Has the national survey of trainee doctors improved training in the UK?

Over the years many concerns have been raised about the context and content of postgraduate medical education and the preparation of junior doctors for their future roles as consultants or GPs. In response there have been many changes to training both at national and at local level. Since 2005 the Postgraduate Medical Education and Training Board (now the General Medical Council) has had the statutory role of quality assuring postgraduate medical education. Effective quality assurance and, crucially, quality improvement needs to be based on good evidence. One source of evidence is the General Medical Council's national survey of trainee doctors.

The survey is an annual 'snapshot' and in the last 2 years has achieved a response rate of over 80%. Based on London's point of view surveys developed over 10 years by Elisabeth Paice, it measures trainees' perceptions of compliance with the General Medical Council's (2010) generic standards for training. These include satisfaction, availability and quality of clinical supervision, workload, clinical experience, educational opportunities and whether key processes such as induction and feedback are in place. The focus is on individual posts and not programmes of training. It is not designed to reflect the adequacy of curricula or preparedness for work as consultants or GPs, as this is not its purpose – a different, post Certificate of Completion of Training survey would be needed for this.

Survey results

Since 2006 there have been four annual surveys and 147 697 responses. This large dataset provides consistent data on training experiences at all acute and mental health hospitals and primary care education providers and is internationally unique. Contacting the target population has not been a straightforward task and the improving response rate (87.5% in 2010) reflects a vast amount of coordinated work by the General Medical Council, deaneries and postgraduate centres. Each trainee spends about 18 minutes on his/her response to the survey. This time and energy investment by so many people requires justification. The question of whether and how the survey impacts on the quality of training is therefore an important one.

Survey results are publicly available from the Postgraduate Medical Education and Training Board's website (reports.pmetbtrainingsurveys.org/). It is possible, for example, to compare the ratings of trainees in one specialty (say trauma and orthopaedics) from one trust against all surgical trainees UK-wide. Statistical criteria are used to flag scores that, when compared to the UK-wide peer group, are clearly outliers in either direction (red for below and green for above). The benefit of the consistency of the survey tool is that while one or two negative outliers may occur by chance, multiple outliers over repeated years for the same specialty at the same trust should raise concern.

The reporting site is well used. The Postgraduate Medical Education and Training Board reported 28 027 absolute unique visitors at 31 July 2009 over the previous 2-month period. Deaneries expect consultants and education leads responsible for training in hospitals to review their local results and respond to the findings. All London trusts developed an action plan for improvement in all areas where poor performance was indicated by the 2010 survey results (General Medical Council, 2011).

Uses for the data

Survey headings are easily recognized and the format allows training units to compare themselves with their peers. The survey is seen as credible enough for teaching organizations to use it to drive improvement. Of the 12 884 trainers who completed the 2009 National Survey of Trainers two-thirds were aware of the survey; of these 48% were aware of the results for their department and 29% said that action had been taken in response to the findings (Bruce et al, 2009). Clearly, the survey is prompting action within trusts.

Deaneries use survey data to trigger and support quality improvement work including risk-based visiting. More recently data from the survey have been used to inform the decommissioning of training posts. For example, in London some specialty schools have used it to rank trusts' educational performance, and results of the survey have also been used to inform parts of the annual speciality school reports on the quality of training that are required by General Medical Council and the Royal colleges. Action plans submitted by the trusts to overcome the 'red triangles' have been followed up through hospital visits. So there is some expert opinion that the survey is being used to improve training in the UK but this is the lowest level of evidence.

The first three national summary reports present data on the reliability of the survey's indicators and their construct validity (Smith et al, 2007, 2008; Bruce et al, 2009). The survey findings have yet to be compared with a validated external criterion to give a measure of its predictive validity: there is a need to establish whether negative survey results link to real issues with training as captured via another method to triangulate and validate the survey's structure and findings. The first national summary report (Smith et al, 2007) shows, using multi-level modelling, that the survey does capture variation in trainees' clinical supervision and satisfaction with training by hospital and department (based on the post specialty of the trainee), but that it is not possible to reliably identify poor providers on the basis of the survey data alone.

Trusts' focus on clinical targets and metrics are credited with the improve-

ment in aspects of the quality of clinical care reported by the Care Quality Commission in 2010. Now, the same focus is needed on training. The survey is unlikely to be the only tool in a 'training account'. Medical Education England are developing other indicators as part of their education commissioning for quality – medical indicators work programme. Trusts have and will continue to challenge performance data; therefore it is imperative that more evidence of the survey's reliability and validity is in place to allow those concerned with postgraduate medical education to make greater use of it. Possible improvements to the survey might include the ability to compare the results over time. The ability for trainers to track changes in the survey results through reporting the actions that have been taken would provide the data to demonstrate improvement at level 2c and significantly add to the construct validity of the survey indicators.

The UK General Medical Council survey is a unique tool that allows comparison of training between units and across specialties and reflects change over time. Collaboration between the General Medical Council and the deaneries will continue to build on the survey as one of several measures of the quality of training.

Conclusions

Work is now needed on the impact of interventions which have been put in place as a response to the survey findings and on external validation of the criteria within the survey. A consistent, regular survey that is criterion referenced and used in conjunction with a range of effective interventions is likely to be a significant contributor to a culture of quality improvement in postgraduate medical training. BJHM

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KEY POINTS

- The national survey of trainee doctors can be a useful indicator of units that require additional support to improve educational standards although it should be used with caution.
- The survey alone should not be used to determine actions by deaneries on training units.
- External validation of the survey indicators needs to be undertaken.
- Small units and specialties may not receive a report which may lead to a lack of attention on their standards.
- Further work is needed on the impact of interventions put in place in response to survey findings.