organised sessions) in their post as good or very good. Less than one in ten [9.3%] rate it as poor or very poor. This response is slightly less positive than in 2017, when 76.4% of doctors in training rated their teaching as good or very good (and just 7.5% rated it as poor or very poor); but around 5% better than in 2015 and 2016.

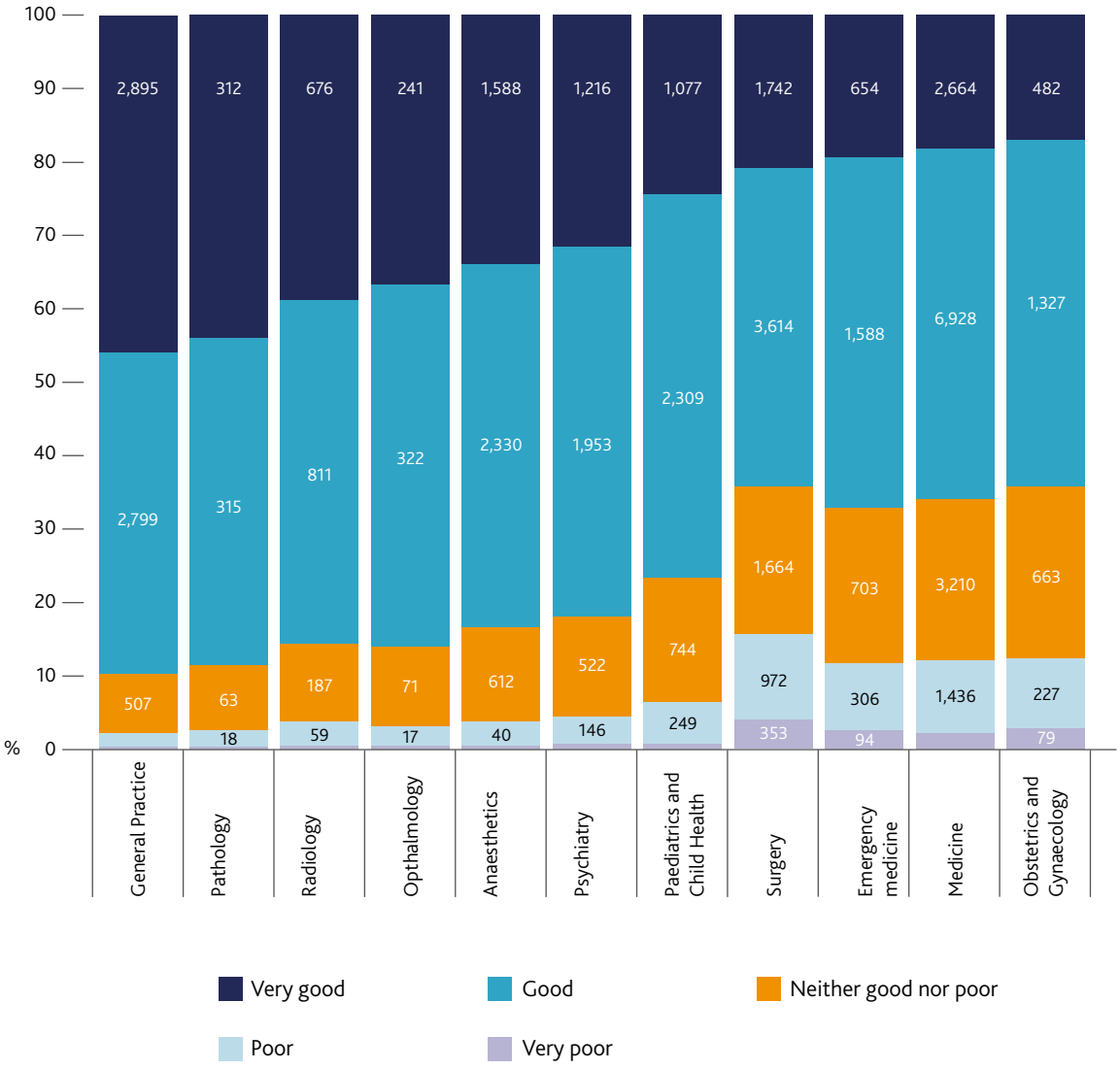
The standards we set in *Promoting excellence* require organisations to make sure each doctor in training has access to a named clinical supervisor who oversees their clinical or medical practice throughout a placement [R2.14]. The survey shows that most trainees are extremely satisfied with their clinical supervision. 88.3% rate the quality of in-hours clinical supervision as good or very good, and 74.6% consider out of hours supervision to be good or very good.

And more than four out of five [81.4%] doctors in training rate the overall quality of their experience as excellent or good. This result has remained consistent since 2012. Satisfaction with teaching, clinical supervision and experience varies only slightly by country and by training specialty.

Most doctors in training said their working environment was supportive and fair, and that this helps build their confidence.

	Agree/ strongly agree	Disagree/ strongly disagree
The working environment is a fully supportive one.	82.0%	5.6%
Staff are always treated fairly.	72.9%	10.5%
Staff always treat each other with respect.	79.8%	7.6%
Your working environment fully supports the confidence building of doctors in training.	73.0%	9.2%

Figure 1a Trainees: Please rate the quality of training in this post.



Please note: we've excluded some specialties from charts in this report, where the number of respondents was too low for meaningful comparisons.

Figure 1b Trainees: Please rate the quality of clinical supervision in this post.

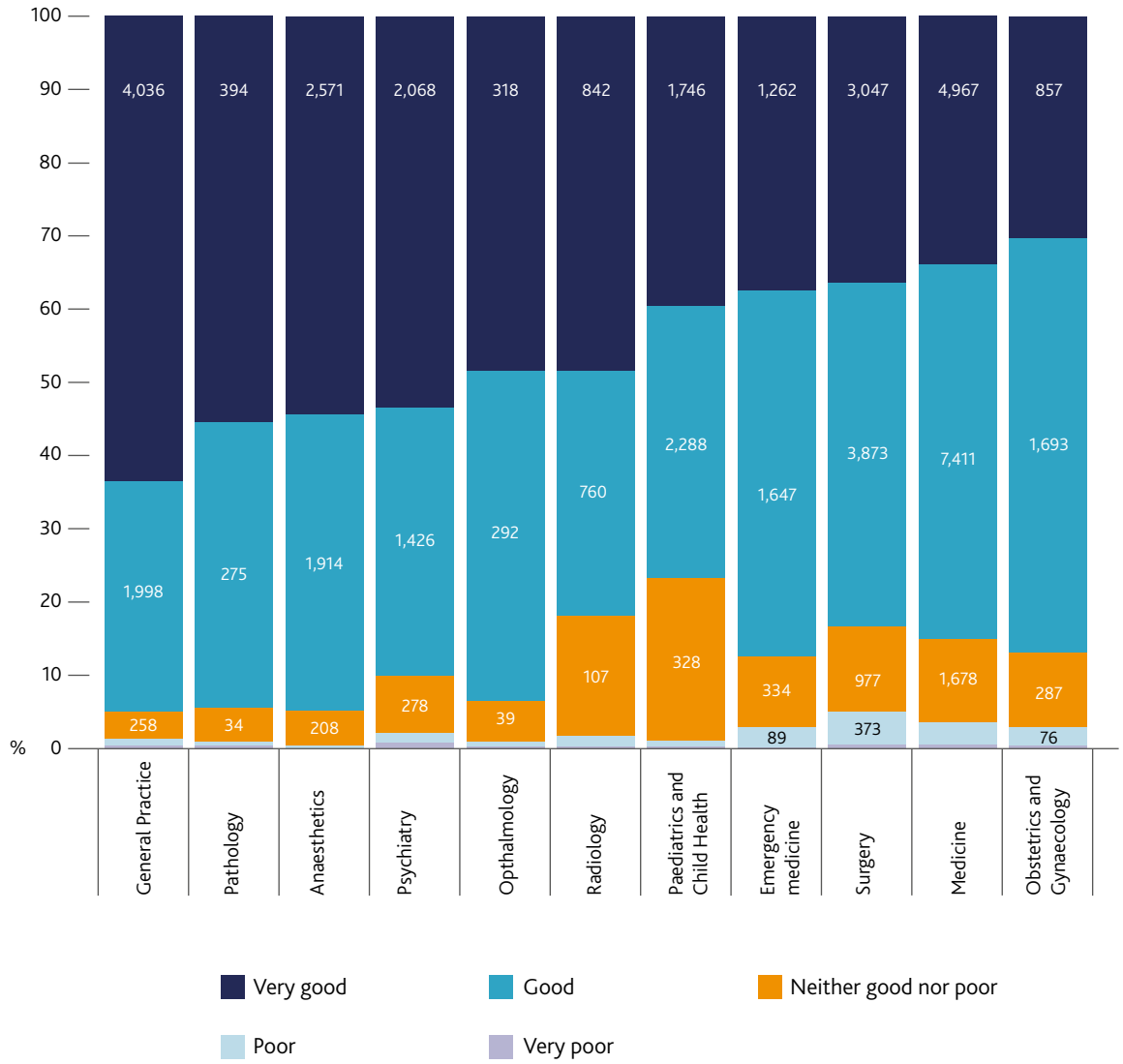
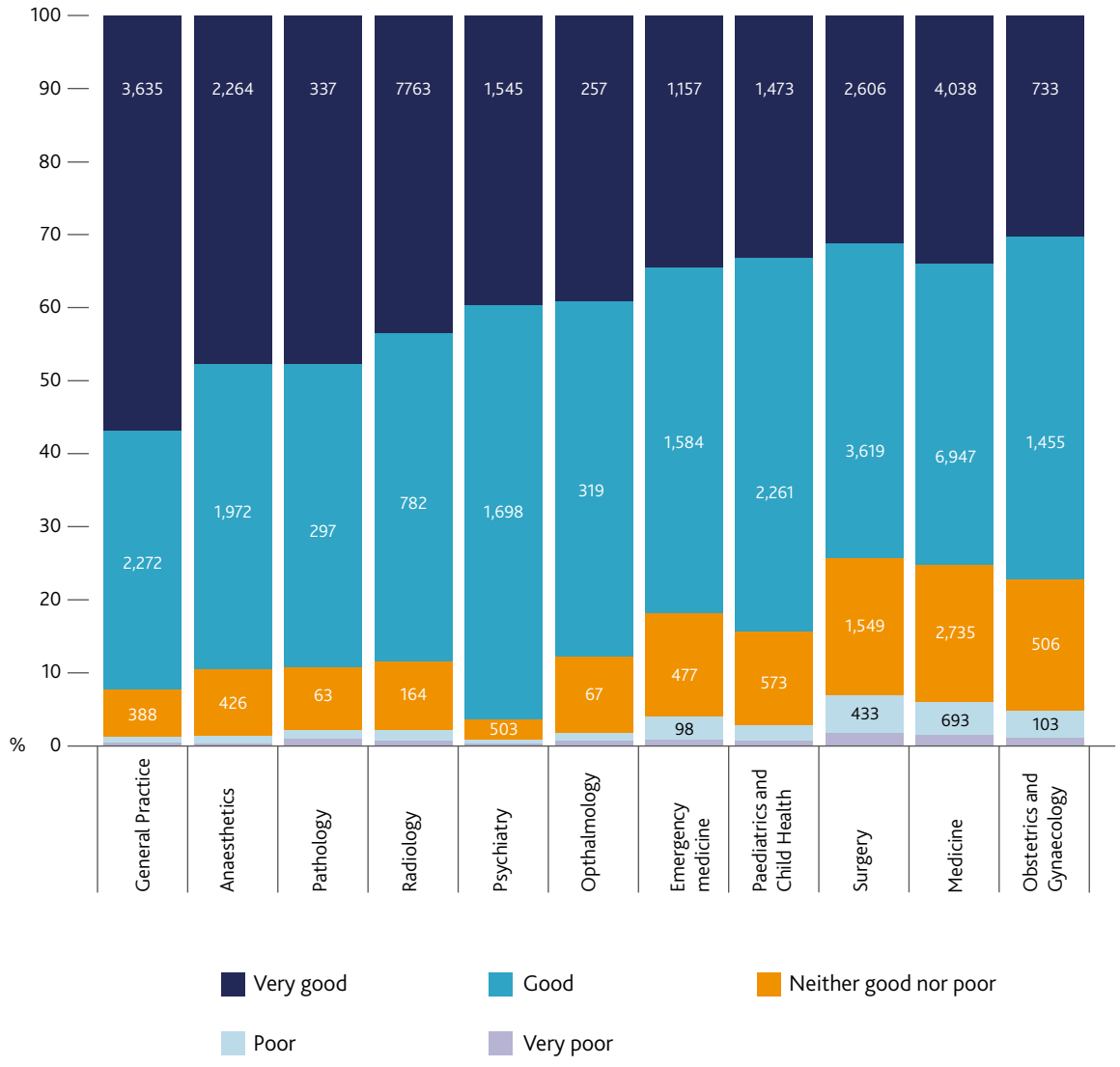


Figure 1c Trainees: How would you rate the quality of experience in this post?



The majority [61.6%] of doctors in training told us they never feel forced to cope with clinical problems beyond their competence or experience.

However, 15.9% told us they feel forced to do so on at least a monthly basis. A higher proportion of trainees in medicine, emergency medicine and surgery reported that this was the case. The proportion of doctors who feel forced to cope with clinical problems beyond their competence decreases considerably after foundation into core and specialty training levels – perhaps reflecting the growing confidence and development of trainees as they progress in their postgraduate training. These findings are broadly similar to those for 2017. Of doctors who worked out of hours, almost the same proportion [61.3%] told us they never felt forced to cope with problems beyond their competence or expertise.

Many doctors in training told us they still experience intense workloads, although there has been an improvement since last year.

Many trainees told us they regularly work beyond their rostered/contracted hours. One in ten [10.7%] told us they do so on a daily basis, and an additional third [37.8%] on a weekly basis. These findings show around a 5% improvement on the 2017 results, when 13.6% reported that they worked beyond their hours on a daily basis, and 39.9% on a weekly basis – and a 10% improvement on the 2016 result. If we break down this year's results by training specialty, we see that a higher proportion of trainees in medicine and surgery posts reported that they work beyond their rostered/contracted hours on a regular basis [Figure 2].

Two in five [40.7%] doctors in training rate the intensity of their work as heavy or very heavy. Again, as Figure 3 shows, doctors in training in emergency medicine posts reported by far the heaviest workloads; 73.8% rate the intensity of their workload as heavy or very heavy. Trainees in medicine, obstetrics and gynaecology, paediatrics and surgery posts all also reported heavier workloads than the average across all specialities [Figure 3].

One in five [21.3%] doctors in training feel short of sleep at work on a daily or weekly basis – this is a slightly smaller proportion than in 2017, when 22.5% told us the same. However, the number of doctors who told us this affects them remains an area of concern. Trainees in emergency medicine posts told us they most regularly feel short of sleep [46% on at least a weekly basis], followed by those in surgery, paediatrics, medicine, and obstetrics and gynaecology posts.

Figure 2 Trainees: In this post, how often (if at all) have you worked beyond your contracted/ rostered hours?

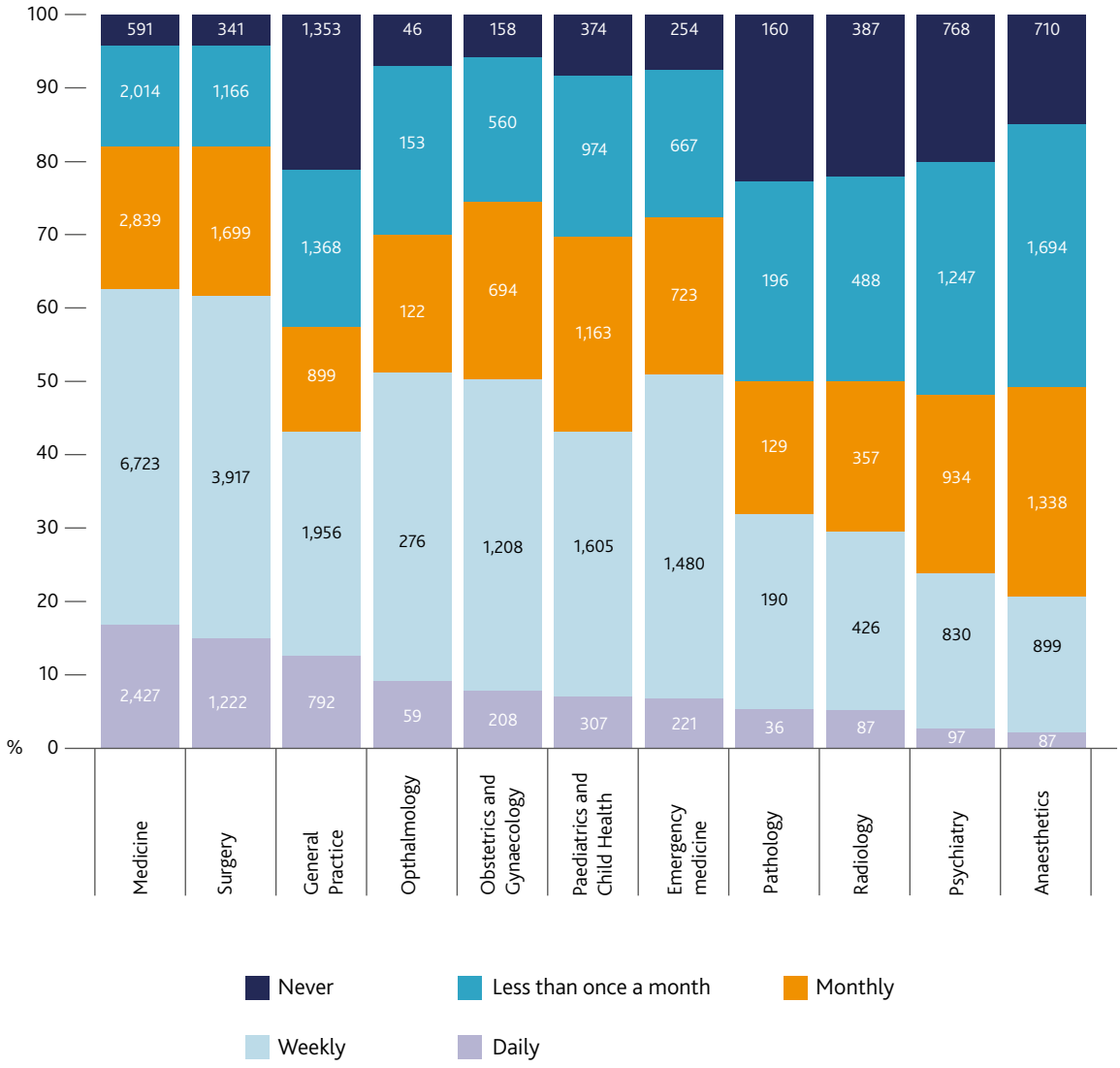
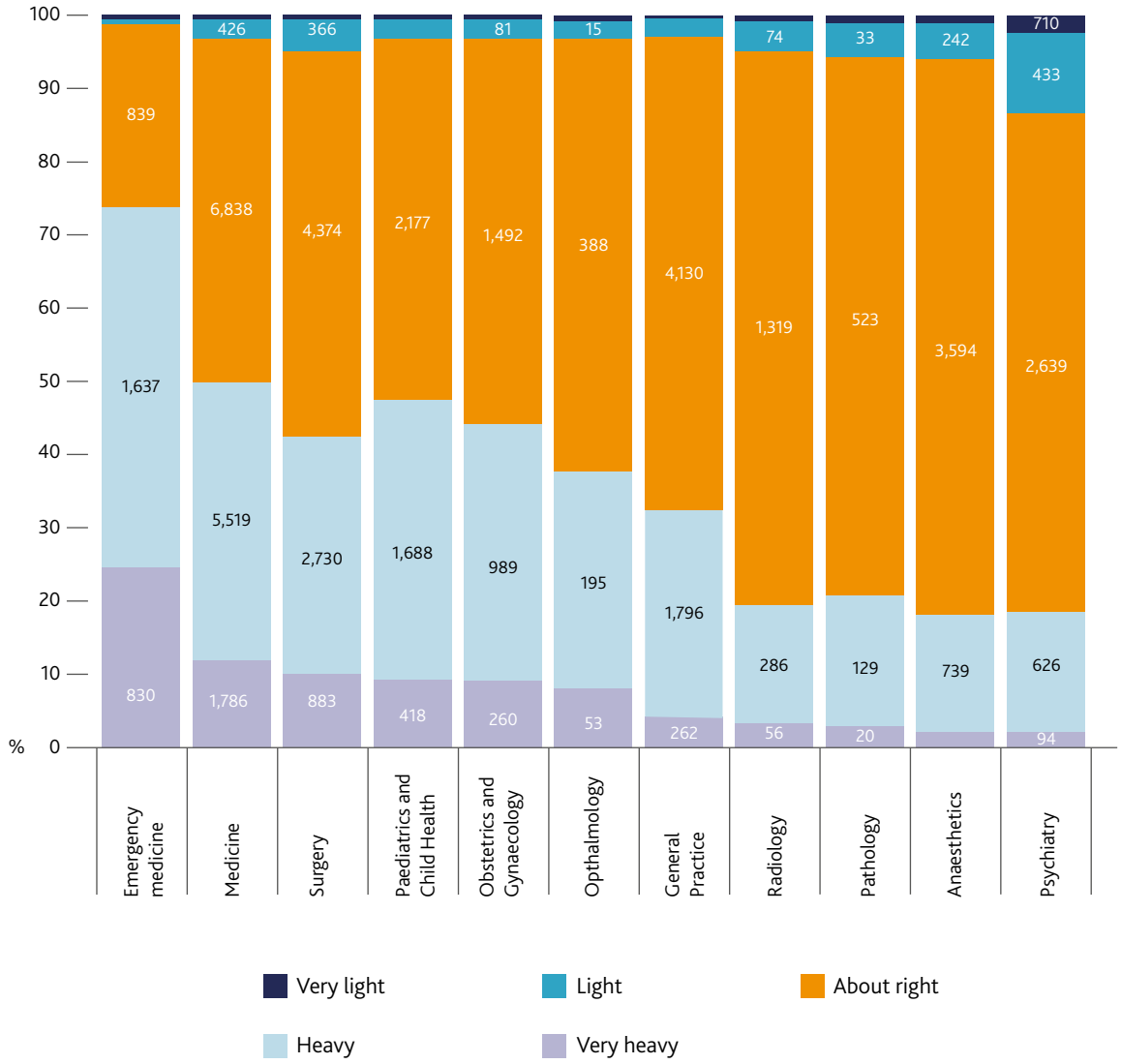


Figure 3 Trainees: How would you rate the intensity of your work, by day, in this post?



Heavy workloads are associated with educational and patient safety issues.

Survey results show that where respondents report heavy workloads, they also report other issues with training.

How do heavy workloads affect training and patient safety?

We compared doctors in training who said their daytime workload was **very heavy** [9.1%, n=4,712] with those who said it was **about right** [54.9%, n=28,370]:

Loss of time to train

- ***Almost three times as many*** [***56.5%*** to ***20.2%***] said that it was not rare to lose training opportunities due to rota gaps.
- ***Five times as many*** [***39.4%*** to ***7.8%***] felt that they do not have enough protected time to attend local/departmental teaching.
- ***Four times as many*** [***39.8%*** to ***9.7%***] felt that they do not have enough protected time to complete all mandatory training requirements.

Patient safety concerns

- ***Seven times as many*** [***19.8%*** to ***2.7%***] feel forced to cope with clinical problems beyond their competence or experience on at least a weekly basis.
- ***Almost three times as many*** [***13%*** to ***4.9%***] felt that handover arrangements do not always ensure continuity of care for patients between shifts.

Training satisfaction issues

- ***Seven times as many*** [***13.8%*** to ***1.8%***] described the quality of their training experience as poor or very poor.
- ***Six times as many*** [***17.3%*** to ***2.7%***] disagreed that their environment was supportive.
- ***Eight times as many*** [***22.4%*** to ***2.7%***] would describe this post as poor to a friend.

Exception reporting

In 2016, exception reporting was introduced in England – a process which enables trainees to flag up if their actual work has varied from their agreed work schedule. This includes instances where trainees have worked extra hours, or have missed out on educational or training opportunities.

We have welcomed the introduction of this new system, and hope that it can deliver detailed evidence of where problems are occurring, so that efforts to address them can be targeted.

We're working with organisations including NHS Improvement (NHSI), the Academy of Medical Royal Colleges (AoMRC), the Care Quality Commission (CQC) and the British Medical Association (BMA) to look at ways to improve exception reporting, so that it can have a positive impact for doctors in the training environment. This work has led to a joint proposal to standardise reporting, so we can compare each trust's data at a national level.

We strongly encourage trainees in England to use exception reporting so that the data paints a true picture of the pressures doctors are facing. Organisations can't plan their resources better in the future without a full and accurate evidence base. Doctors must feel able to report concerns wherever and whenever they arise – they should never be placed under pressure to feel otherwise.

Although exception reporting only applies to England, we are currently working with partner organisations in Scotland, Wales and Northern Ireland to find ways of improving the consistency of rota monitoring, and supporting doctors in training, in those countries.

Case study: Exception reporting, two years on…

Exception reports were introduced in England in 2016 as part of the new terms and conditions of service for doctors and dentists in training. They aim to give trainees a real time tool to report times when they work beyond their rostered hours. Dr Christopher Kirwan, the guardian of safe working hours at Barts Health NHS Trust, tells us what lessons have been learnt so far from this initiative.

'Two years on, exception reporting at Barts Health (a large trust in London with 1044 trainee posts) has given valuable insight into working practices of trainees and the problems they face. They have also helped to direct improvements in working conditions and practices to support safe working.

- Over the last year at Barts Health, exception reports have predominantly come from foundation year one doctors (60%) despite them only being 11% of the trainee workforce.
- A further 21% have come from foundation year two doctors (again, 11% of the trainee workforce).
- 16% and 3% have come from core training and specialist training grades respectively (28% and 45% of the trainee work force).
- Some trainees submitted multiple reports but, depending on grade, anywhere between 1% and 20% of individual trainees submitted a report in any given quarter.

Case study: Exception reporting, two years on… (cont.)

We identified a number of different typologies and interesting findings in the exception reports submitted by our trainees:

- Trainees are very busy. Foundation year one trainees, in particular, need support and guidance to prepare them for the complexities of doing their job in a hospital setting; it is no coincidence that spikes in exception reporting are seen just after each rotational change over.
- Failures of the rota pattern have always led to work schedule reviews when the reality of tight shift times and the nature of handovers have been miscalculated. These have tended to be very quickly resolved (usually in under 72 hours) by the team once they have realised the problem.
- 'Service support' encompasses a broad range of issues, such as finding specific kit, late arrival of blood test results, and technical/IT problems. Many of these issues can be easily fixed or improved – which can make a huge difference to the morale of a trainee at work; doctors find it especially annoying when simple things are a struggle.
- Rota gaps and having to provide cover for sick colleagues are both inevitable. But it's key that these are recorded as a measure of both staffing issues within the NHS and the inflexibility of the working patterns and rota rules.
- Finally, it's key that consultants and other senior clinicians ensure they are mindful that decisions they make may have a much bigger impact on trainee working patterns than they realise (e.g. starting a ward round at 5pm instead of 2pm). Thankfully, there is evidence that this message is beginning to get across.

Exception reporting is a positive development from the new junior doctors' contract that has, in many instances, led to rota errors being corrected quickly. It has also highlighted a number of problems that can easily be corrected to improve working conditions for trainees. In a recent internal survey (July 2018), 68% of trainees felt exception reporting was as good as, or better than, previous systems for reporting working hours problems. Yet they also were clear that other changes in the contract had potentially made many things worse. To continue to support safe working, more innovative workforce planning is needed to limit the impact of staff shortages.'

Over half [52.8%] of all doctors in training told us they received less than six weeks' notice of their roster.

One in five [20.6%] trainees felt they were not given enough notice about the rota in advance of starting their post. This year, *NHS Employers and the BMA published recommendations* that, in England, the roster must be made available to doctors no later than six weeks before beginning a post. It's vital that trainees are able to strike the right balance between their professional and personal lives. Across the UK, between 40% and 55% of trainees in every specialty except anaesthetics [36.3%] told us they received less notice than the NHS Employers/BMA* recommendation. Around one in ten [10.5%] of all doctors in training told us they received their rota with: one week's notice [3.7%]; less than one week's notice [3.5%]; or no notice at all [3.3%]. A larger proportion of trainees in general practice [8.5%] and pathology [8.6%] posts did not receive any notice of the rota at all [Figure 4].

Gaps in the rota can disrupt training

The standards and requirements set out in *Promoting excellence* [R1.12] state that organisations must design rotas to make sure doctors in training have:

- appropriate clinical supervision
- provide learning opportunities that allow doctors in training to meet the requirements of their curriculum and training programme
- minimise the adverse effects of fatigue and workload

In 2017, we introduced survey questions on the quality of rotas and their impact on postgraduate medical education. That year, many doctors in training and trainers told us they were concerned that poor and incomplete rotas were having a detrimental impact on medical education. This year's survey tells a similar story. Just under a third [32.6%] of all trainees said that training opportunities being lost due to rota gaps was not a rare occurrence. This was a slight improvement from 2017, when 33.9% said the same.

A larger proportion of trainees in certain specialties reported that issues with rota design disrupt training [Figure 5]. Trainees in obstetrics and gynaecology posts had the most negative response to this question; almost half [46.9%] disagreed that training opportunities are rarely lost due to rota gaps.

When rota gaps do occur, many doctors in training think they are not always dealt with appropriately to protect training. Over a quarter [27.3%] of doctors in training said that rota gaps are not always dealt with appropriately to ensure training is not adversely affected. Similarly, a quarter of all doctors in training [24.8%] disagree that rota design helps to optimise their education and development.

Other professional bodies have recently explored this issue. This year, the *Royal College of Physicians reported* that two thirds of their trainees experienced frequent gaps in their rota, causing problems for patient safety and leading many doctors to find work-around solutions. Our forthcoming annual report, *The state of medical education and practice in the UK*, will look in more detail at the everyday adjustments doctors have to make to fulfil their training and clinical responsibilities.

* For GPs in training specialty posts, we will explore this issue further to clarify where this is based on a failure to communicate the rota, and where this reflects the accepted practice of designing rotas once trainees begin their placement.

Figure 4 Trainees: Approximately how many weeks' notice, if any, were you given about the rota in advance of starting your current post?

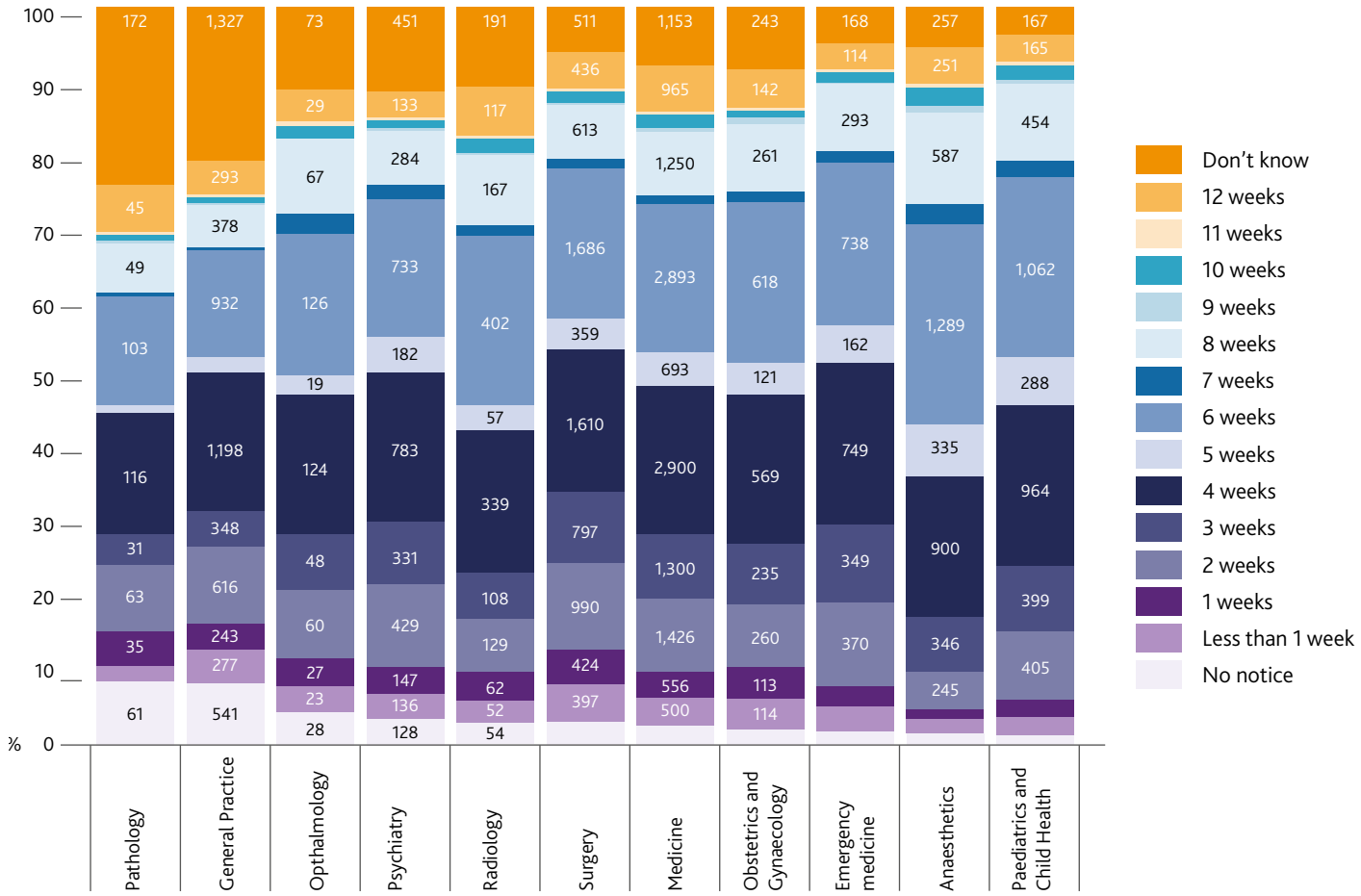
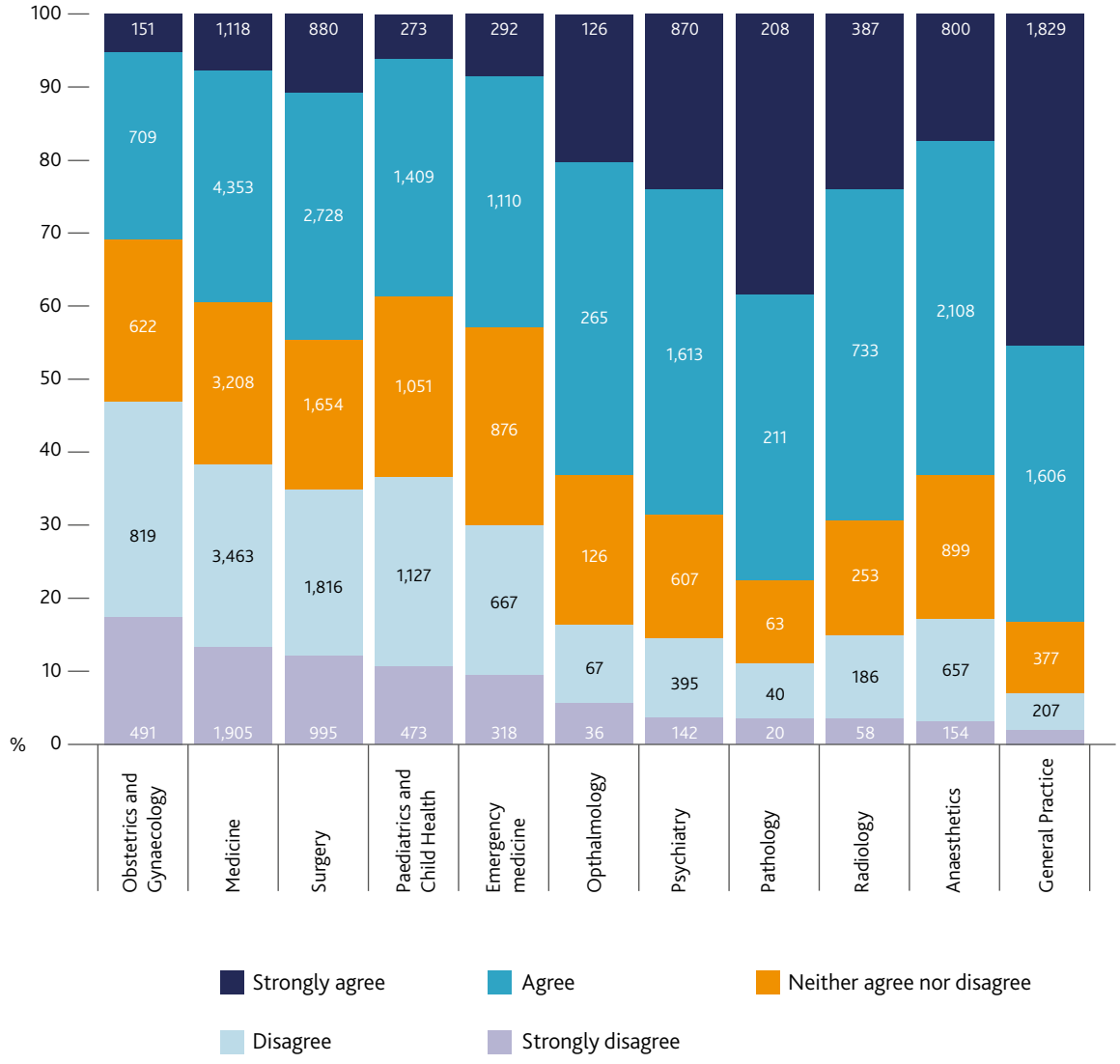


Figure 5 Trainees: In my current post educational/training opportunities are rarely lost due to gaps in the rota.



We're already working closely with our local partners across the UK, and the BMA in particular, to find ways to improve the consistency of rota monitoring, and better support doctors in training.

Poor handovers and inductions have a negative impact on trainees' education and development, and can lead to issues with continuity of care for patients.

High quality handovers and inductions help to make sure postgraduate medical training and patient care is safe and effective. However, problems with handovers and inductions can be a warning sign for other issues.

Although 82.5% of trainees agree that handover arrangements ensure continuity of care for patients between shifts, there was some variation in response by specialty [Figure 6]. Around one in ten trainees in ophthalmology, surgery and medicine posts disagreed with that statement.

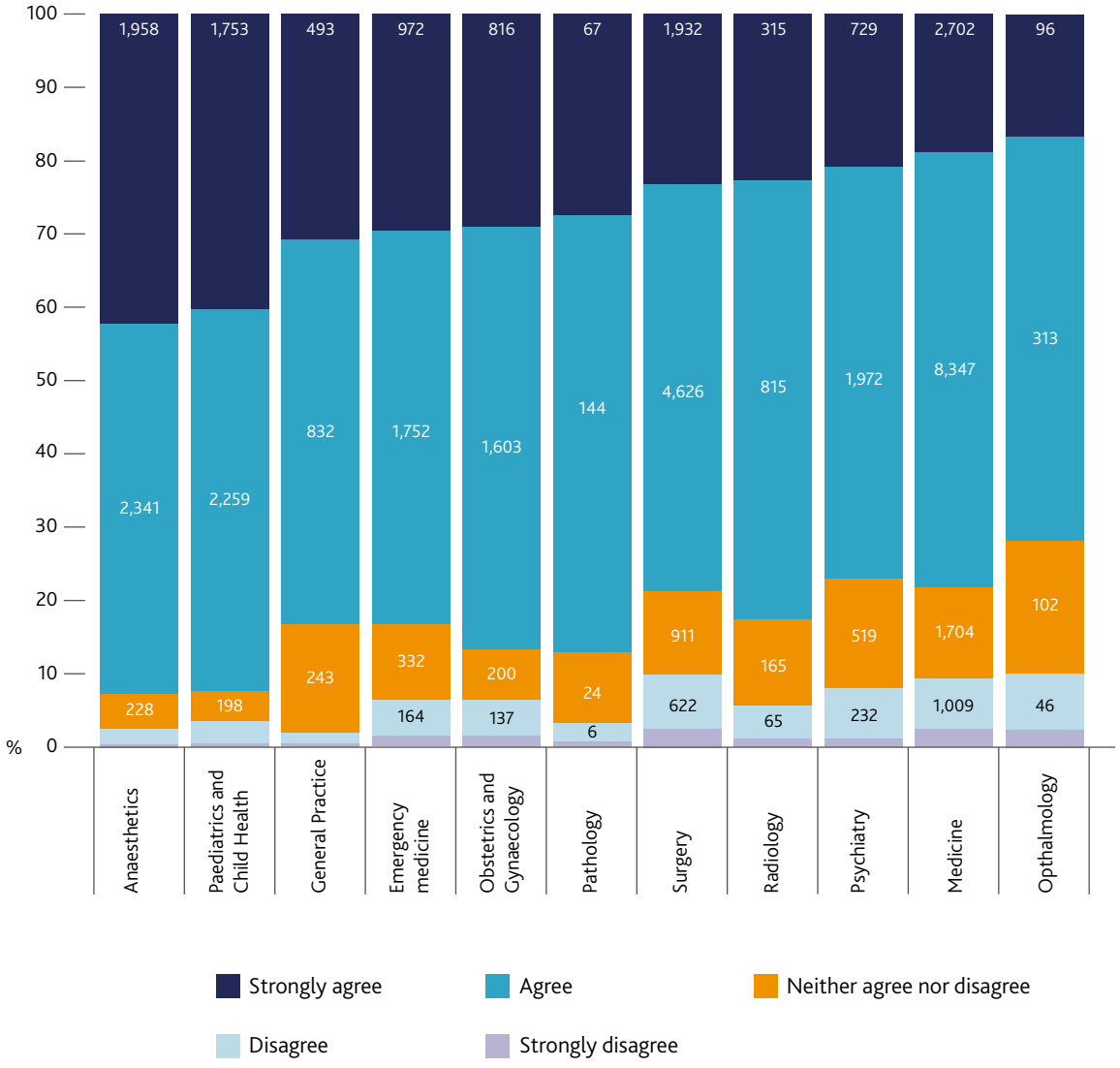
And over a fifth of trainees in surgery and medicine posts think that handover arrangements do not always ensure continuity of care for patients between departments. Overall, around one in six [16.2%] of all doctors in training said the same.

Handovers that include appropriate members of the multi-disciplinary team can help to create a good team working culture. Comparing trainees who said this didn't always happen to those who did, four times as many [21.7% to 5%] think their organisation doesn't encourage a culture of teamwork between clinical departments.

Our standards require organisations to plan and schedule handover of care to maximise learning opportunities for doctors in training in clinical practice [R1.14]. However, this year's results show that handovers are not always used to learn lessons about the working environment. One in three [33.7%] doctors in training told us that handovers are not always used as a learning opportunity. Over 40% of trainees in medicine training posts, and over 35% of those in psychiatry and surgery training posts, reported this.

Our findings suggest that a good handover, where learning lessons is central to the process, can lead to a better overall training experience – but where this is not happening, doctors report a range of other issues with their training.

Figure 6 Trainees: Handover arrangements in this post always ensure continuity of care for patients *between shifts*.



Why are good handovers important to trainees' education and development?

We compared doctors in training who told us that handovers were ***not always*** used as a learning opportunity [33.7%, n=14,617] with those who ***felt they were*** [40.6%, n=17,591]:

- ***Almost five times as many*** [***15.2%*** to ***3.2%***] felt that their organisation does not encourage a culture of teamwork between clinical departments.
- ***Five times as many*** [***21.4%*** to ***4%***] rated their overall teaching experience as poor or very poor.
- ***Almost three times as many*** [***46.1%*** to ***16%***] felt that rota design doesn't help optimise trainee doctors' education and development.
- ***Five times as many*** [***20.6%*** to ***4%***] felt that their post doesn't fully support the confidence-building of doctors in training.
- ***Five times as many*** [***14.4%*** to ***2.6%***] rated the quality of their practical experience as poor or very poor.

Good inductions play an important role in training and patient care.

Our standards say that organisations must make sure learners have an induction in preparation for each placement, where they will meet their team and other health and social care professionals they will be working with. The induction must also clearly set out:

- their duties and supervision arrangements
- their role in the team
- how to gain support from senior colleagues
- the clinical or medical guidelines and workplace policies they must follow
- how to access clinical and learning resources.

Although around three quarters [73.2%] of doctors in training told us their induction was good or very good, over 4,000 [8.1%] doctors in training still reported that they didn't receive an explanation of their role and responsibilities at the start of their post. Overall, almost one in ten [9.3%] rate their induction as poor or very poor. And over one in ten [12%] also disagree that they got all the information they needed about their workplace when starting their post.

Furthermore, where issues exist with inductions, we also see negative responses around patient care and supportive working environment:

How can poor inductions impact on training and patient care?

We compared trainees who rated their induction as ***poor/very poor*** [9.3%, n=4,715] with those who said it was ***good/very good*** [73.2%, n=37,034]*:*

- ***Four times as many*** [***20.8%*** to ***4.4%***] felt that handover arrangements didn't always ensure continuity of care for patients between shifts.
- ***Three times as many*** [***36.6%*** to ***11.5%***] felt that handover arrangements don't always ensure continuity of care for patients between departments.
- ***Three times as many*** [***58.5%*** to ***19.8%***] felt that gaps in the rota aren't always dealt with appropriately to ensure education and training is not adversely affected.
- ***Nine times as many*** [***22.9%*** to ***2.5%***] felt that their working environment isn't fully supportive.
- ***Four times as many*** [***20.5%*** to ***4.5%***] felt that there isn't a strong culture of teamwork in their post between clinical departments.

Comparing trainees who weren't given all the information they needed when starting their post to those who were, three times as many [17.8% to 5.1%] said they do not always know who is providing their clinical supervision when working. A greater proportion of this group also told us they have to work beyond their clinical competence on at least a monthly basis [33.7% compared to 12.1%], and feel their working environment does not support the confidence building of doctors [28.6% to 5.6%]. Where doctors in training are forced to work beyond their clinical competence, it is vital that they feel able to speak up knowing that they will be heard and that appropriate action will be taken.

Around half of all doctors in training told us that supervisors, colleagues, employers and their specialty are supportive of less than full time training.

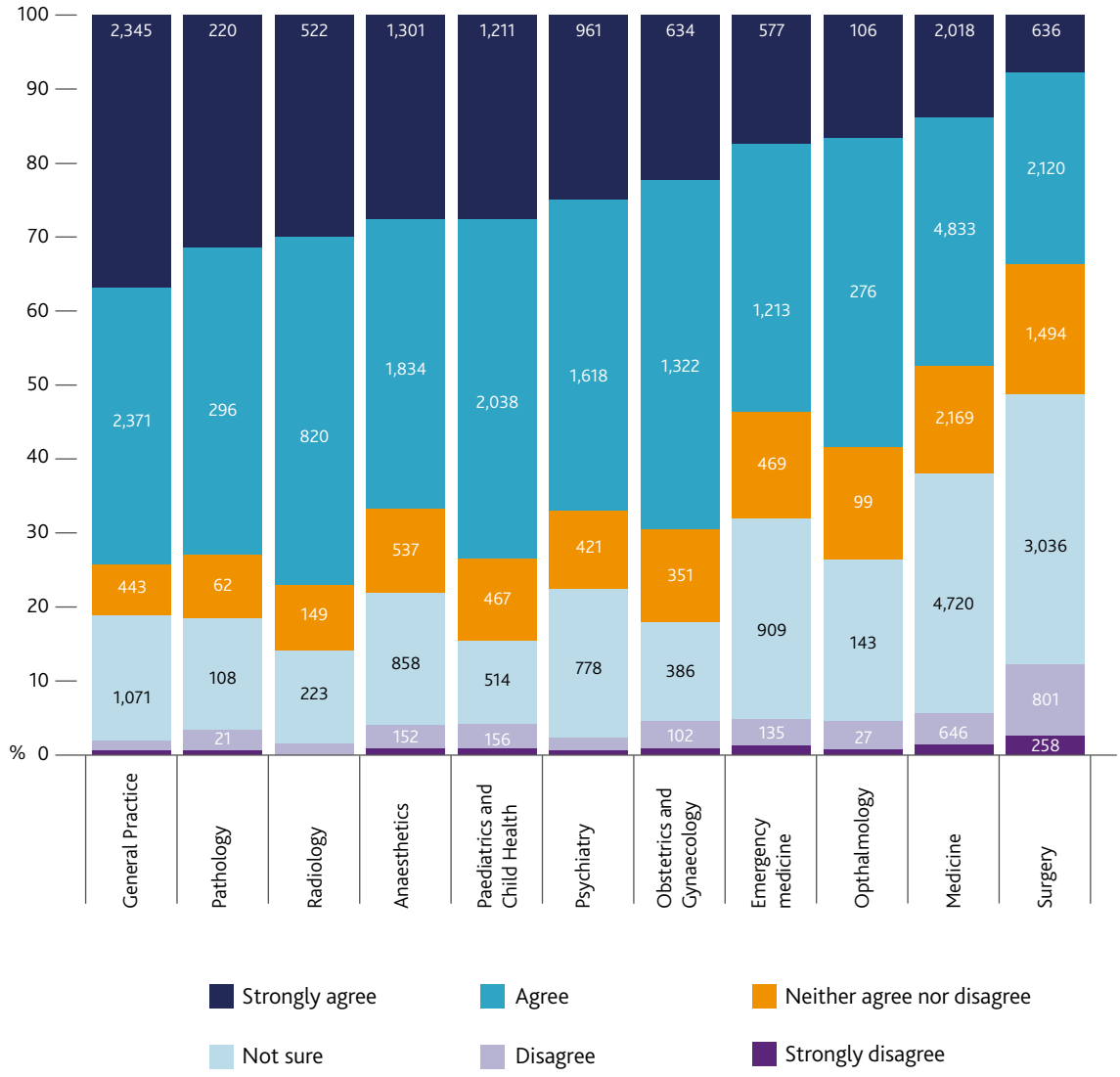
In our 2017 report, *Adapting for the future: a plan for improving the flexibility of UK postgraduate medical training*, we called for greater flexibility in training arrangements. And the standards set out in *Promoting excellence* require doctors in training to have access to systems and information to support less than full-time (LTFT) training [R3.10]. The *conditions for LTFT training* should make sure 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.

In this year's survey, over half [53%] of doctors in training reported that if they were to request to formally work on a long-term LTFT basis, their supervisors and colleagues would be supportive. Just less than half [45.6%] told us they thought their deanery or local Health Education England office would be supportive of this decision.

While the majority of doctors in training feel their specialty is supportive of trainees who wish to work on a LTFT basis, if we break down the results by speciality, we see some variation [Figure 7].

Surgery is perceived to be the specialty least supportive of LTFT, with one in ten [12.7%] trainees reporting this. But this is an area we know the *Royal College of Surgeons of England, Wales and Northern Ireland, Royal College of Surgeons of Edinburgh and Royal College of Physicians and Surgeons of Glasgow are trying to address*.

Figure 7 Trainees: I feel that my specialty is supportive of trainees who wish to work on a LTFT basis.



Conclusion

There are a number of familiar themes in what trainees told us this year. It's pleasing to know that doctors in training still rate their experience, teaching and clinical supervision highly. However, elsewhere the survey paints a more worrying picture. Workload pressures, rota gaps, poor inductions and poor handovers continue to affect training and present risks for patient management and care. We will continue to use the survey to identify where these issues exist and make sure training providers take appropriate action.

We're particularly concerned that where there are pressures on the working environment, training is often compromised. In the run-up to and during what is likely to be another challenging winter for health services across the UK, we will continue to closely monitor this situation.

We have emphasised handovers and inductions in this year's report because our analysis shows that where these are done well, they make a big difference to both training and patient care. And, where they're not, this can be a warning sign that there are other issues. Each year, we use the survey data to create indicators on handover and induction. We make those results available to employers, via *the online reporting tool*, and we expect them to use this to identify where there are issues – or 'red flags' – and take action.

In September this year, we wrote to chairs and chief executives of trusts and boards across the UK, to highlight their obligation to provide appropriate inductions. And we've also started a dedicated programme of work on induction, to make sure all doctors are supported when they begin a new role or return to practice after time away. This is one of a number of initiatives we've introduced to address the issues that have been raised with us about the environments doctors work and train in, and the impact of systems pressures on medical practice.

We also focused on rota notice because it's important for employers to get this right to improve their trainees' quality of experience. The BMA and NHS Employers published guidelines on this topic in May of this year, shortly after our survey closed. It is striking just how many trainees did not receive the minimum six weeks' notice, as recommended. We will be paying close attention to whether this changes in next year's survey.

Overall, much of this chapter has highlighted the importance of human factors and supportive environments to training. We encourage employers to recognise the value of a positive working and training culture, as this can help to build trainees' confidence. Our *Generic professional capabilities framework* requires trainees to demonstrate that they can work effectively in multidisciplinary and inter-professional teams. What doctors in training told us in the survey suggests that supportive environments often reflect such positive teamwork. Just as we require trainees to promote and participate in this, employers need to take responsibility to create and maintain this culture and environment too.

2: What did trainers tell us?

2: What did trainers tell us?

Chapter summary

- The majority of trainers* told us they enjoy their roles and the opportunities they bring.
- Most trainers are satisfied with the level of support they receive in their roles.
- The lack of time to train remains a significant issue for many trainers.
- Intense workloads and rota gaps often disrupt training.

Trainers play a vital role in teaching, mentoring and inspiring the next generation of doctors. And as the previous chapter explores, the majority of doctors in training recognise that trainers are performing that role to a high standard. Since we reintroduced our survey of trainers in 2016, the overwhelming majority of respondents have consistently told us that they enjoy what they do and the opportunities their role provides.

But trainers are also under great pressure. Some are finding balancing their training and clinical duties challenging, which can lead to insufficient time being recognised in job plans to support training. There was an association between how trainers rated the provision and protection of time for training and their overall satisfaction in their role.

Many of the challenges faced by trainers are similar to those experienced by doctors in training, such as heavy workloads and working beyond rostered hours on a regular basis. And where trainers report high workloads, a greater proportion also say it's harder to find time for training, and that the training environment is less supportive.

Our standards say that employers must provide trainers with the support and resources they need, as well as making sure that time to train is protected against competing demands. Organisations are required to design and manage the rota so that trainers have sufficient designated time to fulfil their educational roles [R1.12]. In this and previous years' surveys, trainers have told us this does not always happen. This year, a quarter of trainers told us that educational/training opportunities being lost due to gaps in the rota was not a rare occurrence. A similar number reported that rota gaps are not always dealt with appropriately to protect training.

We use the trainer survey results to identify where organisations are not meeting these standards. We then expect employers to take appropriate action to address this.

* Excluding GP trainers. This year we introduced a specific set of questions for GP trainers; these responses are covered in Chapter 3.

This year, we also wrote to chairs and chief executives of trusts and boards across the UK to reinforce their obligation to protect time for training.

We also look for examples of where training is working well, so that instances of good practice can be shared across the profession.

16,297 trainers (excluding GP trainers) completed the national training surveys in 2018. They answered questions on the environment in which they teach and work, and the support and opportunities they receive as part of their role. This year, the survey response rate for trainers decreased from around 55% to 41.4%. We will work with trainers and the professional bodies that represent them to understand why this happened and respond to that. Input from as many trainers as possible is vital, as it helps us to get the fullest picture of the issues that affect them.

Over a quarter of trainers feel that they don't have enough designated time to train, and that the time they do have isn't always sufficiently protected.

Our standards for medical education and training make it a requirement for employers to monitor how educational resources are allocated and used, including ensuring time in trainers' job plans [R2.10]. Trainers must also have enough time in their 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 [R4.2].

We continue to call on employers to protect training time in pressured environments. In the last two years, we have added questions on the provision of time for training to the national training surveys. While 2018's results suggests some small improvements since last year, many trainers still told us that the lack of time to train – and the knock-on effect this has – was an important issue.

More than a quarter [28.3%] of trainers disagree that their job plan contains enough designated time for their role as a trainer. While trainers in anaesthetics were most positive about the time they had available – two thirds [67.9%] agreeing with this statement – a lower proportion of trainers in emergency medicine, medicine and surgery told us they had sufficient time [Figure 8]. A fifth [22.1%] of educational supervisors also told us that their job plan didn't contain enough time to meet with their trainees frequently.

Even where training time is allocated, this does not always guarantee that it will be protected against the demands and pressures of a clinical environment. A third of all trainers disagree that they are always able to use the time allocated to them specifically for training. A larger proportion of trainers in medicine and radiology disagreed with the statement [Figure 9].

Figure 8 Trainers: My job plan contains enough designated time for my role as a trainer.

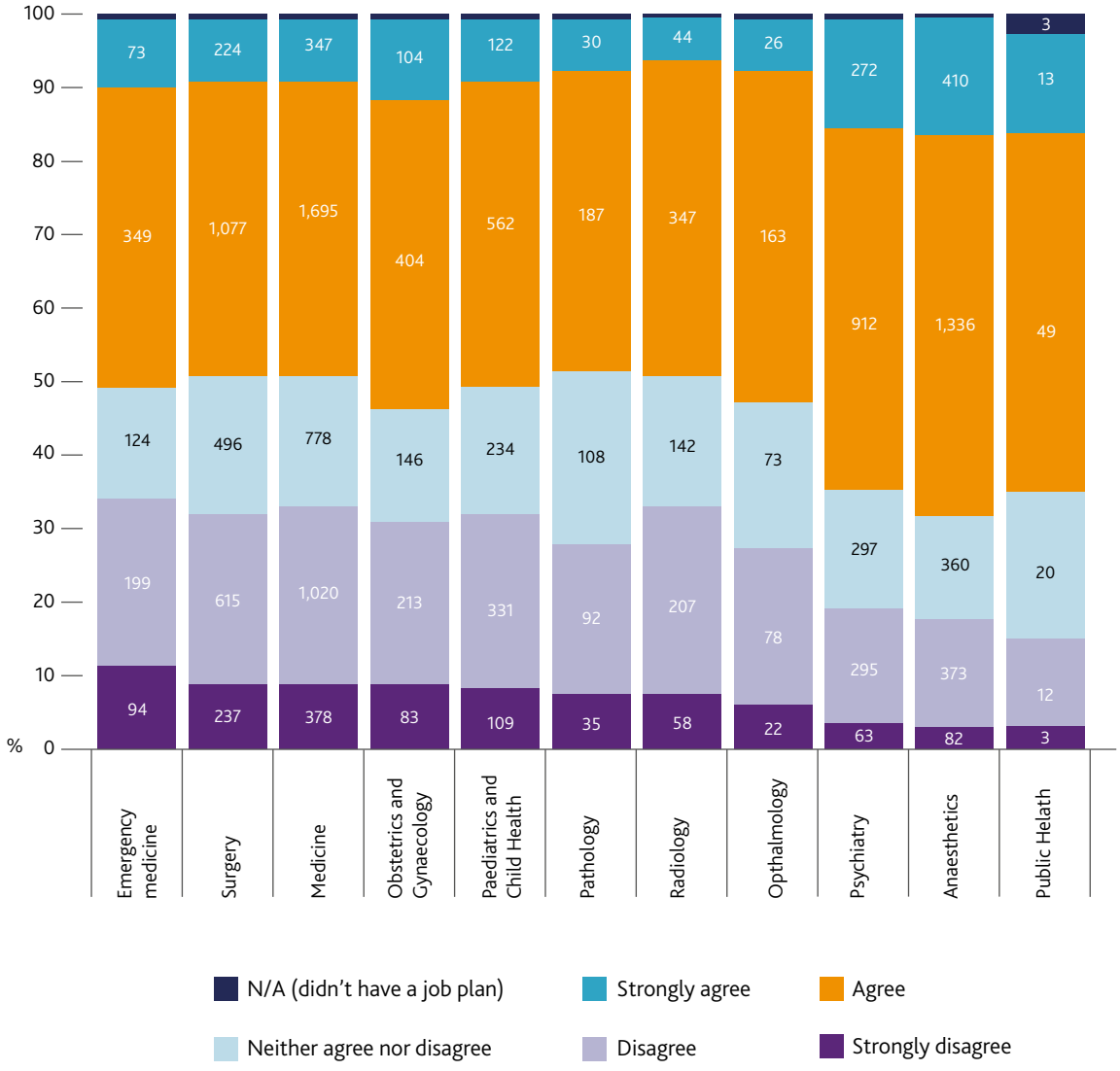
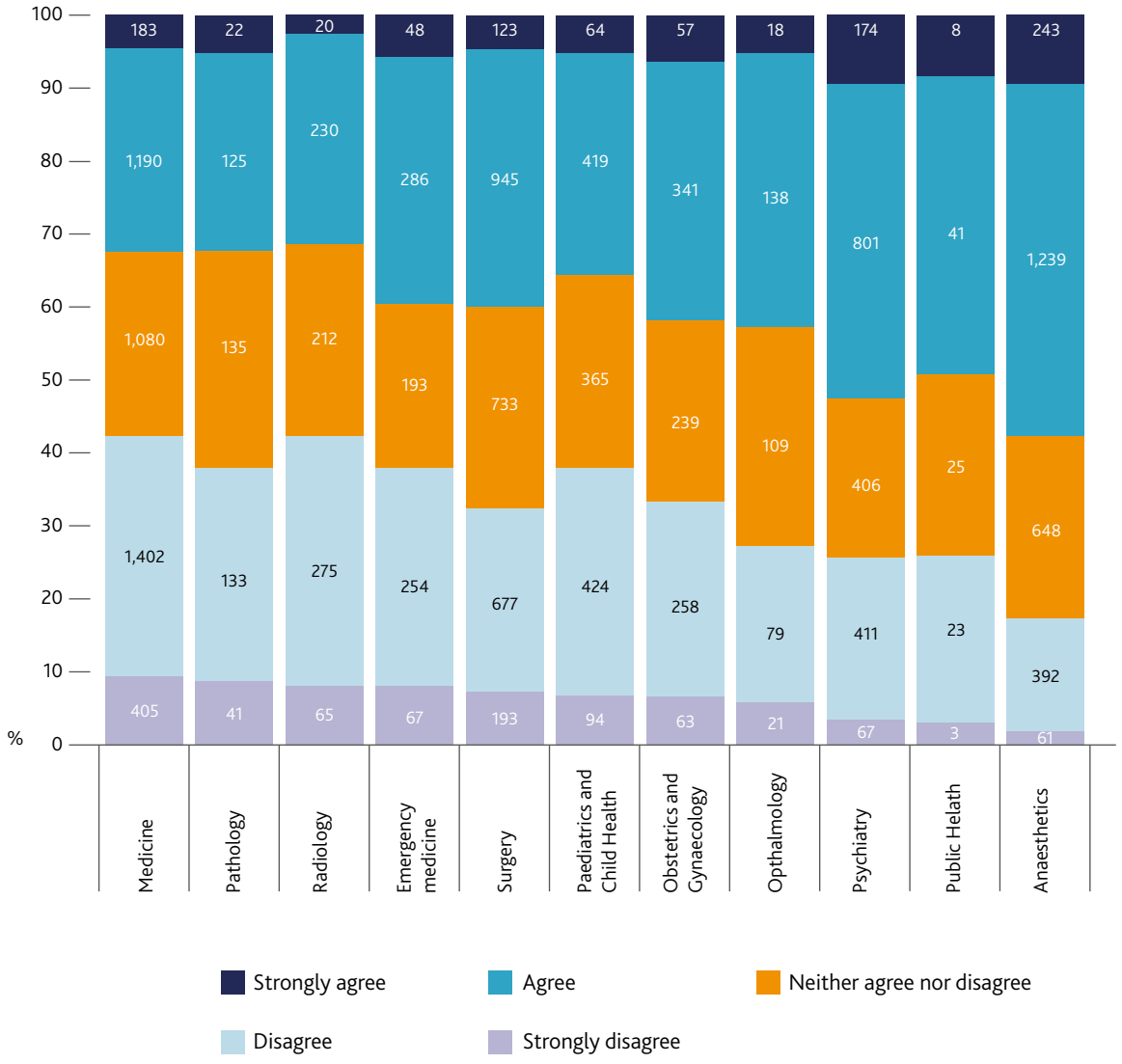


Figure 9 Trainers: I am always able to use the time allocated to me in my role as a trainer specifically for that purpose.



A higher proportion of trainers reported heavy workloads compared to trainees. Intense workloads can also affect the provision of training.

Many trainers reported heavy workloads, and that they regularly work beyond their rostered hours. Two thirds of trainers [66.3%] describe the intensity of their work through the day as heavy or very heavy. This is twice as many as those who consider the intensity of their workload to be 'about right'. It's also considerably higher than the 40.7% of doctors in training who described their work during the day in the same way. One in four [26.5%] trainers described the intensity of their work through the night as heavy or very heavy.

Trainers told us that they continue to work extra hours regularly. The majority of respondents [71.6%] said that they work beyond their rostered hours on at least a weekly basis – with almost a third of trainers saying that this occurred daily [21.7%]. Again, this is much higher than the proportion of trainees who said the same (48.5% on at least a weekly basis). Over one in six [16.8%] trainers felt short of sleep at work on a weekly basis, and 3.3% on a daily basis. Despite trainers reporting heavier workloads and having to work beyond their hours more regularly, a similar proportion of both trainers and trainees felt short of sleep at work.

We found an association between how trainers rate the intensity of their workload and the provision of time to train. Almost half [47.4%] of all trainers who describe their day workload as very heavy disagree that they have enough designated time to train, compared to just 15.2% who describe their workload as 'about right'.

Twice as many trainers who felt short of sleep on a daily or weekly basis reported that their job plan does not contain enough designated training time, compared with those who reported lower levels of fatigue [47.8% to 23.4%].

Reporting a heavy workload is also associated with feeling that your working environment is unsupportive.

We compared who said their workload was ***very heavy*** [17.3%, n=2,817] with those who said their daytime workload was ***about right*** [33.1%, n=5,394]:

- ***Three times as many*** [*47.4%* to ***15.4%***] felt that their job plan doesn't contain enough designated time to train.
- ***Twice as many*** [*19.3%* to ***8.6%***] disagreed that their work environment fully supports the confidence-building of doctors.
- ***Four times as many*** [*19.5%* to ***5.5%***] described the support they received as a trainer from their trust/board as poor.
- ***Twice as many*** [*50.4%* to ***19%***] felt that they weren't always able to use their allocated training time for that purpose.
- ***Three times as many*** [*14%* to ***4.4%***] were unsatisfied with the opportunities offered to them as a trainer.

Many trainers remain concerned that gaps in the rota often disrupt training.

In the 2017 survey, trainers told us that issues with the rota often disrupted or made it a challenge to fulfil their educational responsibilities. While there have been small improvements this year, rota gaps remain an issue.

Over a quarter [28%] of trainers did not consider educational/training opportunities being lost due to gaps in the rota to be a rare occurrence. This is around 2% less than in 2017. And around a quarter [24.7%] of trainers said that gaps in the rota are not always dealt with appropriately to protect training.

While the majority of trainers [65.6%] think that rota design helps optimise education and development, 13.8% disagreed with that statement.

Trainers also told us that handovers do not always promote trainees' education and development. 15.8% of trainers disagreed that handovers are always used as a learning opportunity for doctors in training.

Despite workload and rota issues, most trainers enjoy their role, and are satisfied with the support they receive.

As discussed in the previous chapter, doctors in training are very positive about the quality of teaching they receive. Trainers are working exceptionally hard to achieve high standards of medical training and patient care, especially in light of the various pressures they experience in their role.

And it's clear from this year's survey that trainers also feel positive about what they do. Nine out of ten [92.1%] trainers* enjoy their role as an educator. This is almost identical to the results for both 2016 and 2017. Just 1.5% [n=279] of trainers disagree that they enjoy their role.

Trainers are also positive about the opportunities their role provides and the support that they receive. More than two thirds [71.4%] of trainers are satisfied with the opportunities offered to them as a trainer. And three quarters [74.9%] agree that the working environment in their trust/board is fully supportive. Less than one in ten [9.27%] disagree with this statement.

Most trainers are content with the support they receive from their department, trust/board and deanery:

	Departmental/ practice support		Trust/ board support		Deanery/ HEE support	
	2017	2018	2017	2018	2017	2018
Good/very good	72.0%	70.2%	55.4%	56.4%	56.7%	56.5%
Poor/very poor	7.6%	7.2%	10.8%	10.4%	8.4%	9.0%

* This figure alone in this chapter does include GP trainers.

Conclusion

The national training surveys show that the majority of trainers are performing well in a role they enjoy. However, trainers also continue to tell us about the pressures that make their role difficult – many of which stem from having to balance competing responsibilities in healthcare systems working beyond capacity.

Our framework for recognising trainers aims to protect and enhance the status of postgraduate clinical and educational supervisors. The quality of medical practice and the safety of patients are crucially dependent on the quality of the training provided to doctors in training. Each local education provider is responsible for the settings in which training is delivered – and our framework sets out clear expectations for their responsibilities for trainers.

We expect each local education provider to:

- Ensure that sufficient trainers are in post and available to train.
- Support trainers through:
  - job plans
  - appraisal and revalidation
  - support for the training and professional development of trainers
  - deal effectively with concerns and difficulties
- Take effective action where training is poor and remediation is not sufficient.
- Be accountable for the use of the resources received to support medical education and training.

Where there are concerns in any of these areas, we use our enhanced monitoring process to work with all organisations involved to address the concern and develop a sustainable solution. We require frequent progress updates from those responsible, and provide representation on a locally-led visit to investigate issues. We publish information on enhanced monitoring cases on our website, and share information with other healthcare regulators where appropriate.

When local processes fail to address serious concerns, we may decide to use our legal powers to place conditions on the approval of postgraduate training posts. We may attach conditions to any approval that we have already given. If it becomes clear that it is unlikely the conditions will be met, we may decide to withdraw our approval for training.

To make sure the trainer recognition framework remains as effective and relevant as possible, we're carrying out an evaluation to assess how well it's being embedded, and the impact it has had. This will involve independent research and we'll report on the findings in 2019.

3: What did GP trainers tell us?

3: What did GP trainers tell us?

Chapter summary

- Over half of all GP trainers report working beyond their normal working hours on a daily basis.
- These working practices can impact upon the delivery of GP training as well as trainers' health and wellbeing.
- Despite these pressures, GP trainers enjoy their role and the opportunities it brings.

Following the 2017 survey, we received feedback that the wording and focus of the questions we asked GP trainers did not reflect their experiences, or that direct comparisons with other specialties overlooked these differences.

So in 2018, we introduced *a new set of questions to* the trainer survey, designed specifically for GP trainers. 2,896 GP trainers completed these questions this year. This is still fewer than in 2017, when 3,616 GP trainers completed the survey. We will continue to encourage GP trainers to respond to the survey, by developing and promoting our new set of questions.

Recently, concern about GPs leaving the profession and a declining or insufficient number of trainees choosing the specialty has drawn public attention to the topic of GP training and workforce planning. The intensity of the job is often identified as a key factor driving these trends. The *BMA's workload and wellbeing second quarterly survey* (2018) found that GPs were the most likely specialty to report working outside their regular hours 'very often'. Likewise, in the national training survey, nine out of ten GP trainers told us they work beyond their normal hours on at least a weekly basis. These working practices can impact upon the delivery of GP training as well as trainers' health and wellbeing.

But despite these pressures, GP trainers are still delivering a high level of teaching. And the majority told us that they enjoy their role, are satisfied with the support they receive, and appreciate the opportunities that being a trainer brings.

GP trainers have exceptionally heavy workloads.

Around nine out of ten GP trainers report working beyond their normal hours on at least a weekly basis. 57.8% work beyond their hours on a daily basis. This is a much higher proportion of trainers than in any other specialty. And this is four times higher than the proportion of trainees in GP posts who said the same [12.4%].

These heavy workloads have a negative effect on GP trainers' health and wellbeing. A third [33.3%] report feeling short of sleep at work on a daily or weekly basis, and two thirds [67%] often or always feel worn out at the end of the working day. Over half [52%] find their work emotionally exhausting, and over one in five [23.1%] are exhausted at the thought of another day in work.

These findings are particularly concerning in the context of *recent research by Mind*, which found a high prevalence of mental health concerns among GPs in England and Wales. The charity identified excessive workloads and long hours as two of the main drivers of these concerns, and has called upon clinical commissioning groups in England and GP practices to provide appropriate support to all their employees.

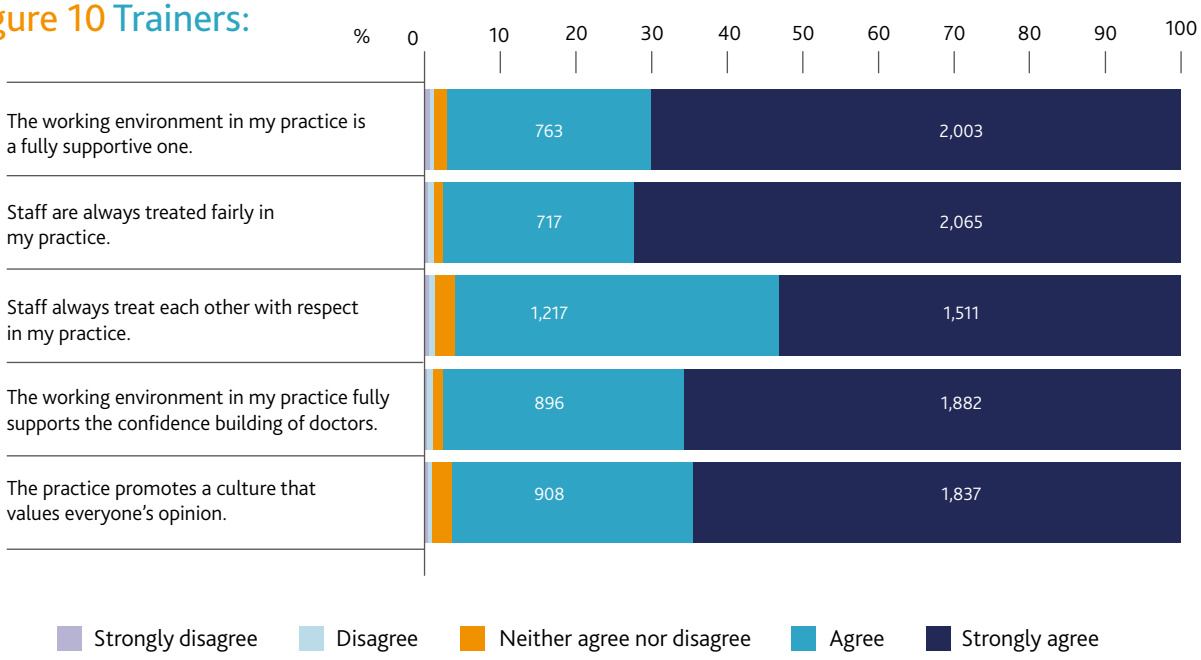
Workload pressures can be an obstacle to GP trainers fulfilling their educational responsibilities.

One in five [20.2%] told us that not enough time for training is allocated in their working week, and a similar number [17.8%] said that they were not always able to use their allocated time for that purpose. And the majority of GP trainers [91.8%] told us the demands of clinical work are not always dealt with appropriately to make sure that trainees are not adversely affected. Later this year, our annual report on *The state of medical education and practice in the UK* will look at the strategies that many doctors are employing to meet their clinical and training responsibilities.

Despite these pressures, the majority of GP trainers enjoy their role.

95.3% told us that they enjoyed being a trainer, and four in five [84.1%] are satisfied with the opportunities training provides. GP trainers also feel they are well-supported at work [Figure 10], with 97% agreeing that their working environment is fully supportive; in fact, 70.2% strongly agree with that statement.

Figure 10 Trainers:



Case study: GP trainers in Wales

Dr Andrew Proctor is a GP Trainer at Roath House Surgery, in Wales.

'We are a GP training practice with approximately 12,500 patients. We have five partners (two GP trainers), two salaried GPs and one to two GP trainees. We also participate in training foundation year two doctors and third year medical students.

In addition, this year we have been involved in the Further Trainers Practice Network, a network of GP training practices in Wales that has specific training and experience in providing refresher training placements for qualified GPs from the UK or overseas who have either never worked in UK general practice or have not worked in it for 2 or more years. The placements provide an opportunity for familiarisation or refamiliarisation with UK general practice under the supervision of a trainer.

The practice is grateful for the opportunity to be involved in training GP registrars. We find the registrars bring enthusiasm to the practice and experience from other backgrounds (both inside and outside of medicine). The process of learning keeps us as trainers up-to-date and sometimes challenges the way we do things. In addition, the trainees bring different personalities and ideas to the practice.

> We pride ourselves on being a friendly practice and try to make sure that we apply a whole practice approach to training – whereby all of the team are involved in the education process. We hope that trainees feel valued and very much part of the team. As well as regular hot reviews, we encourage informal discussions after surgery amongst the clinical team.

The main challenges we face in delivering training include the ever-increasing workload, and having to adapt the way we work to meet demands – such as the increased use of triage and working with allied healthcare professionals.

With less and less time in the working day, it is becoming more difficult to prioritise training. By using a whole practice approach to training, it remains a priority in the working day. On discussing the positive aspects of training as a team, it was noted that a debrief with the registrars after surgery was often a mutually beneficial experience – both in terms of learning and dealing with stressful or difficult surgeries.'

Despite the challenges outlined above, it is encouraging that GP trainees are reporting high levels of satisfaction in the GMC's national training surveys – it is important that the emphasis on training is not lost within the growing workload in primary care.'

Conclusion

A high proportion of GP trainers reported that they regularly work beyond their normal hours – more so than trainers in any other specialty. Many also told us that allocated time for training is being lost to these pressures. However, GP trainers also continue to deliver excellent teaching and supervision to doctors in training, and the majority enjoy their role. As the survey results and the case study in this chapter suggest, this is partly due to the support they receive from their practice and the wider networks many GP trainers have set up, in light of the pressure they are under. We will continue to ask GP trainers a tailored set of survey questions about their experiences. And we'll work to make sure that, where necessary, action is taken to meet *our standards and requirements.*

We also recognise that while GP training places are increasing year on year and many GPs are returning to practice, some practices continue to face recruitment issues. This is alongside a *growing trend* of newly qualified GPs working as locum doctors rather than joining a practice as a permanent GP. And some older GPs are also leaving the profession early. This is leaving a gap between the number of doctors that practices want, and the numbers they are successfully recruiting and retaining. Recruitment issues can also affect the provision of training, and the workloads demanded of GP trainers.

We know that there's a lot of work underway to address some of these issues – including the Scottish government's strategy to drive GP recruitment and NHS England's commitment to recruit at least 2,000 qualified doctors into GP practices by 2020. To help support this programme, we've been working with the Royal College of GPs to review and streamline the application process for GPs from other countries, where the curriculum and training standards have been assessed and found to be similar to ours.

4: Burnout

4: Burnout

Chapter summary

- A quarter of doctors in training and a fifth of trainers reported feeling burnt out to a high or very degree.
- Burnout is associated with high workloads, a lack of or disruption of time to train, and feeling unsupported.
- Burnout also affects trainees' satisfaction with their medical education.

Work-related burnout is defined in the *Copenhagen Burnout Inventory (CBI)* – an internationally-recognised and validated tool for measuring burnout – as a state of prolonged physical and psychological exhaustion, which is perceived as related to the person's work. This can include emotional exhaustion, loss of energy and confidence, and sustained negative feelings towards colleagues or patients. Burnout can affect an individual's physical, mental and emotional wellbeing. And it can lead to mistakes being made in the workplace, or individuals not performing to the best of their ability. *Recent research from the University of Manchester* found that doctors suffering from burnout are twice as likely to make mistakes, such as incorrect diagnoses or prescriptions.

A report from the Society of Occupational Medicine and the Louise Tebboth Foundation also concluded that UK doctors are at greater risk of work-related stress, burnout and depression and anxiety than the general population. It suggested that trainee doctors and GPs early in their career were particularly susceptible to experiencing burnout. As the regulator for medical education and training, and, more specifically, so that we can help address burnout, we want to understand how this condition affects:

- the standard and quality of education and learning experience
- the health and wellbeing of doctors in training and trainers
- patient safety and the quality of clinical care
- trainees' progression along the training pathway

So, in this year's survey, we asked doctors in training and trainers seven questions taken from the Copenhagen Burnout Inventory. These questions weren't mandatory, but almost 50,000 doctors chose to complete them.* This makes the national training survey currently one of the largest research projects internationally to use the CBI.

As we are trialling these survey questions for the first time, there is no comparative data for previous years and we won't be publishing breakdowns of the data by training site as we do for other indicators. However, other research suggests that burnout is also an issue for doctors in other health systems and for other professions in the UK. The discussion here is intended to provide a high level picture of the survey findings, rather than a detailed trend analysis. Furthermore, our analysis identifies correlations between burnout and other aspects of trainee and trainers' experiences.

* A demographic breakdown of respondents to burnout questions is provided in the appendix.

Many doctors in training and trainers feel burnt out, emotionally exhausted and frustrated by their work.

Burnout was reported by doctors working in all specialties, across both the trainee and trainer populations. Overall, around a quarter of doctors in training and one in five trainers told us they feel burnt out to a high or very high degree.

		Doctors in training	Trainers (exc. GPs)	GP trainers
Is your work emotionally exhausting?	High/very high degree	39%	42.3%	52%
	Low/very low degree	17.5%	15.9%	10%
Do you feel burnt out because of your work?	High/very high degree	23.9%	21%	17.7%
	Low/very low degree	37.1%	38.1%	39.9%
Does your work frustrate you?	High/very high degree	25.3%	28.6%	27.4%
	Low/very low degree	36.5%	31.2%	29.2%
Do you feel worn out at the end of the working day?	Always/often	56.7%	49.8%	67%
	Seldom/never	9.6%	11.9%	5.5%
Are you exhausted in the morning at the thought of another day at work?	Always/often	31.6%	19%	23.1%
	Seldom/never	32.8%	47.8%	40.4%
Do you feel that every working hour is tiring for you?	Always/often	12.6%	9.9%	17.9%
	Seldom/never	59.7%	63.8%	49.9%
Do you have enough energy for family and friends during leisure time?	Seldom/never	16.9%	13%	9.6%
	Always/often	47.3%	52%	58.7%

Case study: Anaesthetists in Training working group on fatigue

The Association of Anaesthetists established a working group to help anaesthetics trainees with safe sleeping patterns. Here, Dr Emma Plunkett, consultant anaesthetist and chair of the working group, talks more about new initiatives to fight fatigue and why it's important to monitor the impact of tiredness in the national training surveys:

'Following the death of an anaesthetist in an accident driving home after a night shift, we investigated the impact of fatigue and shift work on trainee anaesthetists. An initial survey of Welsh trainees expanded across the UK with the help of the Association of Anaesthetists and Royal College of Anaesthetists (RCoA). *Our findings* highlighted a serious problem with fatigue among our UK trainees.

To address the issues raised, we established a fatigue working group with the Association of Anaesthetists, RCoA, Faculty of Intensive Care Medicine and experts in the field. The group developed standards for rest facilities and culture. *We produced educational resources* with factsheets about fatigue, sleep, how to manage shift working, and handover tools to promote consideration of the fatigue levels of staff. These are designed to be displayed in shared areas such as changing rooms or included in induction packs. Other resources include an induction slide set and video, as well as relaxation audio.

In March 2018, the working group invited organisations to back our *#fightfatigue campaign*. Anecdotally, we are aware that some organisations responded by finding rest facilities and adopting the handover tools. For others, change has been slower. Respondents to our initial trainee survey described feeling it wasn't appropriate to ask for a break during a night shift, and many described negative attitudes from management if they were 'caught sleeping'. We recognise that changing cultures like these will take time.

Case study: Anaesthetists in Training working group on fatigue

This year, all anaesthetics trainees were asked four new questions about fatigue and shift work as part of the speciality-specific questions in the national training survey. Three quarters of those who had received teaching on fatigue or sleep found it useful, but this opportunity was only available for about one third of trainees. One in three trainees felt too tired to get home safely monthly or more frequently. And over one third reported that work-related fatigue had some impact or a significant impact on their progress through training. The inclusion of questions about fatigue in the national training survey is crucial, and we hope we can encourage continued improvement in all these areas.

Night-workers should expect access to and the opportunity to use rest facilities. Some places do this well. We seek to encourage good practice and publicise successes to demonstrate that fatigue management has a positive effect on patient care and may also improve recruitment, retention, sickness rates and morale.'

Dr Laura McClelland, anaesthetist in specialist training involved in the project:

'Undertaking work within this area has been both challenging and rewarding. Knowing that our endeavours will secure a safer future for both doctors and patients is what keeps us pushing forwards.

We are witnessing a very welcome and exciting change within the culture of the workforce. Fatigue is being openly discussed and collectively, doctors and employers are making steps to prevent and manage it. The landscape has already changed drastically and we are confident that the future will be better still.

As a member of the fatigue group, I've experienced first-hand the challenges that have been navigated in order to produce real and sustainable change within this area. It is with great pride and gratitude to the efforts of so many that I am witnessing the evolution of a progressive fatigue culture improved safety for all.'

Quotes from the working group's survey on fatigue in trainee anaesthetists:

> I am absolutely certain that fatigue negatively affects my ability to revise for exams, my memory and recall and most of all my mood and general happiness.

> It makes such a difference to close my eyes in a quiet room for 20-30 minutes (even if I am unable to sleep) – either during the shift if workload allows, or in the morning before travelling home.

> Knowing there is an on call room makes a HUGE difference to how I feel approaching night shifts (much less dread). Even if I only lie down for a brief period, I feel much more refreshed and able to work later in the shift.

Dr Nancy Redfern, Vice President of the Association of Anaesthetists:

'The Association of Anaesthetists is working hard to raise awareness of the impacts of staff fatigue on the quality and safety of patient care and on our own wellbeing. Through our *#fightfatigue campaign*, we are providing practical resources to help to develop a culture in which the dangers of tiredness are recognised and managed. Our aim is to see good sleep hygiene during and after shifts become the norm and the provision of facilities for all NHS night shift workers to take power naps.'

Response from Royal College of Anaesthetists:

'The Royal College of Anaesthetists remains committed to the safety, health and wellbeing of anaesthetists in training. We will continue to encourage, support and highlight examples of good practice in the field of fatigue support, education and safety. Looking to the future, we will continue to work with other organisations to tackle the long term issues of fatigue on the workforce.'

Burnout is associated with intensity of workload and having a supportive working environment.

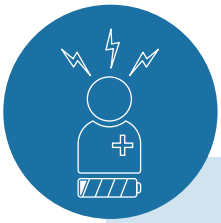
Research published this year in the *Journal of Internal Medicine* contended that, based on a review of several different studies, the five primary drivers for burnout in doctors are excessive workloads, inefficient work processes and environments, a poor 'work-home balance', a loss of control and autonomy at work, and a lack of support from colleagues. As part of our analysis, we investigated how our burnout data correlates with national training survey indicators.

In our survey of doctors in training, the strongest correlation is indeed between burnout and workload; twice as many trainees who described the intensity of their workload as heavy feel burnt out to a high degree, when compared to those who described their workload as about right. And twice as many trainees who described the intensity of their workload as about right or light feel burnt out to a low degree, when compared to those who described their workload as heavy. However, we also found correlations with the indicators for rota gaps, supportive environment and overall satisfaction with training.

Analysis of the trainer survey indicators tells a similar story. Workload, supportive environment, overall satisfaction with their role, time to train and support for training all correlated with burnout. These correlations suggest that employers and training providers can reduce the impact of burnout by protecting time to train; by ensuring rota gaps do not interfere with training; and by creating a supportive environment.

Conversely, a greater proportion of trainers and trainees who told us they experience burnout and its affects to a low degree, also told us their working environment was supportive, that they had enough time to train, and that rota design supported training.

* These analyses have all been tested for statistical rigour; all correlations listed have at least a *Pearson correlation coefficient* of 0.3. Where we have described a correlation as 'strong', it has a coefficient in excess of 0.5. Burnout (trainees), with: workload = 0.52; rota gaps = 0.43; supportive environment = 0.41; overall satisfaction = 0.39. Burnout (trainers) with: workload = 0.46; supportive environment = 0.37; overall satisfaction = 0.35; time to train = 0.35; support for trainers = 0.31.



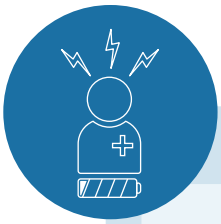
Burnout is associated with high workloads and unsupportive working environments

Doctors in training

Of those who…	**Twice as many** felt….	When compared to….
Disagree that their working environment is fully supportive	Exhausted at the thought of another day at work	Those who agree that their working environment is fully supportive
Disagree that their working environment fully supports the confidence-building of doctors	Burnt out because of their work	Those who agree that their working environment supports the confidence building of doctors
Disagree that the rota design helps optimise trainee doctors' education and development	Burnt out because of their work Exhausted at the thought of another day at work	Those who agree that rota design does optimise education and development
Rate the quality of their clinical supervision as poor	Burnt out because of their work	Those who rate the quality of supervision as good

Trainers

Of those who…	**Three times as many** felt….	When compared to….
Disagree that the working environment in their trust/ board is fully supportive	Every working hour is tiring Exhausted in the morning at the thought of another day at work	Those who agree that their working environment in their trust/board is fully supportive
Disagree that their working environment fully supports the confidence-building of doctors	Every working hour is tiring	Those who agree that their working environment supports the confidence building of doctors



Burnout is associated with high workloads and unsupportive working environments

Trainers

Of those who…	**Twice as many** felt….	When compared to….
Disagree that staff are always treated fairly by their trust/ board	Exhausted at the thought of another day at work Feel burnt out because of their work	Those who agree that staff are always treated fairly
Disagree that staff are always treated fairly by their trust/ board	Exhausted at the thought of another day at work Feel burnt out because of their work	Those who agree that staff always treat each other with respect
Disagree that they are always able to use the time allocated to them in their role	Feel burnt out because of their work	Those who agree that they are always able to use the time allocated to them
Rate the support they receive from their trust/board as poor	Feel burnt out because of their work	Those who rated the support they receive as good

Burnout corresponds with doctors feeling unsatisfied with their overall training experience.

91.5% of doctors in training who feel burnt out to a very low degree rate their quality of experience in post as excellent or good, compared to just 58.8% of doctors who feel burnt out to a very high degree. And 37.2% of doctors in training who rate their quality of experience in post as very poor feel burnt out to a very high degree, compared to just 3.8% of doctors who rate their experience as excellent.

Case study: Birmingham Women's and Children's NHS Foundation Trust - staff support

As part of their focus on the health and wellbeing of their employees, the trust has introduced a number of initiatives to support their staff, including trainers and doctors in training. Our research suggests that where there is a supportive working environment, trainers and trainees are less likely to feel burnt out.

In recent years, the national staff and training surveys indicated that employees at the trust felt increasingly under pressure at work, and that instances of stress were becoming more common. After some initial engagement sessions with staff, the trust identified some simple interventions they could make to better support their employees.

The trust introduced an employee assistance programme, run by an external organisation, providing around the clock access to a trained counsellor for triage. At a cost of around £40,000 per year, the trust thinks this service provides good value for money for a trust of their size. This includes six sessions of counselling for every employee who requires it. The trust has 5,500 members of staff, and anyone, and their families, can use the service. Around 10% of employees do so each year.

Most importantly, the trust believes strongly in constantly listening to staff and has undertaken many different listening sessions and events. The trust ran a workshop for around 25 doctors in training involved in their Hospital at Night rota, as they noticed increased sickness levels. Trainees fed back on what went well and areas that weren't working, and developed a list of improvements. These included: feeding back to consultants about handover; improving the labs system to allow for add on tests (which save time); and redeveloping and re-communicating the bleep policy and 'bleep etiquette'.

Recently one of the doctors in training said that she had seen a marked difference in communication between the consultants and trainees; it had improved morale and enabled better conversations. They have also experienced smoother working, less wasted time, and better handover.

> The trust has been delighted with the impact of these initiatives, but acknowledges that there is still progress to be made, especially around consultants accepting that 'it's OK not to be OK' and to ask for help. However, they believe that the resilience and wellbeing of doctors in training in particular has improved. The next steps are to continue to develop the offer for staff, with a focus on empowering employees to take personal responsibility for their own health and wellbeing.

Our standards require learners to have access to resources to support their health and wellbeing, and to educational and pastoral support [R3.2]. Our survey analysis on burnout demonstrates the importance of providing this support, and Birmingham Women and Children's Trust's story highlights the positive effect it can have.

The national training survey shows that trainees and trainers in emergency medicine are most susceptible to burnout.

When comparing responses across different specialty groups, a larger proportion of doctors working in emergency medicine settings reported high rates of burnout – 58.9% of trainees and 65% of trainers in that specialty told us they find their work emotionally exhausting to a high or very high degree [Figures 11a and b].

A larger proportion of doctors at the end of their foundation training years reported feeling burnt out. As a general rule, burnout becomes less prevalent with each step in the training pathway.

The trainee survey results broadly show that a larger proportion of doctors experience burnout at the end of foundation years. This proportion then gradually decreases through core to higher specialist training [Figure 12].

Although a smaller proportion of doctors in training feel frustrated by work as their training progresses, there is a notable difference (around 5%) between trainees in foundation training and those in core/specialist training, perhaps reflecting the move from generalist to specialist medical education and practice. Likewise, a larger proportion of doctors in foundation and core training find their work emotionally exhausting. A smaller proportion of doctors (around 5-8% lower, compared to foundation and core) at the beginning of specialist training feel this way – although the prevalence of emotional exhaustion gradually increases again as specialist training progresses (but not to the same levels we see in foundation or core).

There could be a number of reasons for these patterns. As doctors continue along the training pathway, becoming more confident in their clinical ability and more familiar with their working environment, this may make them less susceptible to burnout. And we know there is an association between burnout and intensity of workload; a higher proportion of doctors in foundation training reported heavy workloads than those in core or specialist training.

Figure 11a Trainees: Do you feel burnt out because of your work?

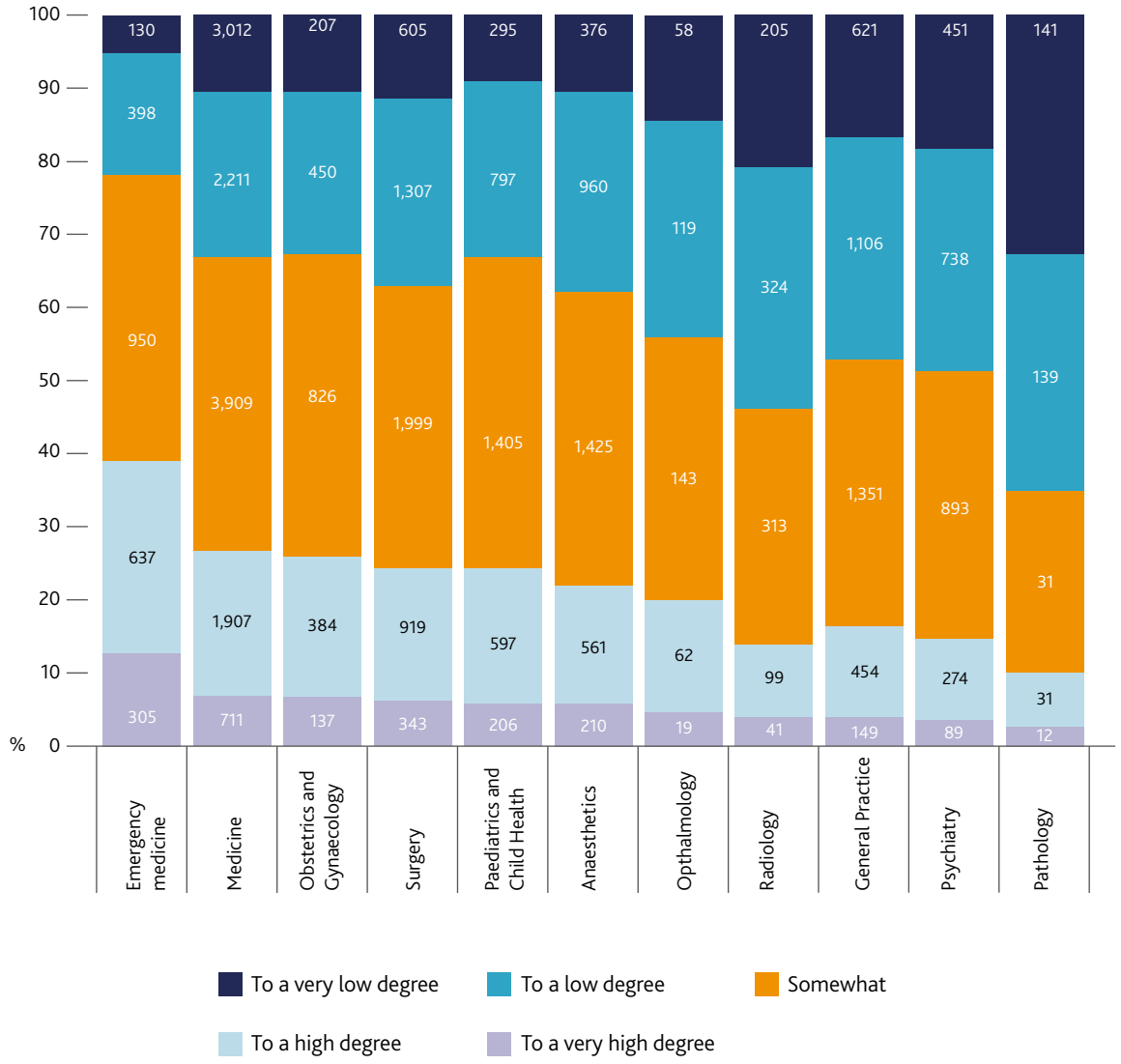


Figure 11b Trainers: Do you feel burnt out because of your work?

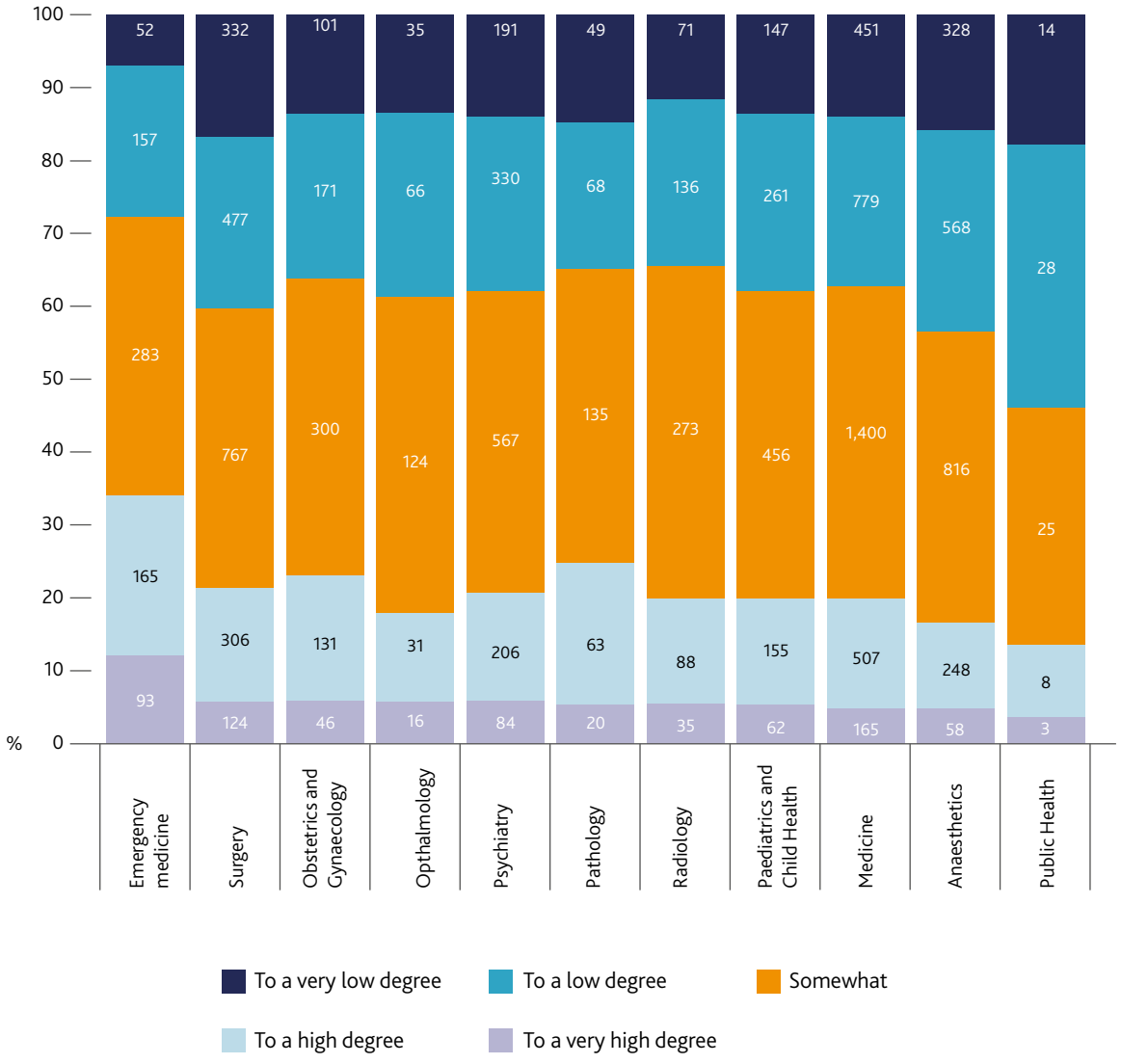
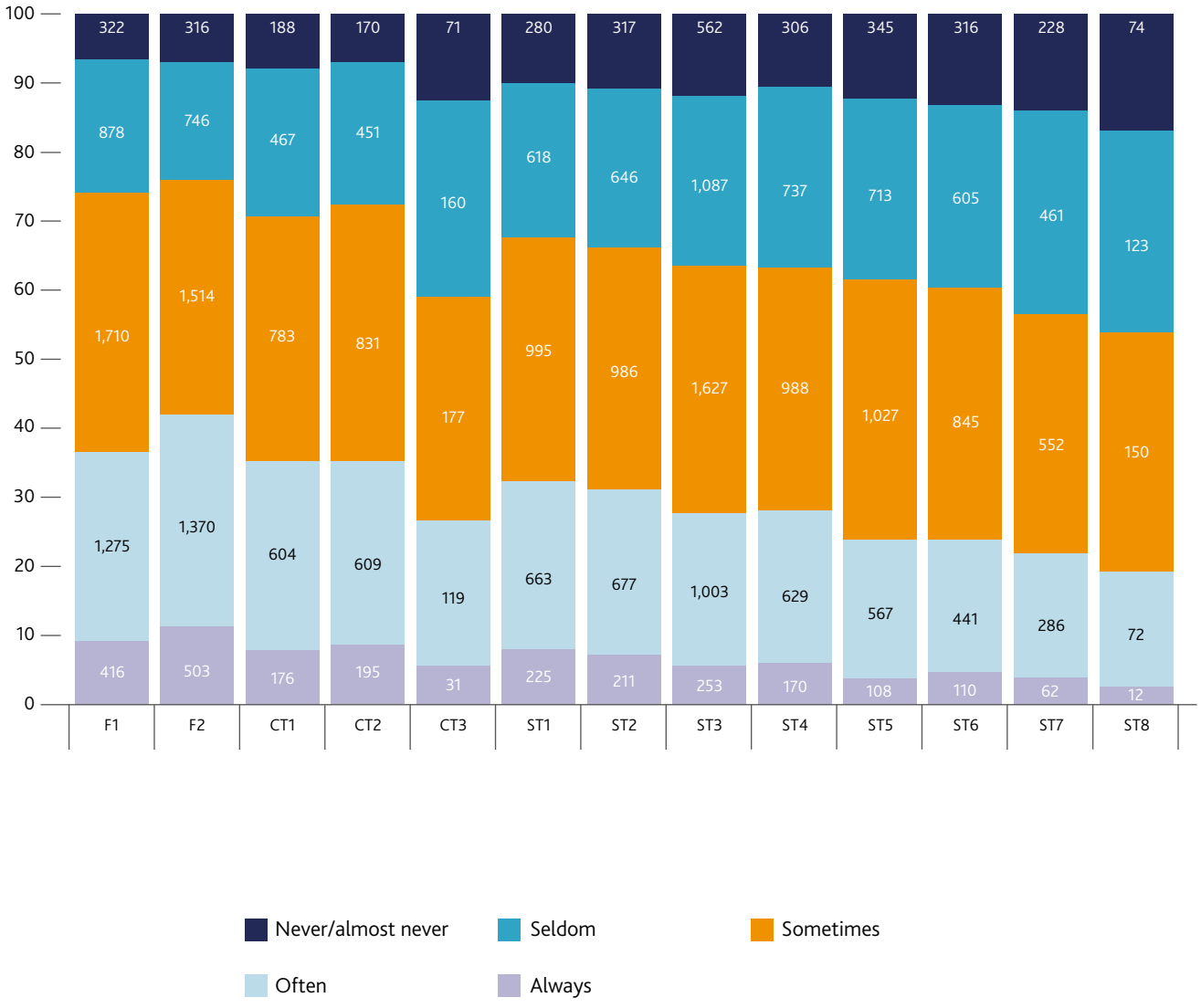


Figure 12 Trainees: Are you exhausted in the morning at the thought of another day at work?



Conclusion

What doctors in training and trainers told us in this year's survey will inform our forthcoming research on workplace culture and wellbeing, such as the *independently-led UK-wide review* of this issue (see 7: Taking action) we commisioned. Over the summer, we've been working with our survey advisory group – which includes education providers and trainees – to check the reliability of the burnout questions.
We're confident that they're providing us with valid results, and will be including them in next year's survey. We are also currently assessing the viability of making burnout data for individual organisations publicly available in the reporting tool in 2019.

5: Reporting and acting on concerns

5: Reporting and acting on concerns

Chapter summary

- The results of the 2018 national training surveys suggest that doctors in training and trainers are confident in the processes for reporting concerns about education and patient safety.
- However, this contrasts with feedback we're hearing from other sources.

This year's national training surveys present a positive overall picture of the processes for reporting patient safety and educational concerns. The majority of doctors in training and trainers told us that there is a culture of proactively reporting concerns. Most doctors also reported feeling confident that their concerns are addressed and lessons are learnt.

But these results contrast with what we're hearing in other research and from our frontline teams. *Recent research from the BMA* found that not even half (48%) of doctors in their survey always felt confident in raising concerns. Our liaison advisors across the UK work closely with doctors, health bodies and deaneries on the ground to help break down some of the cultural or procedural barriers to speaking up. As the case study in this chapter explains, data from our liaison service shows that many doctors in training and trainers think there are challenges with reporting and acting upon concerns.

It is vital that when any healthcare professional has a concern about patient safety or the provision and standard of education (or patient care), they feel able to speak up, knowing they will be heard and that appropriate action will be taken. Raising, listening to and acting on concerns can identify and prevent issues from arising, or make sure that lessons are learnt so that training and clinical environments improve.

Developing a culture where healthcare professionals who speak up feel supported and valued is especially important. Trainers are responsible for the education and supervision of the next generation of doctors, and so can play a key role in promoting this culture at an early stage in trainees' careers. Doctors in training also have a big role to play in evolving a positive culture around raising concerns.

Employers must demonstrate that they will provide a safe and supportive environment for those who speak up. They must also demonstrate that they have taken appropriate steps to respond to and learn from concerns that have been raised. *Promoting excellence*, our standards and requirements for medical education and training, states:

> 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.
>
> R1.2 Organisations must investigate and take appropriate action locally to make sure concerns are properly dealt with. Concerns affecting the safety of patients or learners must be addressed immediately and effectively.
>
> R2.7 Organisations must have a system for raising concerns about education and training within the organisation. They must investigate and respond when such concerns are raised, and this must involve to the individuals who raised the concerns.

Patient safety concerns

Workplace culture is a key factor in encouraging doctors to speak up and making sure organisations act on concerns. And this year, four in five [81.2%] doctors in training told us there is a culture of proactively reporting concerns in their post. However, this perception varies according to training specialty. A higher proportion of trainees in GP, obstetrics and gynaecology, and paediatrics posts experience this culture, especially when compared to trainees in surgery, medicine and occupational medicine posts. [Figure 13]

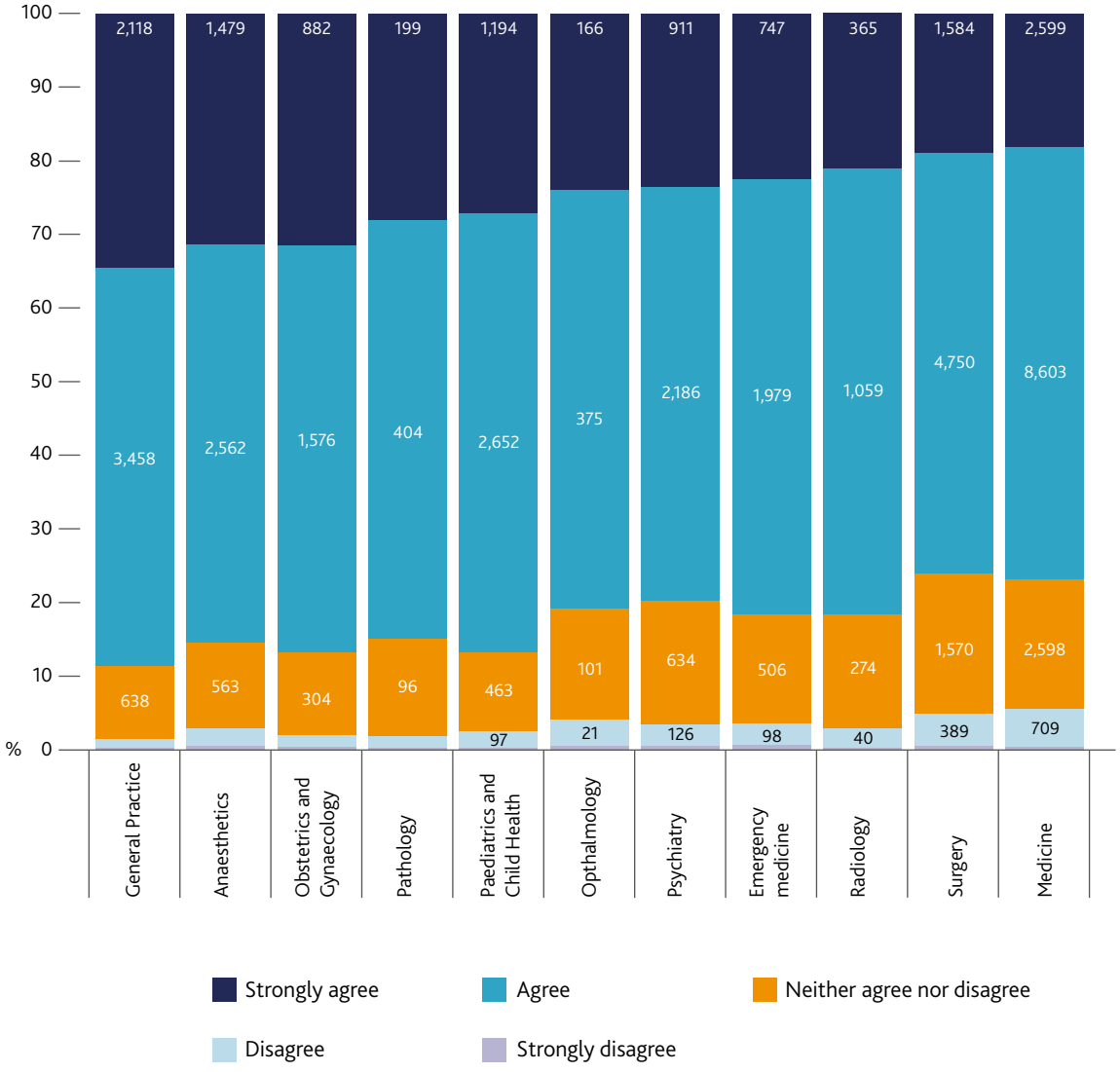
What happens after a concern has been raised is critical, not just in terms of addressing the issue itself, but in demonstrating to doctors that they have done the right thing – and so promoting a culture of speaking up. Two thirds [67.3%] of doctors in training are confident that patient safety concerns are effectively dealt with in their post. But there are striking differences between specialties. Four in five [83.7%] trainees in GP posts agreed with the same statement. By comparison, just 63.8% of trainees in psychiatry posts and 62.2% of trainees in surgery posts said the same.

Three in every five [61%] doctors in training agree that when concerns are raised the subsequent actions are fed back appropriately. Almost four in five [79.2%] trainees in GP posts agree with this compared to only around half [55.8%] of those in surgery posts.

On the whole, doctors in training reported that they are confident that speaking up about concerns leads to lessons being learnt. Four in five [82.7%] doctors in training agreed with that sentiment. Again, trainees in GP posts were particularly positive; 94.1% reported a culture of lessons being learnt.

In total, 805 doctors in training used this year's national training survey to report a local patient safety issue. This is an increase from 747 in 2017. The majority of patient safety concerns were related to a lack of staffing or resources [31.1%], problems with patient management [20.7%] and problems with the work expected of the trainee [15.4%]. We make sure that all concerns reported in the national training survey are investigated by the relevant deanery or local Health Education England office, and we must be satisfied with the outcome of that investigation.

Figure 13 Trainees:
In my post, there is a culture of proactively reporting concerns.



Focus on: Raising concerns and our liaison service

As part of their workshop sessions on promoting professionalism, our liaison service runs workshops to help doctors feel confident speaking up. Between January 2017 and September 2018, the liaison service delivered 515 workshops, attended by almost 11,000 doctors across England, Northern Ireland, Scotland and Wales.

Doctors who attend our workshops are clear that they wouldn't hesitate to raise a concern when immediate patient safety is at stake. But they face a number of barriers which can make this difficult.

In workshops across the UK, the main challenges relate to understanding the reporting routes and complications with the systems for raising a concern. In England, doctors were sometimes not aware of the existence of, or contact information for their Freedom to Speak Up Guardian. And, due to trainees and locum doctors moving around different locations, many in these groups reported that they found it hard to familiarise themselves with each hospital or practice's procedures. To tackle this, our workshops try to introduce doctors to support available at their workplace, by making connections to the freedom to speak up guardians and other local systems in the four countries. Doctors also mentioned that the 'feeling that nothing will change' or that they will receive no response discourages them further in finding out the routes at a new location.

Doctors also spoke about the fear of blame if they raised a concern about a colleague or organisation. Their feedback often referred to doctors worrying that they will be perceived as 'trouble-makers' and the impact that raising concerns can have on their professional relationships and career. And some fear that if they raised a concern about the pressures of resources and workload they would be labelled 'weak' or their own efficiency would be questioned.

Doctors in training in particular felt that they might leave a negative impression on senior staff if they raised a concern with them. These discussions were often related to issues around organisational culture and its impact on confidence to speak up.

Quotes from liaison service sessions in Northern Ireland:

> "I now feel able to speak up when witnessing any practices that can be deemed as not being up to GMC guidance standards."

> "[This session] reinforced how important it is to raise concerns when patient safety is being compromised."

We encourage doctors to use the national training surveys to highlight any issues around speaking up they may have. We take great care to make sure that the information we receive in the survey is confidential, and we will emphasise and explain the steps we take to do this in next years' survey.

Educational concerns

When asked about speaking up regarding the provision and standard of education and training, trainees and trainers had a similarly positive response. 93.9% of doctors in training told us that they know who to approach in confidence if they have any educational or personal concerns in their post. And the majority [90.3%] of doctors in training knew how to raise a concern about education and training, with two in three [66.7%] confident that it would be addressed. However, one in ten doctors in training [10.5%] told us they were not always confident that this would happen.

Almost four in five [78.9%] trainees in GP posts were confident that a reported concern would be addressed. Three in five trainees in occupational medicine [61.2%], obstetrics and gynaecology [61.1%], and medicine [60.3%] agree with that statement. Doctors in training become gradually more confident as they progress through the training pathway that a concern would be addressed. [Figure 14]. And around four in five (78.2%) doctors in training are confident that they would know how to escalate an education concern that wasn't being addressed.

Trainers were positive about the systems in place for reporting educational concerns. Almost four in five [78.5%] trainers (excluding GPs) agree that there is a culture of proactively reporting concerns about education within their department or practice. Nine in ten [90.1%] GP trainers told us the same.

And around two thirds [62.7%] of trainers (excluding GPs) told us that there is a culture of proactively reporting concerns about education within their trust/board [Figure 15a]. However, almost one in ten [9.5%] trainers disagrees with that statement. Almost four out five [79%] GP trainers agree that there is a culture of proactively reporting concerns about education in their deanery/local Health Education England office [Figure 15b].

The majority of trainers were also confident that their trust, board, deanery or local Health Education England office would act effectively if concerns about education were raised, and that they would make effective changes to improve the provision of education. Collaboration is an important part of this process; over half [52.9%] of trainers excluding GPs, and around two thirds [65.2%] of GP trainers, think that their deanery/local Health Education England office works well with their trust/board/secondary care placement providers to strike the right balance between trainees' educational needs and service commitments.

Figure 14 Trainees: If I were to raise a concern about my education and training, I'm confident it would be addressed.

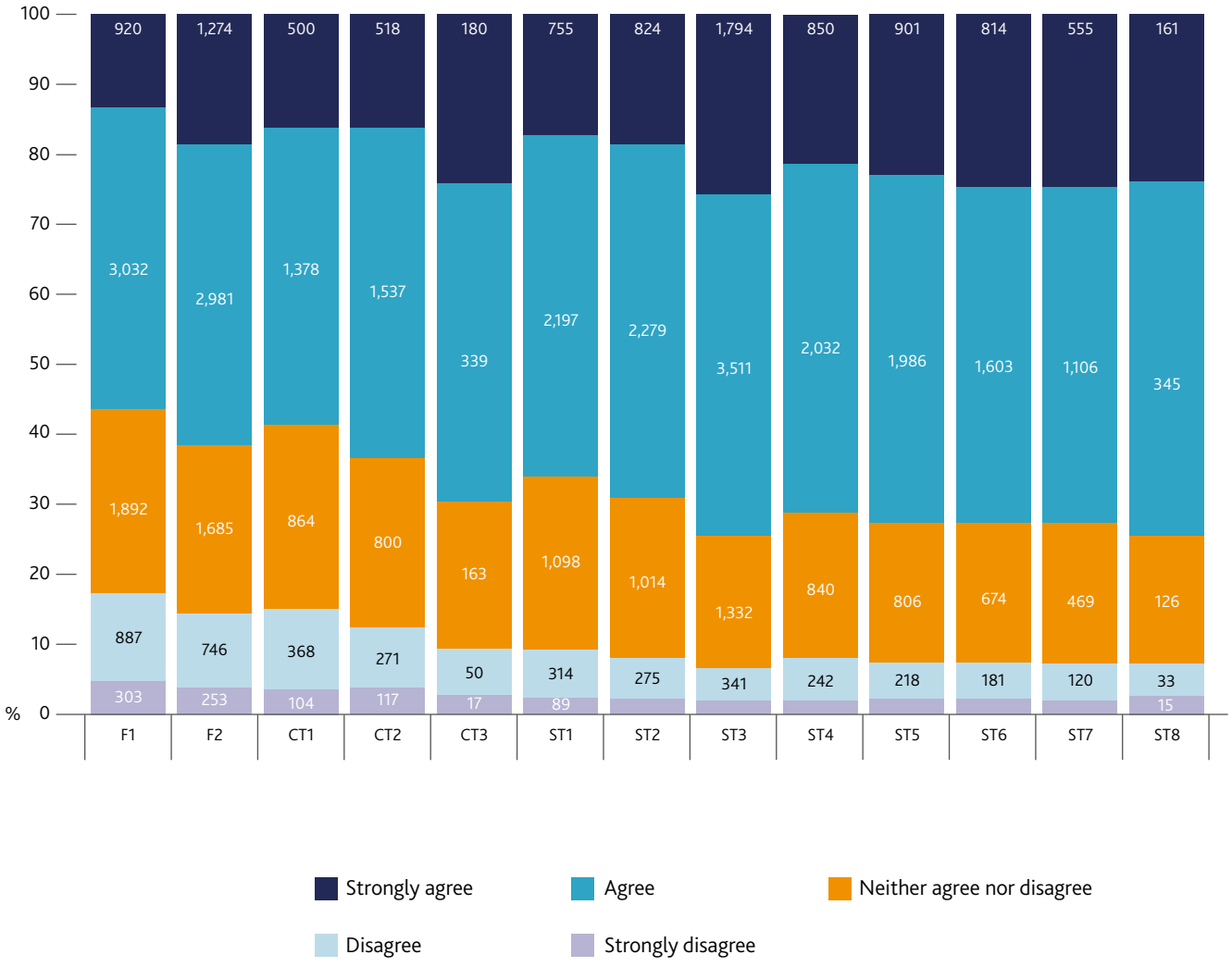


Figure 15a Trainees:
In my post, there is a culture of proactively reporting concerns.

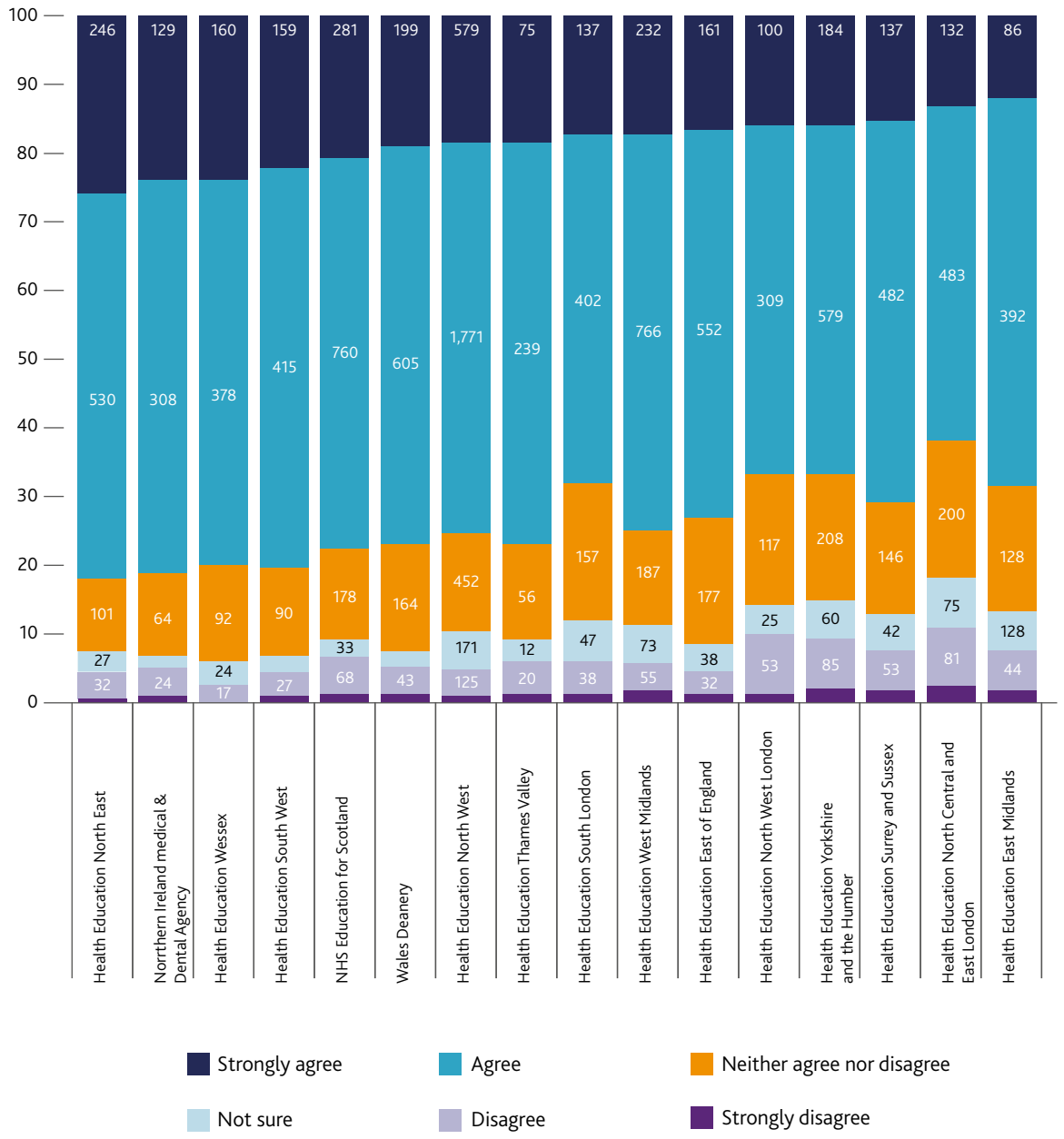
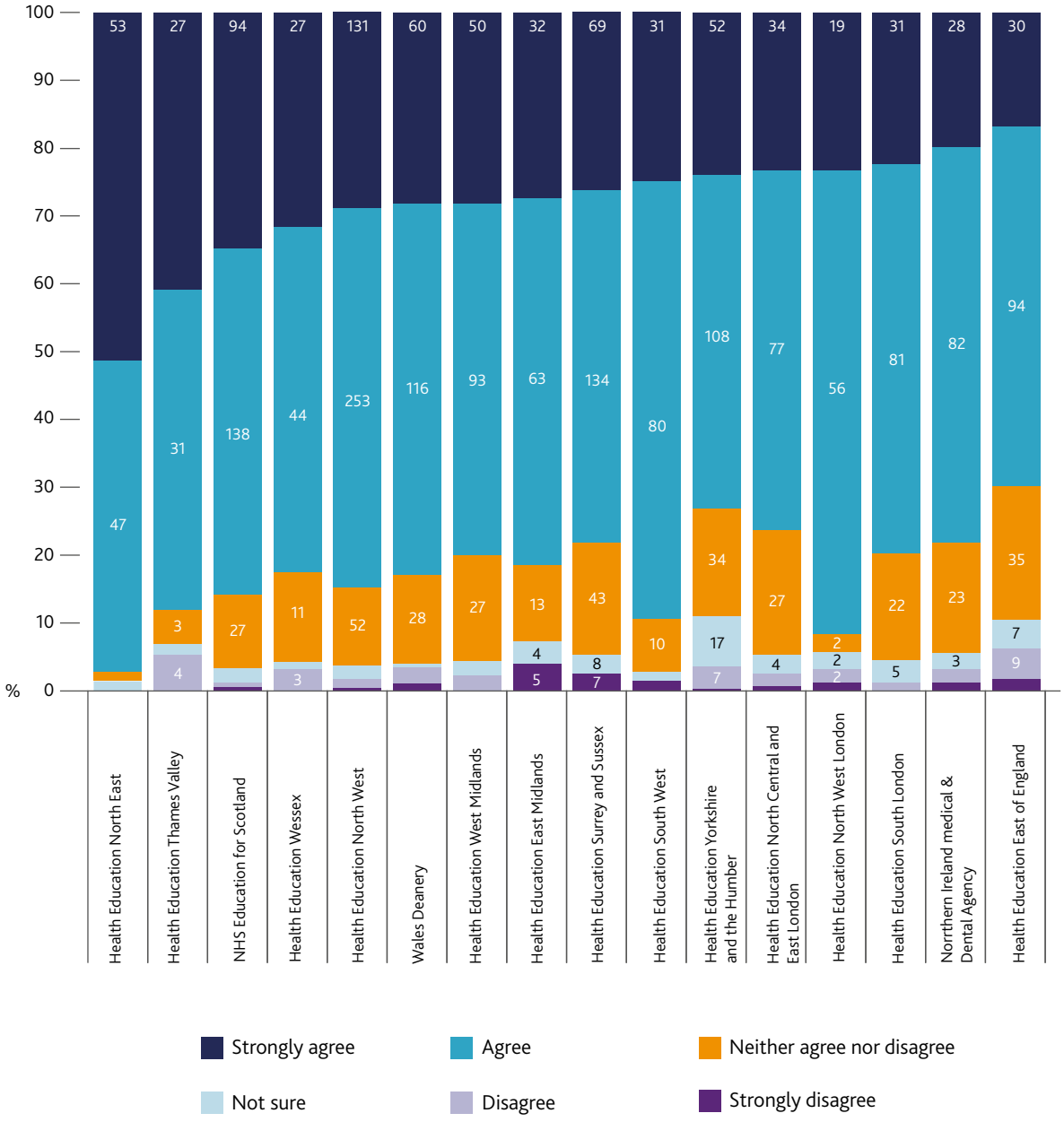


Figure 15b Trainees: In my post, there is a culture of proactively reporting concerns.



Bullying and harassment

In October 2018, the *BMA published a report* that found two in five doctors say bullying and harassment is a problem in their workplace, with one in five personally experiencing it in the past year. *Our standards* require that learners must not be subjected to, or subject others to, behaviour that undermines their professional confidence, performance or self-esteem [R3.3].

This year, one in twenty [5.8%, n=2,972] doctors in training told us that they had been the victim of, or had witnessed, bullying or harassment in their current post. However, most of these doctors [5.4% of total, n=2,784] didn't want to provide specific details in the survey. Their reasons for this were (%):

I don't think reporting will make a difference	24.4
Fear of adverse consequences	21.5
I have raised it, or intend to raise the issue locally instead	16.9
The issue has already been resolved locally	16.8
I don't think the issue is serious enough to report	15.6
Other	4.6

A small number of doctors [188] did choose to report a specific instance of bullying or harassment. They told us (%):

Who has been doing the undermining/ bullying described in your concern?

Consultant/GP (within my post)	24.3
Nurse/Midwife	21.5
Other doctor	24.3
Management	21.5
Other	16.9
Consultant/GP (outside my post)	16.8
Other trainee	15.6
Patient/relative	4.6

Which behaviour types describe your concern?

Belittling or humiliation	39.8
Threatening or insulting behaviour	23.2
Other	16.3
Bullying rlated to a protected characteristic	10.2
Deliberately preventing access to training	10.2

We take all instances of reported bullying and harassment extremely seriously. Just as with patient safety and educational concerns, it is important that doctors in training feel confident that they can speak up, that their voice will be heard, and that appropriate action will be taken. In 2018, we joined with the *National Guardian for the NHS in England* and other healthcare organisations across the UK to establish a collaborative alliance to address high levels of undermining and bullying behaviour throughout the NHS. The alliance will coordinate activity, share best practice and develop resources to tackle undermining and bullying, while also scrutinising the complex cultural, behavioural and systematic issues underpinning it.

Conclusion

We have two contrasting perspectives on this subject – a broadly positive message from the national training surveys, and a more challenging message from our work on the ground with doctors. We need to undertake more research to understand what these differences mean - and what we can do to take further action in this area.

And even though only a minority of trainers and trainees did not always feel confident about speaking up and acting on concerns, this minority group still constitutes a large number of doctors.

In the meantime, through our *liaison services* across the UK, we continue to take steps to support doctors to speak up. We also promote other initiatives in the profession to help reduce cultural and procedural barriers to raising concerns, such as the national freedom to speak up guardians in England. In Scotland we are working with the Scottish Public Services Ombudsman on the implementation of the new Independent National Whistleblowing Officer for NHS Scotland.

6: Career intentions

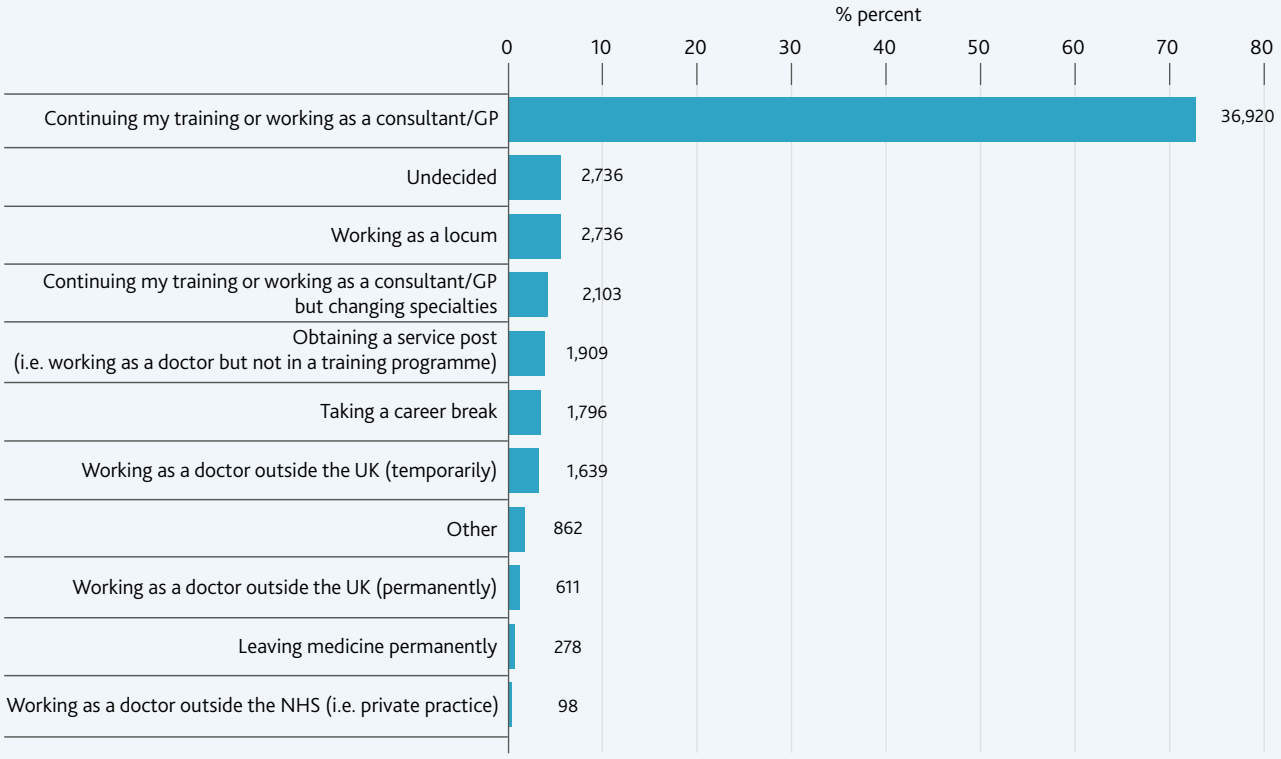
6: Career intentions

We asked doctors in training what they saw themselves doing one year on. 71.4% thought they would either be continuing with their training or working as a consultant/GP. Around 5% were undecided, and a similar proportion thought that they would be working as a locum.

3.5% of doctors in training foresee themselves taking a career break (spending time not working as a doctor in any capacity). A larger proportion of women than men are considering this [4.1% to 2.8%].

These results are similar to last year's survey, when 70.7% of trainees told us they would continue with training or working as a GP/consultant, and 5.9% were undecided. In 2017, a slightly larger proportion of doctors in training planned to take a career break [3.9%].

Which of the following best describes what you see yourself doing one year from now?



Comparing trainees who didn't feel burnt out with those who did, over 20% more doctors said they would continue training or working in their chosen specialty (79.2% to 56.7%).

Over one in ten (13.7%) doctors in foundation training levels told us they were considering leaving or taking a break from training.

Of these doctors, the majority were either planning to obtain a service post (work as a doctor but not in a training programme; 31.1%) or take a career break (before returning to practice medicine in the future; 26.3%). 5.2% thought they would leave medicine permanently.

Taking time out of training is common; around a third of the current training population have taken a break in the past five years and breaks immediately after completing the Foundation Programme are increasing, from 30% of the trainees who completed F2 in 2012, to 60% in 2017. And nearly 90% of doctors who complete the Foundation Programme go on to enter specialty or core training in the UK within the following three years. Of the doctors who completed the Foundation Programme in 2012, 7% did not return to UK training within five years.

Conclusion

Earlier this year, we published our second report on *Training pathways*. It explored the reasons, motivations and experiences of doctors taking a break in training. We also sought views on the benefits and outcomes of a training break, the factors affecting the return to training, and the perceived constraints of the current training pathway for trainees. We carried out this research to understand changing trends in career intentions, and how we can best support trainees, trainers and education providers to respond to these trends. It is also important to understand these trends in order to plan how the training pathway can best meet the future workforce needs of healthcare systems.

We recognise that doctors increasingly want greater choice in the way they develop their careers, greater flexibility in the way they train and a better work-life balance.

Our 2017 flexibility review, *Adapting for the future: a plan for improving the flexibility of UK postgraduate medical training*, examined the barriers – or snakes-and-ladders effect – trainees face when they switch specialties and have to start training from scratch. By 2020, we want trainees to have a much clearer view of, and confidence in, what it will mean for them if they switch specialties – for example, the flexibility to go into a new specialty at a higher level if they can demonstrate they have the relevant knowledge and skills. We're working with the Academy of Medical Royal Colleges (AoMRC) to develop a clearer process to support transfers.

We have asked the AoMRC to look at how shared curricula content across specialty programmes could better support transferability and trainee development. We believe that patients and the health service will benefit from doctors capable of working and caring for patients with medical conditions that extend beyond their immediate specialty or subspecialty boundaries.

7: Taking action

7: Taking action

Throughout this year's report, it's clear to see the strong link between supportive working cultures, positive training experiences and developing doctors' confidence. Our key findings underline many encouraging aspects of medical training, but also the challenges and complexities of our health services and the local environments in which training takes place.

Collectively, regulators and employers need to do more to promote and develop a supportive culture.

What we're doing

The issues reported by trainees and trainers in the 2018 surveys reinforce the strong feedback we've heard in our face-to-face engagement with the profession throughout this year. Doctors, of all grades and specialties, have highlighted deep concerns about the challenges they face in their working environments.

We think there is a clear need to address immediate system pressures and understaffing to give doctors and patients the support they deserve. That's why we have asked those responsible for allocating healthcare funding across the UK to look at the issues raised by the surveys, and make sure that suitable provision is made for education and training. And we've made a series of commitments to improve how we support doctors to provide the care that patients need. These include:

Improving medical students' and doctors' wellbeing

With our new burnout questions, we're substantially growing our UK-wide evidence base on the health and wellbeing of trainees and trainers. But we need to understand more about how this issue affects doctors across all career stages. This is something the *independent review* into medical students' and doctors' wellbeing, led by Professor Michael West and Dame Denise Coia, has set out to do. The findings will enable us to work with other organisations to agree priority areas to tackle underlying causes of poor wellbeing, and to enhance the support available to doctors.

A greater focus on human factors

Looking to the future, we believe there needs to be a greater focus on the essential human factors that underpin professional behaviour, promote safe and effective practice, wellbeing and foster a positive organisational culture. Human factors approaches aim to reduce error and influence behaviour through an understanding of the effects of teamwork, tasks, equipment, workspace, culture on human behaviour, and the application of that knowledge to clinical practice and clinical settings.

That's why we have prioritised human factors in the *Generic capabilities framework*. All colleges and faculty curricula must now show how human factors have been integrated into specialty training.

Understanding human factors is something that's important to our own processes too. All of our fitness to practice decision makers, case examiners and clinical experts will be trained on this, so they can fully evaluate the role of systems and workplaces when assessing incidents that have been reported to us.

Induction and support for doctors returning to work or starting a new role

Good quality inductions, mentoring schemes and access to other support mechanisms are important ways of making sure doctors can deliver safe and effective care to patients as soon as they start a new job. And this is set out clearly in our standards for medical education and training, as well as our guidance on leadership and management for all doctors.

We're working with healthcare providers to reinforce the importance of our standards, including the knock-on effects of poor inductions which are clear to see in this year's report.

Raising and acting on concerns

We want to help all doctors speak up about their concerns, whatever their circumstances. At the same time, doctors need to know that when they do, action will be taken to resolve them. We're collaborating with partners across the UK to make sure doctors and other healthcare professionals are supported to raise concerns.

In 2016, exception reporting was introduced in England – a process where doctors in training can flag up if their actual work has varied from their agreed work schedule. We're working with organisations such as NHS Improvement (NHSI), the Care Quality Commission (CQC) and the BMA to standardise exception reporting, so we can compare data on a national level, and to encourage doctors to exception report in a confident and efficient manner. And our work with other regulators in England as part of our Joint Strategic Oversight Group will create a shared set of practices for escalating concerns.

We are also extending our partnership with the National Freedom to Speak Up (F2SU) Guardian and the network of F2SU guardians across England. This includes on-the-ground support for guardians and sharing information on risks to the profession and patients across England.

In Scotland, we are working with the Scottish Public Services Ombudsman on the implementation of the new Independent National Whistleblowing Officer for NHS Scotland.

And our liaison service will continue to work closely with doctors and their employers across England, Scotland, Wales Deanery (now part of Health Education and Improvement Wales) and Northern Ireland to provide support to those who speak up.

What we expect of others

The survey findings confirm the view that trainers, training providers and trainees are working exceptionally hard to achieve high standards of medical training and patient care, despite intense workloads and feeling emotionally and physically burnt-out. However, we can't take continued levels of quality training for granted. It's vital that employers take action to address the warning signs highlighted in this year's report, particularly in three key areas:

- protecting time for training
- promoting quality handovers and inductions
- creating a supportive workplace culture

Our *Promoting excellence* standards set out our clear expectations on these important aspects of medical education and training, and this report highlights the risks if these standards aren't in place. We expect employers to use the data and tools that we provide in our *online reporting tool* to identify and tackle issues at an early stage.

Developing the survey

Once the national training surveys close, we always reflect on how we might develop them for the following year. We check that the questions are working effectively, including holding focus groups with doctors in training and trainers to check our questions remain relevant and useful. We also work with medical education providers and other organisations to identify where we might change or introduce questions to reflect developments in the training environment or our standards. In recent years, this has led to new questions on rota design and burnout.

As always, what trainees and trainers tell us in the surveys is vital to what we do. We use this information to make sure training environments meet our standards, to help produce the next generation of successful doctors.

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

In 2016, we introduced *Promoting excellence: standards for medical education and training*. This sets out ten standards that we expect organisations responsible for educating and training medical students and doctors in the UK to meet. These standards and requirements are organised around five themes:

- learning environment and culture
- educational governance and leadership
- supporting learners
- supporting educators
- developing and implementing curricula and assessments.

The national training surveys gather feedback from doctors about their training experience and environment. They measure how our standards are being delivered, to explore whether educational experiences are being provided in safe, effective and appropriately supportive training environments.

Where responses from training sites indicate concerns, we work in partnership with the relevant postgraduate dean to put procedures in place to resolve the problem. This year, we also wrote to employers across the UK to reinforce their obligation to protect time for training. We set out how we expect governance boards and senior leaders to scrutinise their survey data to identify improvements to the training posts and programmes they are responsible for.

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.

Doctors in training may use the survey to report a patient safety or bullying or undermining concern. When this happens, we share it with the relevant postgraduate dean at NHS Education for Scotland, Northern Ireland Medical and Dental Training Agency, Wales Deanery, or Health Education England (HEE) 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. You can read more about some of these initiatives in chapter seven.

Appendix

Appendix: Who answered the survey this year?

Trainees

	No. of eligible trainees invited to respond	Completions	Response rate
England	45,175	43,005	95.2%
Northern Ireland	1,664	1,662	99.9%
Scotland	5,220	5,082	97.4%
Wales	2,234	2,207	98.8%
UK	**54,293**	**51,956**	**95.7%**

	Number of completions	% of all completions
Male	23,093	44.4%
Female	28,863	55.6%

	Academic	Anaesthetics Posts	Emergency Medicine Posts	General Practice Posts	Medicine Posts	Obstetrics and Gynaecology Posts	Occupational Medicine Posts	Ophthalmology Posts	Paediatrics and Child Health Posts	Pathology Posts	Pharmaceutical medicine	Psychiatry Posts	Radiology Posts	Surgery Posts
no. of completions	188	4,728	3,345	6,368	14,599	2,828	67	656	4,412	711	86	3,875	1,745	8,348
% of completions	0.4%	9.1%	6.4%	12.3%	28.1%	5.4%	0.1%	1.3%	8.5%	1.4%	0.2%	7.5%	3.4%	16.1%

	F1	F2	CT1	CT2	CT3	ST1	ST2	ST3	ST4	ST5	ST6	ST7	ST8
no. of completions	7,066	7,067	3,242	3,270	754	4,471	4,485	7,140	4,073	4,027	3,373	2,306	682
% of completions	13.6%	13.6%	6.2%	6.3%	1.5%	8.6%	8.6%	13.7%	7.8%	7.8%	6.5%	4.4%	1.3%

Trainers

	No. of eligible trainers invited to respond	Completions	Response rate
England	38,525	15,613	40.5%
Northern Ireland	1,155	685	59.3%
Scotland	4,666	1,627	34.9%
Wales	2,052	1,268	61.8%
UK	**46,398**	**19,193**	**41.4%**

	Completions	% of all completions
Man	11,727	61.1%
Woman	7,466	38.9%

	Anaesthetics	Emergency Medicine	General Practice	Medicine	Obstetrics and Gynaecology	Occupational Medicine	Ophthalmology	Paediatrics and Child Health	Pathology	Psychiatry	Public Health	Radiology	Surgery
no. of completions	2,573	848	2,896	4,261	958	39	365	1,366	456	1,858	100	802	2,671
% of completions	13.4%	4.4%	15.1%	22.3%	5.0%	0.2%	1.9%	7.2%	2.4%	9.7%	0.5%	4.2%	13.9%

	F1	F2	CT1	CT2	CT3	ST1	ST2	ST3	ST4	ST5	ST6	ST7	ST8
no. of completions	7,066	7,067	3,242	3,270	754	4,471	4,485	7,140	4,073	4,027	3,373	2,306	682
% of completions	13.6%	13.6%	6.2%	6.3%	1.5%	8.6%	8.6%	13.7%	7.8%	7.8%	6.5%	4.4%	1.3%

Burnout: Trainees

	No. of trainees who answered burnout Q's	% of those who completed survey	% of those eligible to complete survey
England	28,123	65.4%	62.3%
Northern Ireland	1,072	64.5%	64.4%
Scotland	3,507	69.0%	67.2%
Wales	1,455	65.9%	65.1%
UK	**34,157**	**65.7%**	**62.9%**

Burnout: Trainers

	No. of trainers who answered burnout Q's	% of those who completed survey	% of those eligible to complete survey
England	12,030	77.1%	31.2%
Northern Ireland	549	80.1%	47.5%
Scotland	1,366	84.0%	29.3%
Wales	994	78.4%	48.4%
UK	**14,939**	**77.8%**	**32.2%**

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