Second Annual Report of the JCST trainee survey

INTRODUCTION

This report examines the findings of the two most recent, complete iterations of the survey, open during training years 2013/2014 and 2014/2015 and builds on the findings of the first annual survey report, which explored the findings of the first two iterations of the survey – 2011/2012 and 2012/2013. The first annual report can be found here.

The survey was developed in 2011 to measure the achievement of the Quality Indicators (QIs) which detail the JCST's standards for Core Surgical and Specialty Surgical training posts. The QIs are reviewed on an annual basis by the JCST QA Group in partnership with the Specialty Advisory Committees (SACs) and Core Surgical Training Committee (CSTC) to ensure that they remain relevant and fit for purpose. The first 9 QIs are generic and applicable to all surgical training posts at both specialty and Core level. The second section comprises QIs that are relevant to all posts in the given specialty (or Core), and the third section comprises QIs relevant to specialty trainees at certain levels of training (or certain specialty themed posts in Core training). The QIs are available on the JCST website here. Individual specialty standards for the QIs relating to operating sessions, outpatient clinics, hours of formal teaching and numbers of Workplace-Based Assessments (WBAs) to complete can be found in Appendix A.

Trainees are asked to complete one survey outcome per training placement via the ISCP. Access to survey reports is available via the ISCP to Heads of School of Surgery, Training Programme Directors, SAC Chairs and SAC Liaison Members, to help inform and support the quality assurance of surgical training.

THE 2013/2014 AND 2014/2015 SURVEYS

In October 2013, the JCST introduced a single set of generic survey questions for all trainees to complete. There were additional sections for academic and less than full time trainees, and some specialty specific questions for General Surgery specialty trainees.

In October 2014, four specialty specific questions for Otolaryngology trainees were added to the survey. One additional question relating to less than full time training was added to the generic survey questions. All other questions remained unchanged.

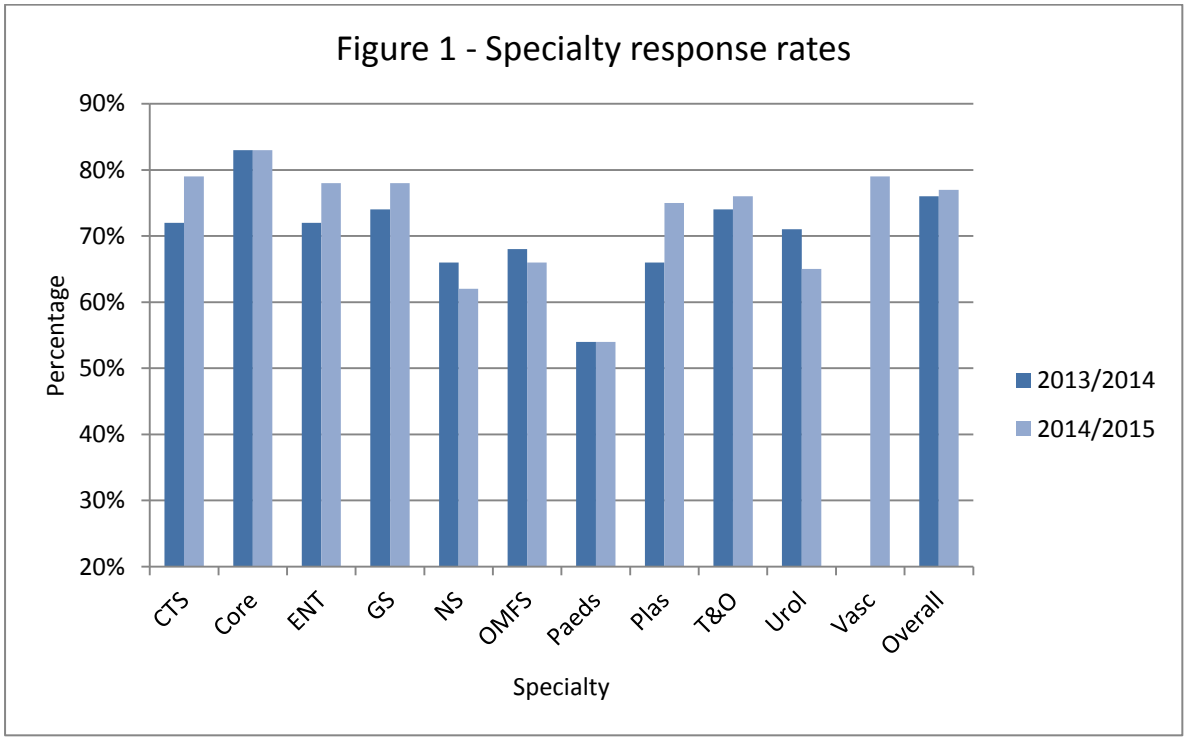
The full text of the questions used in the 2013/2014 and 2014/2015 surveys can be found in Appendix B.

It should be specifically noted that Vascular Surgery is a new specialty and, for the first time, responses from trainees identifying themselves as Vascular Surgery specialty registrars are being

reported. Responses should be considered with caution, as there is some concern that General Surgery trainees with a vascular interest may have responded to some of the questions in error.

RESPONSE RATES

Figure 1 provides a visual summary of the response rates for the two surveys by specialty. The overall response rates for the surveys were 76% in 2013/2014 and 77% in 2014/2015. The response rate for Vascular Surgery specialty trainee responders was not calculated for the 2013/2014 survey, due to the low number of trainees in post at the time.



COMPARATIVE SURVEY OUTCOME DATA

The survey outcome data presented below provides a comparative overview of the outcomes of the generic questions included in the 2013/2014 and 2014/2015 surveys. The focus is the achievement rate of key indicator QIs, with additional areas of good practice and concern also presented. The analysis is divided into four themed sections – Patient Safety, Working Conditions, Training Opportunities and Quality of Experience.

The generic survey questions also contain a section on simulation training opportunities. The outcomes of these questions are communicated directly to the JCST Simulation Group.

PATIENT SAFETY

Good practice

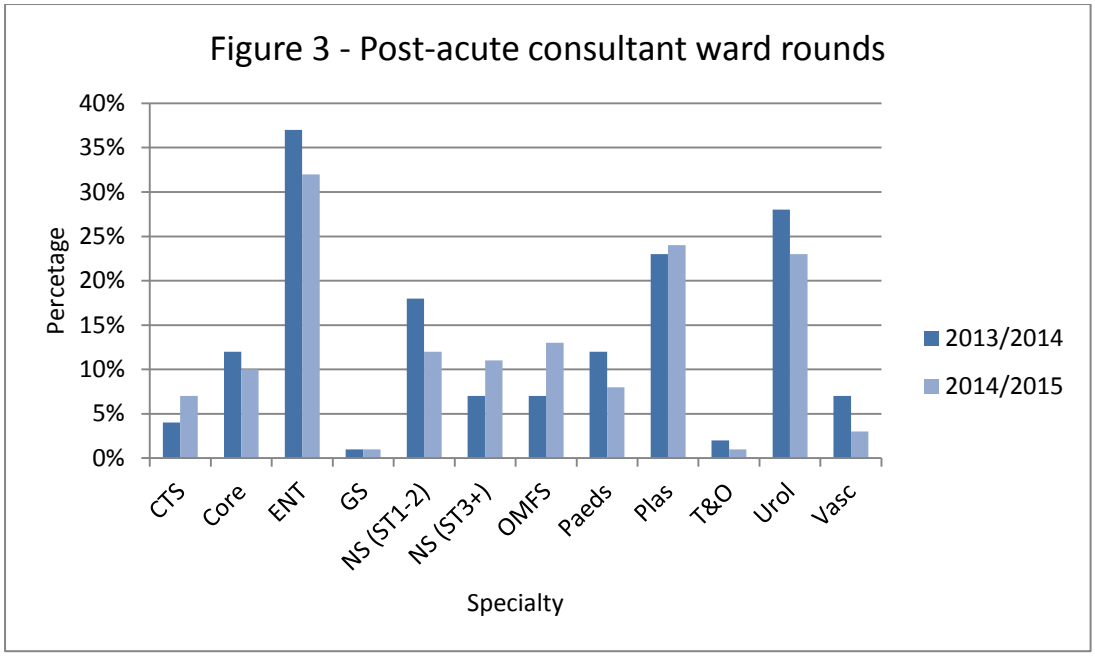
Figure 2 below demonstrates a span of survey outcomes demonstrating good practice in the area of patient safety.

Figure 2 **Question**	**CTS**	**Core**	**ENT**	**GS**	**NS (ST1-2)**	**NS (ST3+)**	**OMFS**	**Paeds**	**Plas**	**T&O**	**Urol**	**Vasc**
Did you routinely participate in pre-operative briefings with use of the WHO checklist or equivalent? (YES)	100% / 98%	97% / 98%	100% / 100%	99% / 99%	82% / 96%	95% / 99%	100% / 100%	100% / 100%	100% / 100%	100% / 100%	98% / 100%	100% / 100%
Were you asked to gain consent for procedures beyond your own operative competency or clinical experience? (NO)	99% / 96%	97% / 94%	100% / 98%	99% / 97%	100% / 96%	98% / 94%	100% / 96%	100% / 98%	100% / 98%	100% / 96%	99% / 98%	100% / 89%
Were you only asked to undertake unsupervised procedures in which you had been trained? (YES)	97% / 99%	98% / 98%	99% / 99%	99% / 99%	96% / 98%	97% / 99%	100% / 99%	100% / 100%	100% / 99%	98% / 99%	100% / 100%	100% / 99%
Were you given appropriate responsibility for your level of training? (YES)	98% / 99%	94% / 95%	99% / 99%	98% / 98%	88% / 96%	97% / 97%	98% / 100%	98% / 99%	98% / 97%	99% / 99%	99% / 100%	95% / 99%
Did you have access to relevant guidelines / protocols for both the unit and hospital? (YES)	99% / 99%	98% / 98%	100% / 99%	98% / 99%	96% / 98%	98% / 99%	99% / 99%	98% / 98%	100% / 99%	99% / 99%	99% / 99%	98% / 98%
Was there a culture of critically appraising systems following an adverse incident? (YES)	98% / 99%	98% / 98%	100% / 100%	98% / 99%	96% / 98%	97% / 98%	99% / 99%	100% / 99%	99% / 99%	99% / 99%	99% / 99%	100% / 97%
Did patient handover at shift change take place safely and reliably? (YES)	97% / 98%	96% / 96%	97% / 99%	98% / 98%	98% / 98%	97% / 98%	98% / 98%	100% / 94%	97% / 96%	98% / 98%	89% / 96%	88% / 97%

Upper – 2013/2014 / Lower – 2014/2015

Concerns

Figure 3 demonstrates the proportion of trainee responders per specialty who indicated that there was not usually a post-acute consultant ward round during their current placement.



WORKING CONDITIONS

Good practice

Figure 4 indicates the number of trainee responders who indicated that they received regular feedback on their performance from their trainers.

Figure 4 **Question**	**CTS**	**Core**	**ENT**	**GS**	**NS (ST1-2)**	**NS (ST3+)**
Did you receive regular feedback on your performance from your Clinical and Educational Supervisors? (YES)	99% 98%	92% 94%	100% 99%	98% 98%	96% 98%	97% 97%
	OMFS	**Paeds**	**Plas**	**T&O**	**Urol**	**Vasc**
	97% 99%	98% 100%	98% 98%	99% 99%	98% 99%	100% 97%

Upper – 2013/2014 / Lower – 2014/2015

Concerns

Figure 5 demonstrates the number of trainee responders who felt that their on-call commitments were arranged in such a way that they had an impact on their elective operating sessions.

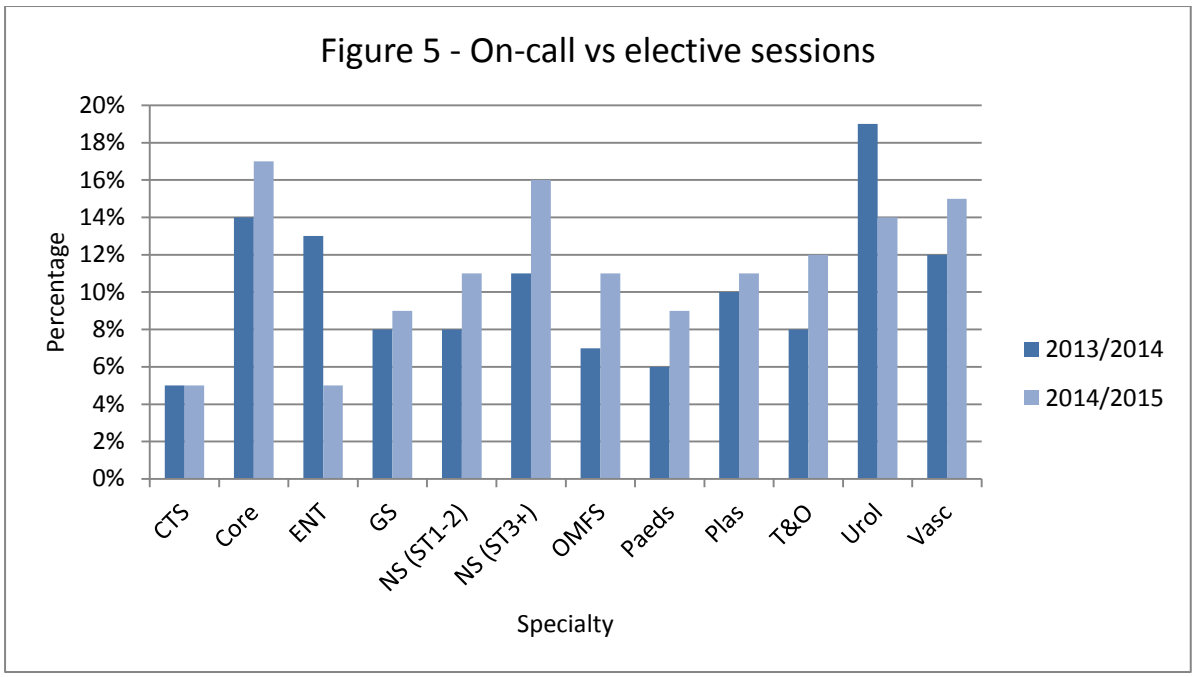


Figure 6 demonstrates the proportion of trainee responders who indicated that they had been subject to persistent behaviours that had undermined their professional confidence and self esteem.

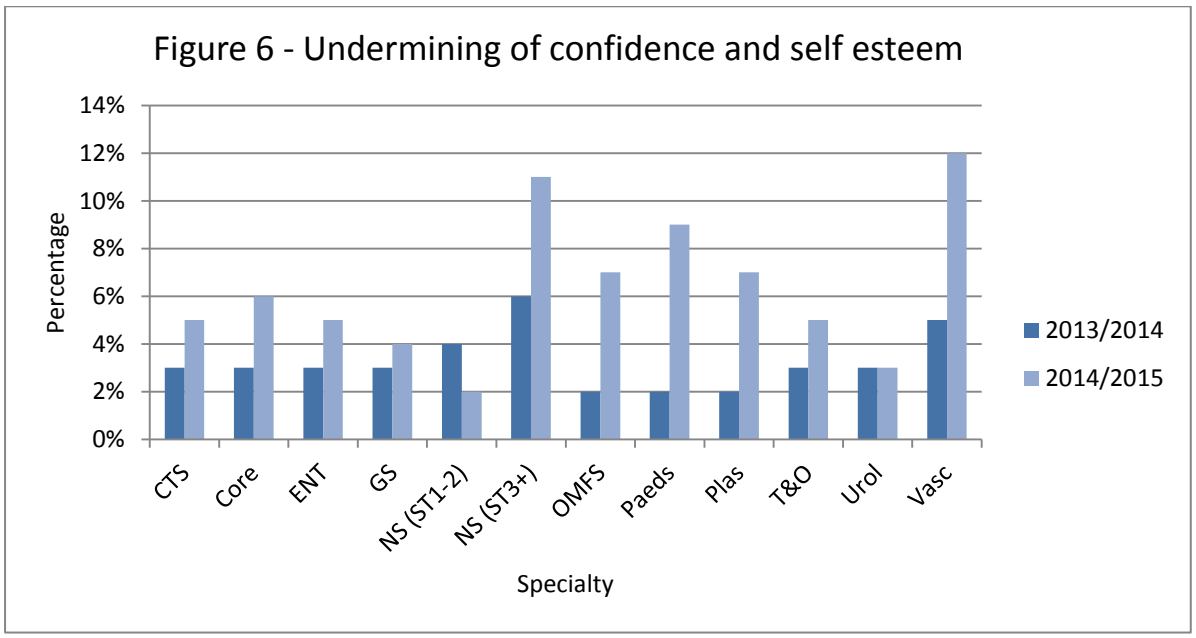


Figure 7 demonstrates a numbers of question responses highlighting areas of concern in relation to working conditions. The responses are particularly notable in regards to Core-level training, although responses from trainees in Neurosurgery ST1-ST2 posts demonstrate improvement in a number of domains.

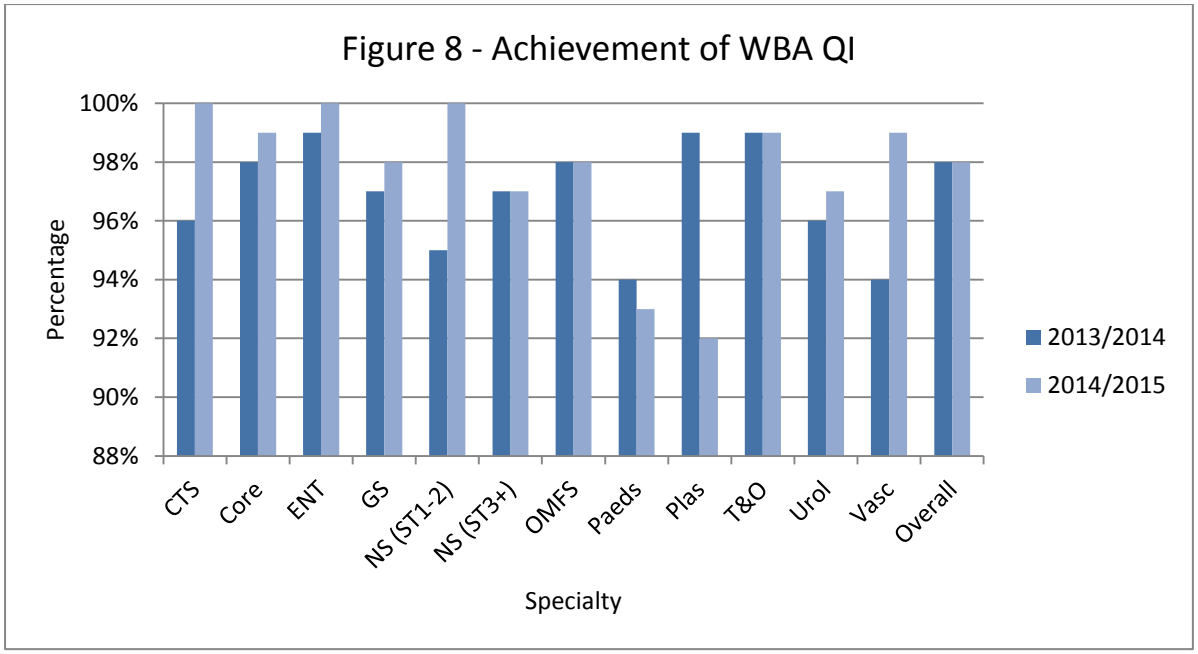
Figure 7 **Question**	**Core**	**GS**	**NS (ST1-2)**	**Plas**	**Vasc**
Were you required to undertake routine clinical work that prevented the acquisition of new skills? (YES)	26% / 33%	No concerns to note	59% / 54%	12% / 21%	No concerns to note
Did you regularly miss training opportunities in order to provide cover for absent colleagues or fill rota gaps? (YES)	19% / 24%		33% / 30%	No concerns to note	
Did the clinical work intensity allow sufficient time for consultant teaching and training? (NO)	15% / 15%		27% / 17%		
Were you released for a centralised surgical teaching programme and were you able to attend >70%? (NO)	14% / 15%	13% / 14%	9% / 13%		13% / 16%

Upper – 2013/2014 / Lower – 2014/2015

TRANING OPPORTUNITIES

Good practice

The QI for WBA completion stipulates that all surgical trainees at both specialty and Core level should have the opportunity to complete a minimum of 40 WBAs per year, which equates to approximately one per working week. **Figure 8** demonstrates the number of trainee responders who indicated that they completed at least one WBA per working week in their training placement.



The responses highlighted in **Figure 9** demonstrate good practice in terms of trainees being assigned an Assigned Education Supervisor (AES) shortly after the commencement of their current training post, and ease of negotiating a learning agreement for their training post.

Figure 9 Question	**CTS**	**Core**	**ENT**	**GS**	**NS (ST1-2)**	**NS (ST3+)**
Were you assigned an AES within six weeks of commencing this post? (YES)	100% / 100%	97% / 97%	100% / 99%	99% / 99%	98% / 100%	100% / 99%
	OMFS	**Paeds**	**Plas**	**T&O**	**Urol**	**Vasc**
	98% / 99%	98% / 99%	98% / 98%	99% / 99%	98% / 100%	100% / 100%
Question	**CTS**	**Core**	**ENT**	**GS**	**NS (ST1-2)**	**NS (ST3+)**
Did you have any difficulty in negotiating your learning agreement for this post? (NO)	98% / 97%	97% / 96%	99% / 96%	98% / 98%	98% / 98%	99% / 94%
	OMFS	**Paeds**	**Plas**	**T&O**	**Urol**	**Vasc**
	99% / 99%	98% / 96%	99% / 97%	98% / 97%	99% / 96%	100% / 100%

Upper – 2013/2014 / Lower – 2014/2015

Concerns

Figure 10 demonstrates the proportion of survey responses indicating that trainees have achieved or exceeded the number of weekly theatre sessions set out in their specialty's QIs. The recommended number for each specialty is given in Appendix A.

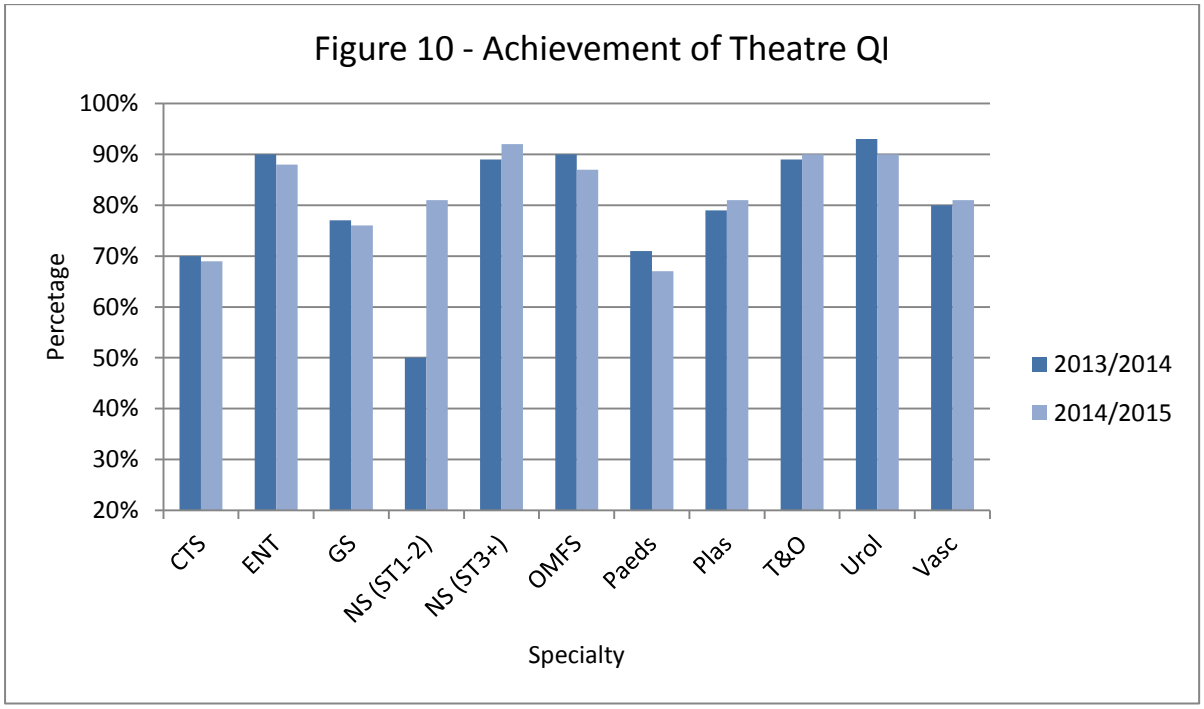


Figure 11 demonstrates the proportion of survey responses indicating that trainees have achieved or exceeded the number of weekly outpatient clinics set out in their specialty's QIs. The recommended number for each specialty is given in Appendix A.

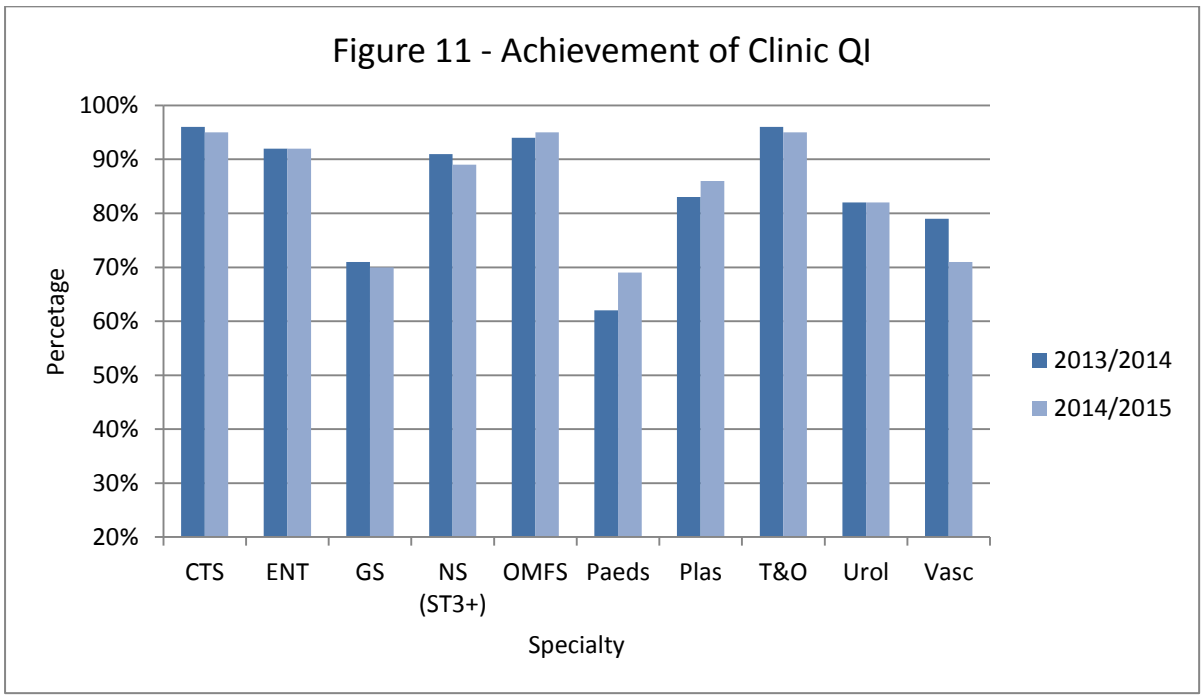


Figure 12 demonstrates the proportion of trainee responders indicating that they received two or more hours of formal teaching per week.

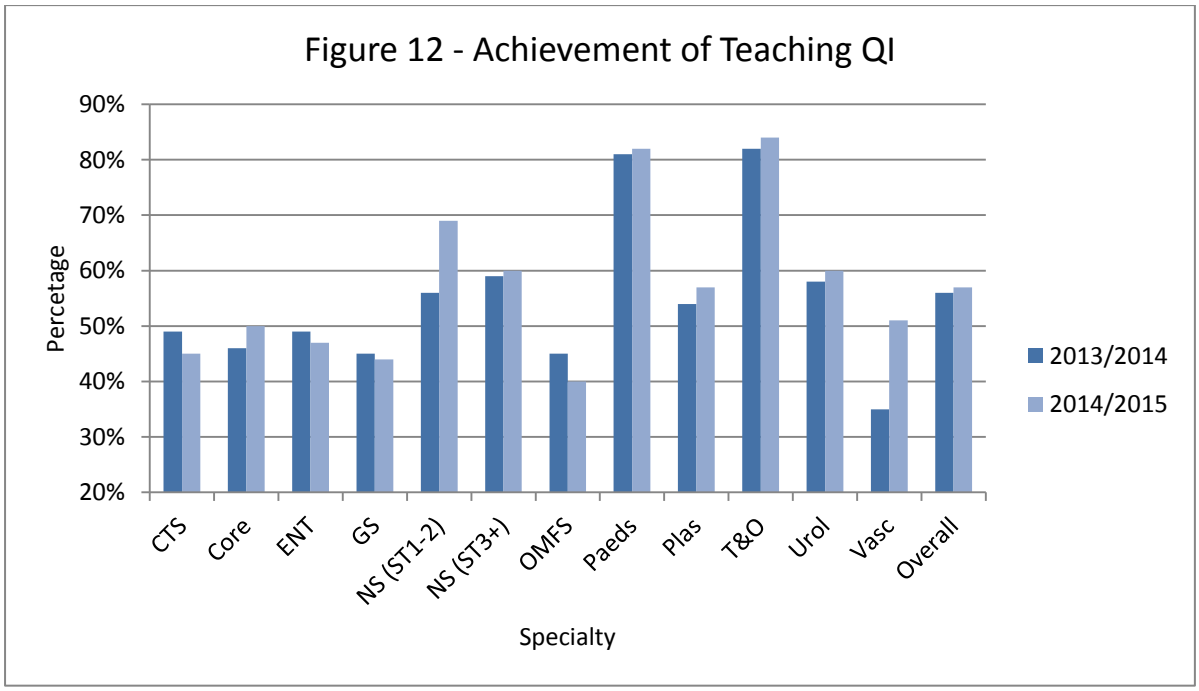
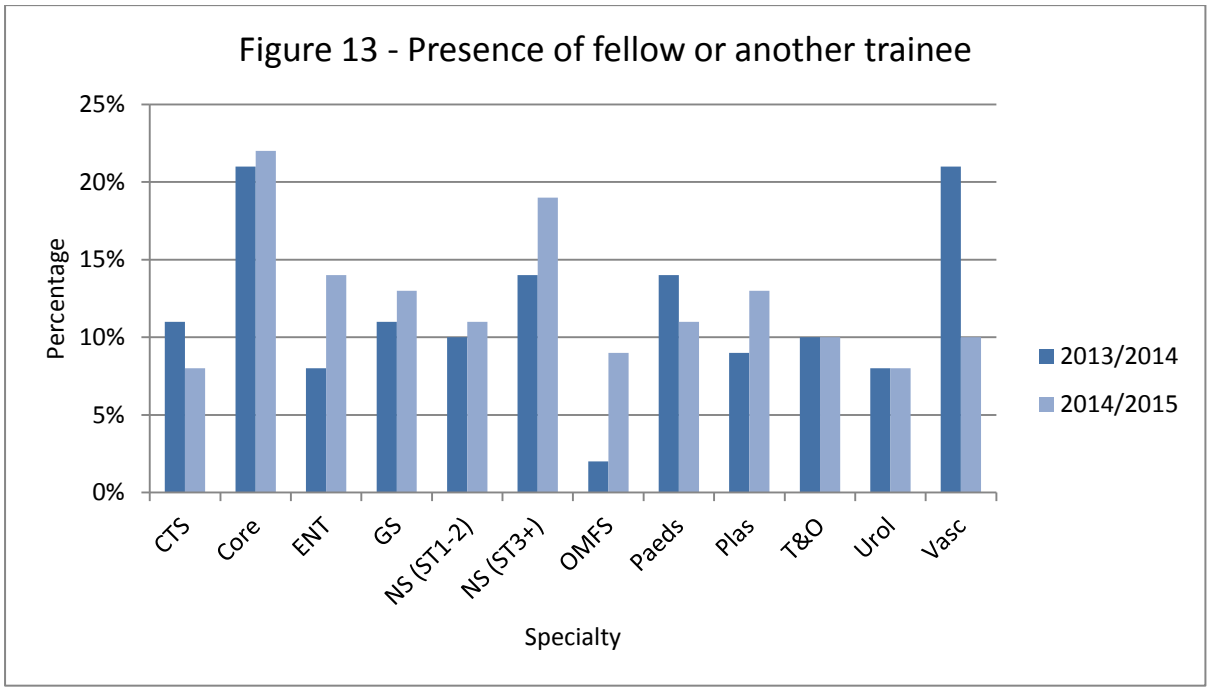


Figure 13 demonstrates the number of trainee responders indicating that they felt that another trainee or fellow in the unit had impacted on their training opportunities in their current placement.



The responses demonstrated in **Figure 14** show the number of Core-level trainee responders who indicated that they were unable to attend emergency theatre regularly. This demonstrates a marked improvement in the Neurosurgery ST1-ST2 responses between the two annual surveys, but still indicates an area of concern.

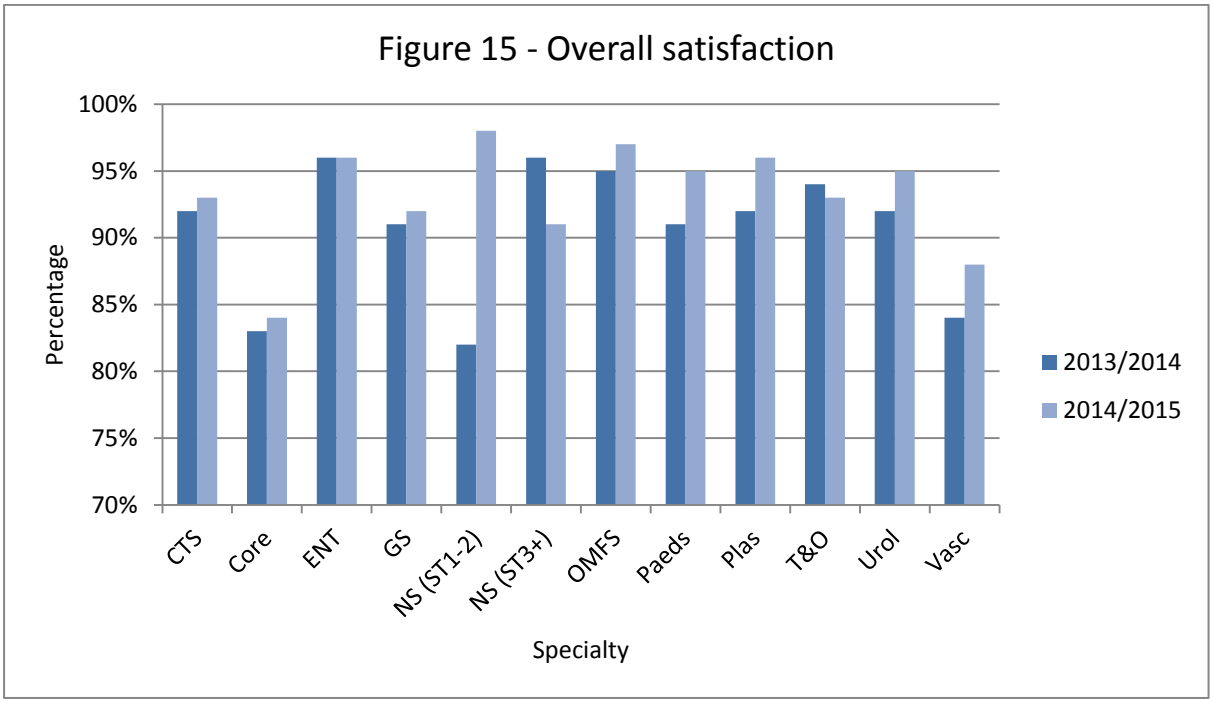
Figure 14 **Question**	**Core**	**NS (ST1-2)**
Were you able to attend emergency theatre regularly (e.g. CEPOD, trauma lists)? (NO)	21% 20%	41% 30%

Upper – 2013/2014 / Lower – 2014/2015

QUALITY OF EXPERIENCE

Good practice

Figure 15 demonstrates the number of trainee responders indicating that they would recommend their training post to another trainee.



In compliment to the previous chart, **Figure 16** demonstrates that a significant proportion of trainees rate the key elements of their teaching and training as either 'good' or 'very good'. However, lower scores are present, particularly in relation to Core-level training posts.

Figure 16 **Question**	**CTS**	**Core**	**ENT**	**GS**	**NS (ST1-2)**	**NS (ST3+)**	**OMFS**	**Paeds**	**Plas**	**T&O**	**Urol**	**Vasc**
How would you rate the quality of consultant teaching & training in the operating theatre? (GOOD or V GOOD)	84% / 90%	76% / 77%	94% / 91%	85% / 87%	60% / 91%	84% / 85%	90% / 97%	86% / 90%	84% / 90%	90% / 89%	90% / 92%	85% / 82%
How would you rate the quality of consultant teaching and training in outpatients? (GOOD or V GOOD)	75% / 79%	67% / 68%	69% / 76%	69% / 71%	44% / 53%	63% / 69%	70% / 79%	78% / 89%	77% / 82%	80% / 81%	68% / 71%	69% / 72%
How would you rate the quality of consultant teaching and training on ward rounds? (GOOD or V GOOD))	69% / 77%	50% / 55%	58% / 59%	64% / 68%	55% / 59%	57% / 62%	65% / 73%	71% / 81%	56% / 65%	69% / 73%	66% / 61%	52% / 62%

Upper – 2013/2014 / Lower – 2014/2015

Concerns

Figure 17 exemplifies concern in terms of Core-level trainees being able to see new patients during outpatient clinics.

Figure 17 **Question**	**Core**	**NS (ST1-2)**
In outpatients did you regularly see new patients? (NO)	14% / 16%	67% / 43%

Upper – 2013/2014 / Lower – 2014/2015

CONCLUSIONS

GOOD PRACTICE

Patient safety

Responses to the patient safety questions continue to show areas of real strength across all Specialties and Core, with precise numbers given in **Figure 2**. It is worth specifically noting instances where specialty responses demonstrated a marked improvement between the two surveys. For instance, the responses for Vascular Surgery and Urology demonstrate a clear increase in the proportion of trainee responders reporting that patient handover at shift change took place safely and reliably. Furthermore, responders in Neurosurgery ST1 and ST2 posts indicated a clear improvement in trainees taking part in pre-operative briefings and being given an appropriate level of responsibility for their year of training.

Working conditions

Trainees in all Specialties and Core indicated that they receive regular feedback from their clinical and educational supervisors (**Figure 4**). Responders in Core Surgical Training posts reported the lowest figures in 2013/2014 at 92%, but this had climbed to 94% in 2014/2015.

Training opportunities

Figure 9 indicates that trainee responders in all Specialties and Core are continuing to report that they receive good support for learning and supervision is their training posts, with the vast majority of trainees being assigned an Assigned Educational Supervisor (AES) within six week of starting their current placement and reporting no difficulties with negotiating a learning agreement. Furthermore, **Figure 8** demonstrates that the vast majority of training posts deliver generic QI 6, allowing trainees the opportunity to complete a minimum of 40 WBAs per year. While responders in Cardiothoracic Surgery and Vascular Surgery specialty training posts and Neurosurgery ST1 and ST2 posts demonstrate the most marked improvement, it would be worth monitoring the responses from Plastic Surgery specialty trainees over coming surveys to ensure that responses do not continue to fall.

Quality of experience

Figures 15 and 16 demonstrate that trainee responders continue to feel broadly satisfied with the training they receive. There is some concern relating to overall satisfaction with Core Surgical Training, and in the component sections of trainee impressions of teaching and training in the operating theatre, outpatient clinics and on ward rounds. In all four domains, responders in Neurosurgery ST1 and ST2 posts have indicated an improvement between the two surveys.

Overall, there are generally lower levels of satisfaction across all Specialties with teaching and training on ward rounds than in either the operating theatre or outpatient clinics.

CONCERNS

Patient safety

A number of trainee responders report that there was not usually a post-acute consultant ward round during their current placement, with numbers given in **Figure 3**. Responses are particularly marked in Otolaryngology (ENT) and Urology, although the responses from trainees in both specialties did indicate some improvement between the two surveys.

Working conditions

The percentages given in **Figure 7** indicate particular concern in the responses of trainees in Core Surgical Training and Neurosurgery ST1 and ST2 posts. A significant proportion of responders indicated that service pressures impact on their training opportunities, for instance being required to undertake routine clinical work that prevented the acquisition of new skills and regularly missing training opportunities to cover for absent colleagues or fill rota gaps. While the responses for Neurosurgery ST1 and ST2 trainees improved between the two surveys, figures still remain a concern, and the responses from Core trainees indicated that a more acute problem is developing. Furthermore, **Figure 5** demonstrates that responders in a number of specialties feel that their on-call commitments impacted on the opportunity to take part in elective operating sessions, with a number of specialties demonstrating increases between the two survey years.

Figure 6 demonstrates an increase in the majority of specialties, sometimes markedly so, of trainee responders reporting instances of undermining behaviour in their current placement.

Training opportunities

Figures 10 and 11 show the outcomes of the QIs for attendance of theatre sessions and outpatient clinics. Although these demonstrate a significant proportion of trainees indicating that their current post met or exceeded the individual levels set out by the specialities in the QIs, there remains room for improvement in a number of specialties. Neurosurgery ST1 and ST2 posts are commended for demonstrating a significant increase in terms of achievement of the theatre sessions QI.

The achievement of the formal teaching QI (**Figure 12**) remains a concern across the majority of specialties. There is some concern that trainee responders are not considering the full range of teaching options when answering the question – efforts to address this by development of the survey are discussed in the 'Future Plans' section of this report.

Figure 13 raises concerns about competition for training opportunities in theatre, with particularly marked responses from responders in Core Surgical Training and Neurosurgery specialty training. Vascular Surgery specialty responders indicate a significant improvement between the two surveys. Further concern about Core Surgical Training and Neurosurgery ST1 and ST2 posts are highlighted in **Figure 14**, with a significant proportion of responders indicating that they were not able to attend emergency theatre regularly. While Neurosurgery ST1 and ST2 posts remain a concern in this area, there is significant improvement demonstrated between the two surveys.

Quality of experience

Responders in Core Surgical Training posts and Neurosurgery ST1 and ST2 posts indicate that they do not regularly see new patients in outpatient clinics (**Figure 17**). While responders in the latter group demonstrate a significant improvement between the two surveys, concern remains.

FUTURE PLANS

The survey questions are subject to an annual review by the JCST QA Group, to ensure that they remain up to date and fit for purpose. Furthermore, specific sections of the survey are reviewed with key members of the JCST. For instance, in summer 2015 the questions relating to simulation training were reviewed in conjunction with the Chair of the JCST Simulation Group. This process produced an expanded number of questions intended to better explore the types of simulation training, both low- and high-fidelity, available in training programmes.

The JCST QA Group has also sought to develop the questions relating to formal teaching. There is some concern that trainees are not considering the full range of formal teaching options available to them in their responses, which may mean that outcomes do not provide a true picture of the opportunities available in programmes. Questions now provide examples of formal teaching methods and ask trainees to indicate how many instances of each example they have received on average during their placement.

Furthermore, the JCST QA Group is working with the SACs to expand the number of specialty specific questions included in the survey. In October 2015, questions targeted at Trauma and Orthopaedic Surgery specialty trainees were added to the survey and plans are underway to include questions for trainees in other specialties in October 2016 and beyond.

Analysis of the survey outcomes is embedded in SAC practice. SAC Liaison Members (LMs) are asked to consider the outcomes of the JCST and GMC trainee surveys for their liaison regions and comment on these as part of their regional reports. Furthermore, SAC Chairs are asked to consider the annual survey data for their specialties when completing their specialty submission for the GMC's Annual Specialty Report. Specialty-wide observations are fed back to the wider SAC, providing LMs with the opportunity to discuss these in their liaison regions.

In 2015, all SACs and the CSTC were asked to appoint a QA Lead from their committee memberships. Part of the QA Lead's role will be to work with the SAC Chair to analyse trainee survey results and form action plans to address any areas of concern. It is hoped that this will allow for greater analysis of outcomes, not just on a specialty level, but also along regional and training level lines.

It remains a strategic aim of the JCST to increase the overall annual survey response rate to 90% and possible methods of achieving this are under discussion.

APPENDIX A – Quality Indicator (QI) standards for 2013/2014 and 2014/2015

QIs for Specialty Trainees

Theatre QI – the minimum number of half-day consultant supervised theatre sessions a trainee should attend per week.
Clinic QI – the minimum number of outpatient clinics a trainee should attend per week.
Teaching QI – the minimum number of hours of formal teaching a trainee should receive per week.
WBA QI – the minimum number of WBAs a trainee should complete per year.

Specialty	Theatre QI	Clinic QI	Teaching QI	WBA QI
Cardiothoracic Surgery	4	1	2	40
General Surgery	3	2	2	40
Neurosurgery (ST1&ST2)	1	-	2	40
Neurosurgery (ST3+)	2	1	2	40
Oral & Maxillofacial Surgery	3	2	2	40
Otolaryngology (ENT)	4	3	2	40
Paediatric Surgery	3	2	2	40
Plastic Surgery	3	2	2	40
Trauma & Orthopaedic Surgery	3	2	2	40
Urology	3	2	2	40
Vascular Surgery	3	2	2	40

QIs for Core Surgical Trainees

Generic Core Surgery QI for trainees in all placements stipulates that trainees should have the opportunity to attend five consultant supervised sessions of 4 hours each week. There is variation depending on the specialty of placement the trainee is undertaking:

Theatre QI – the recommended number of operating sessions a trainee should attend per week.
Clinic QI – the recommended number of outpatient clinics a trainee should attend per week.
Teaching QI – the minimum number of hours of formal teaching a trainee should receive per week.
WBA QI – the minimum number of WBAs a trainee should complete per year.

Specialty of Core Surgery placement	Theatre QI	Clinic QI	Teaching QI	WBA QI
Cardiothoracic Surgery	3	1	2	40
General Surgery	3	2	2	40
Neurosurgery	2	1	2	40
Oral & Maxillofacial Surgery	3	3	2	40
Otolaryngology (ENT)	3	3	2	40
Paediatric Surgery	3	1	2	40
Plastic Surgery	3	1	2	40
Trauma & Orthopaedic Surgery	3	1	2	40
Urology	3	1	2	40

NB QIs for Vascular Surgery placements in Core Surgery set in July 2015.

APPENDIX B – JCST trainee survey questions for 2013/2014 and 2014/2015

GENERIC QUESTIONS

Q no – 13/14	Q no – 14/15	Question text	Answer options
1	1	Were you adequately supervised by senior colleagues during this attachment?	Y/N
2	2	Was there usually a post-acute consultant ward round?	Y/N N/A
3	3	Did patient handover at shift change take place safely and reliably?	Y/N
4	4	Were you asked to obtain consent for procedures beyond your own operative competency or clinical experience?	Y/N
5	5	Did you routinely participate in pre-operative briefings with use of the WHO checklist or equivalent?	Y/N
6	6	Were you only asked to undertake unsupervised procedures in which you had been trained?	Y/N
7	7	Were you given appropriate responsibility for your level of training?	Y/N
8	8	Did you have access to relevant guidelines / protocols for both the unit and hospital?	Y/N
9	9	Was there a culture of critically appraising systems following an adverse incident?	Y/N
10	10	Are any elective sessions combined with on call commitment such that the elective sessions are frequently compromised?	Y/N N/A
11	11	Were you required to undertake routine clinical work that prevented the acquisition of new skills?	Y/N
12	12	Did you regularly miss training opportunities in order to provide cover for absent colleagues or fill rota gaps?	Y/N
13	13	Did the clinical work intensity allow sufficient time for consultant teaching and training?	Y/N
14	14	Did you receive regular feedback on your performance from your Clinical and Educational Supervisors?	Y/N
15	15	In this post, were you personally subjected to persistent behaviour by others that undermined your professional confidence or self esteem?	Y/N
16	16	Were you released for a centralised surgical teaching programme and were you able to attend >70%?	Y/N / N/A
17	17	Was there enough clinical work in the unit to support the number trainees working there?	Y/N
N/A (New in 14/15)	18	Have you ever considered training less than fulltime? Y/N a) If yes to a) above, did you decide to train less than fulltime? b) If no to b) above, why did you decide not to train less th fulltime?	Y/N Y/N/N/A Free text
18	19	Please indicate the number of surgical staff in this department (including yourself). Core Surgical Trainees: ST3/4: ST5/6: ST7/8:	0, 1, 2-3, 4-5, >5

		Staff grade/trust doctor/associate specialist or similar: Nationally appointed fellow: Other type of fellow: Consultants: Other (specify):	
19	20	In a normal week (excluding leave, on-call, compensatory rest)… a) How many consultant supervised theatre sessions did you attend (including elective and emergency/CEPOD theatre work)? (½ day list = 1 session, all day list = 2 sessions) b) How many consultant supervised outpatients sessions did you attend? c) On average, how many hours of formal teaching did you receive each week? (This should be calculated by including local departmental teaching, regional teaching, journal clubs and x-ray meetings or MDTs with an educational component) d) Were you assigned an AES within six weeks of commencing this post? e) Did you have any difficulty in negotiating your learning agreement for this post? f) On average, how many workplace-based assessments did you complete each week?	 0/1/2/3/4/5/>5 0/1/2/3/4/5/>5 0/1/2/3/4/5/>5 Y/N Y/N 0/1/2/3/4/5/>5
20	21	Were you able to attend emergency theatre regularly (e.g. CEPOD, trauma lists)?	Y/N / N/A
21	22	Did the presence of another fellow or trainee frequently compromise/compete for your learning opportunities in this post?	Y/N
22	23	In this post, did you receive simulation and clinical skills training?	Y/N N/A
23	24	If 'yes' to previous question, was this through: a) A formal programme organised by the training programme? b) Locally organised training within the hospital?	Y/N N/A
24	25	Did you have access to a skills centre for practice: a) During normal working hours? b) Outside of normal working hours?	Y/N N/A
25	26	If yes to either part of the question above, did you have a mentor to cover induction on equipment and to monitor progress?	Y/N N/A
26	27	How would you rate the quality of consultant teaching & training on ward rounds (including pre-op cases)?	Very poor/ Poor/ Satisfactory / Good/ Very good
27	28	How would you rate the quality of consultant teaching & training in outpatients?	Very poor/ Poor/ Satisfactory / Good/ Very good
28	29	How would you rate the quality of consultant teaching & training in the operating theatre?	Very poor/ Poor/ Satisfactory / Good/ Very good

29	30	In outpatients did you regularly see new patients?	Y/N
30	31	Did you experience any difficulties relating to the geographical location of this training post?	Y/N
31	32	Would you recommend this attachment to other trainees at the same level?	Y/N

QUESTIONS FOR LESS THAN FULL-TIME TRAINEES

Q no – 13/14	**Q no – 14/15**	**Question text**	**Answer options**
The initial questions provide background information that may not have changed since you completed this questionnaire previously. Please answer anyway.			
1	1	In which year were you appointed to this training programme?	2000 / 2001 / 2002 / 2003 / 2004 / 2005 / 2006 / 2007 / 2008 / 2009 / 2010 / 2011 / 2012 / 2013 / 2014
2	2	In which year did you become a LTFT trainee?	2000 / 2001 / 2002 / 2003 / 2004 / 2005 / 2006 / 2007 / 2008 / 2009 / 2010 / 2011 / 2012 / 2013 / 2014
3	3	How long did it take to obtain a LTFT training slot?	0-6 months / 6-12 months / More than 1 year
4	4	Do you consider that this was prolonged?	Y/N
5	5	Does your LETB or training programme have an identified person who is responsible for LTFT training?	Y/N
6	6	Do you believe that your training programme director understands and is sympathetic to the needs of a LTFT trainee?	Y/N
7	7	Do you consider that training less than fulltime may affect your future career prospects?	Y/N
The following questions are specific to your current placement.			
8	8	Please indicate the proportion of time that you currently work:	<50%, 50%, 60%, 70%, 80%, 90%
9	9	Who determined the proportion of time that you work?	You/ Deanery/ LETB/ TPD
10	10	If this was not determined by you, are you happy with the training	Y/N N/A

		time that you have been given?	
11	11	Are you: a) In a job-sharing arrangement with another trainee? b) Working LTFT in a post normally occupied by a full time trainee (instead of a full time trainee)? c) Working LTFT as a supernumary member of your surgical team (not in a job share, not in an established but vacant training post)?	Select one option
12	12	Have you experienced problems accessing any of the following sessions? Consultant ward rounds Outpatient clinics Operating lists MDT or equivalent Research / audit	 Y/N Y/N Y/N Y/N Y/N
13	13	Have you needed to work additional (non-paid) sessions to achieve specific clinical aims (e.g. endoscopy training, special interest training)?	Y/N
14	14	Are your fixed sessions all undertaken with the same consultant? If No, how many different consultants do you work with?	Y/N 2, 3, 4, 5, >5
15	15	Does your current post include an out of hours on call commitment? If No: a) Is this through choice? b) Is it because the Trust is unwilling to fund on call time for you?	Y/N Y/N N/A Y/N N/A
16	16	Is the level of your on call commitment sufficient to retain your on call competencies?	Y/N N/A
17	17	As a LTFT trainee, have you experienced problems with any of the following? a) Bullying or harassment b) A lack of support/understanding about LTFT training by consultant trainers c) Adverse attitudes to your position and needs by fulltime trainees d) Allocation to sessions with fewer or inferior training opportunities in favour of fulltime trainees e) Negotiating a learning agreement with achievable objectives/goals f) Inappropriate expectations at ARCP g) Achieving your competencies h) Disproportionately less exposure to skills/simulation training than fulltime trainees	 Y/N Y/N Y/N Y/N Y/N Y/N Y/N Y/N
18	18	Please indicate anything that your LETB/current attachment has done which has enhanced the quality of your LTFT training.	Free text
19	19	Please indicate anything that your LETB/current attachment has done which has detracted from the quality of your LTFT training.	Free text

QUESTIONS FOR ACADEMIC TRAINEES

Q no – 13/14	**Q no – 14/15**	**Question text**	**Answer options**

1	1	What proportion of your time is protected for research?	<25%/ 25-35%/ 36-49%/ ≥50%
2	2	How often do you meet with your supervisor and discuss your academic work?	Weekly/ 2 weekly/ Monthly/ 2 monthly/ 3 monthly/ 6 monthly
3	3	Have you applied for funding to support postdoctoral research or educationalist training?	Y/N
4	4	Have you received appropriate support for this from your academic supervisor?	Y/N
5	5	Has your academic supervisor reviewed your personal development plan and academic objectives?	Y/N
6	6	Are there any factors that have adversely affected your academic progress?	Y/N
7	7	How many abstracts/presentations have you made to national or international meetings over the last 12 months?	0/1/2/3/4/5/>5
8	8	Did the academic component of your post meet your expectations?	Y/N
9	9	Do you feel that you made appropriate progress in your clinical training during your post?	Y/N

QUESTIONS FOR GENERAL SURGERY TRAINEES

Q no – 13/14	**Q no – 14/15**	**Question text**	**Answer options**
Special interest			
1	1	What is your special interest within general surgery?	Colorectal/ Upper GI (includes oesophagogastric and hepatopancreatobiliary) / Breast/ Endocrine/ Vascular (trainees appointed before 1.1.13 only)/ Transplantation
2	2	Do you have an additional interest?	Endocrine/ General Surgery of Childhood/ Remote and Rural/

			Trauma/ None
Hospital Facilities			
3	3	Are the following available 24/7 with real time reporting: (a) CT scanning? (b) Interventional radiology?	 Y/N Y/N
4	4	How many days per week is there a CEPOD list?	0/1/2/3/4/5/6/7
5	5	How many other specialties share this list (counting vascular surgery as a separate specialty)?	0/1/2/3/4/5/6/7
Accommodation and IT			
6	6	Do you have office accommodation?	Y/N
7	7	Do you have appropriate IT access for literature searches and on line journals?	Y/N
Timetable			
8	8	How many consultant ward rounds per week do you have?	0/1/2/3/4/5
9	9	Do you perform a daily business round of your team's patients?	Y/N
10	10	Do you attend at least 1 MDT per week?	Y/N
11	11	Do you have timetabled time for research or audit projects during the working week?	Y/N
12	12	Are you timetabled to regularly deliver teaching in this post?	Y/N
Management			
13	13	Do you have the opportunity to contribute to management or leadership at any level, e.g. rota management, trainee representative on hospital/deanery committees, involvement in service development?	Y/N
Study leave			
14	14	Have you had difficulty obtaining study leave?	Y/N
Questions 15 and 16 are only for trainees with a vascular special interest doing a vascular post (appointed to programme before 1.1.13)			
15	15	Did you receive endovascular training in this post?	Yes, regularly/ Yes, but ad hoc with no fixed timetabling/ No
16	16	Did you receive cross-sectional imaging training for: (a) Diagnosis (b) Treatment planning (e.g. EVAR, TEVAR)	 Y/N Y/N
Question 17 is only for trainees with a special interest in colorectal or upper gastrointestinal surgery:			
17	17	Are you given endoscopy training in this post?	Yes, regularly/ Yes, but ad hoc with no fixed timetabling/ No

QUESTIONS FOR OTOLARYNGOLOGY TRAINEES

Q no – 13/14	Q no – 14/15	Question text	Answer options
N/A	1	When on call in this post, do you have immediate access to dedicated cover from consultants so that the on call consultant is not also responsible for admissions to another hospital?	Y/N/N/A
N/A	2	Have you ever had occasions in this post when you have been unable to obtain immediate advice from consultants when on call?	Y/N/N/A
N/A	3	Out of hours (5pm-8am), do you have the following routine timetabled work scheduled: a) Operating list b) Outpatients clinic	 Y/N Y/N
N/A	4	If yes to either part of Question 3 above, are you supervised by a consultant for this work?	Y/N/N/A