Annual report for the JCST trainee survey

Introduction

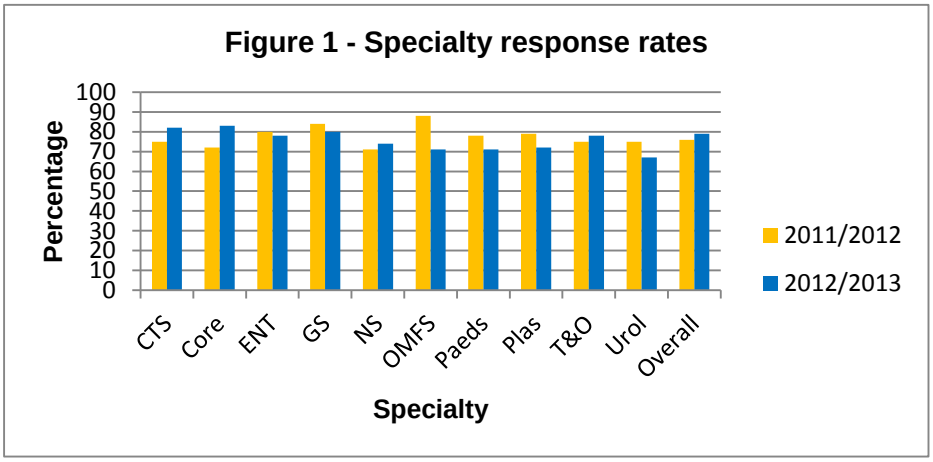
The JCST trainee survey is now in its third year of operation and has, to date, provided some valuable information about the quality of surgical training nationally, which the JCST intends to share with key stakeholders in the form of an annual report. This report, as the first such annual report, will provide key points from the survey results for the 2011/12 and 2012/13 training years, along with details of future plans for the survey and its reporting mechanisms.

In 2011, the Specialty Advisory Committees (SACs) and the Core Surgical Training Committee (CSTC) developed a series of quality indicators (QIs) to assess the quality of surgical training placements in each specialty and at core level. As such, the QIs act as a benchmark against which the quality of training placements, and not the achievements of individual trainees, is measured in order to assess the standard of training they deliver. The first 9 QIs are generic and are applicable to all training placements, regardless of their specialty or level. The remaining QIs are divided into two groups: those for all placements within each surgical specialty; and those relevant to training placements at specific levels. The QIs can be found at: http://www.jcst.org/quality-assurance/jcst-quality-indicators-and-trainee-survey.

The JCST trainee surveys, which were developed in conjunction with the Confederation of Postgraduate Schools of Surgery, were introduced in 2011. For the 2011/12 and 2012/13 training years, trainees in the majority of the surgical specialties answered a 20-question survey, whilst core and Paediatric Surgery trainees answered a more detailed survey with questions relating to curriculum delivery. However, since October 2013, all trainees have answered the same 31-question survey, regardless of their level or specialty. There are also additional questions for General Surgery, less than fulltime and academic trainees to answer. The different versions of the survey questions can be found in Appendices 1-3.

The survey is one of the tools by which the deliverability of the JCST QIs is measured. The survey reports are available, via the ISCP, to Heads of School, TPDs and SAC Chairs and Liaison Members and are used to help identify good and poor quality training placements in order that appropriate action may be taken. The surveys are also accessible through the ISCP and trainees are requested to complete one for each training placement they undertake.

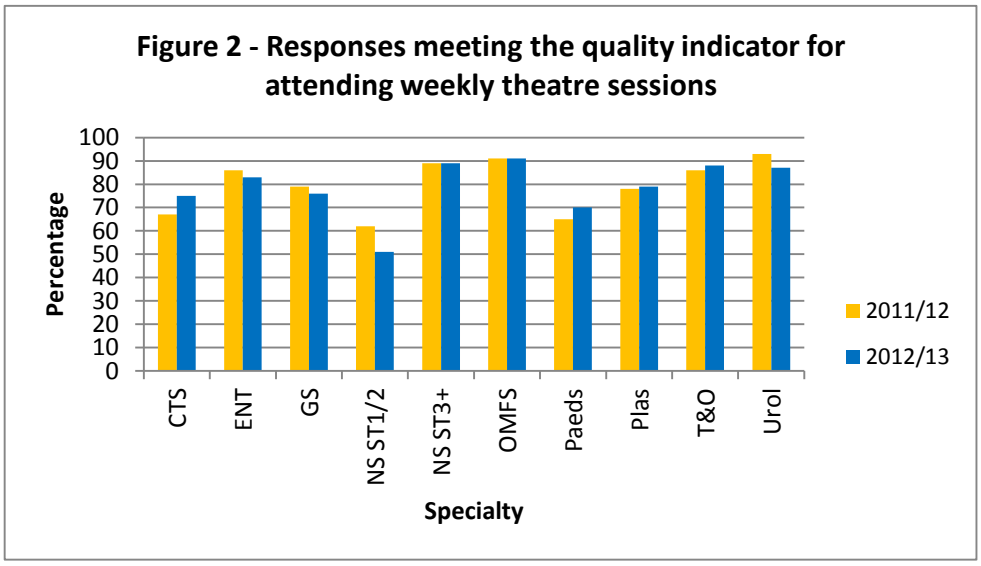
Figure 1 shows the response rates for the 2011/12 and 2012/13 surveys. The overall response rate for 2011/12 was previously reported as 70%, however, as the survey is open continuously and trainees can complete it retrospectively for previous placements they have undertaken, by the time of writing, this rate had increased to 76%.

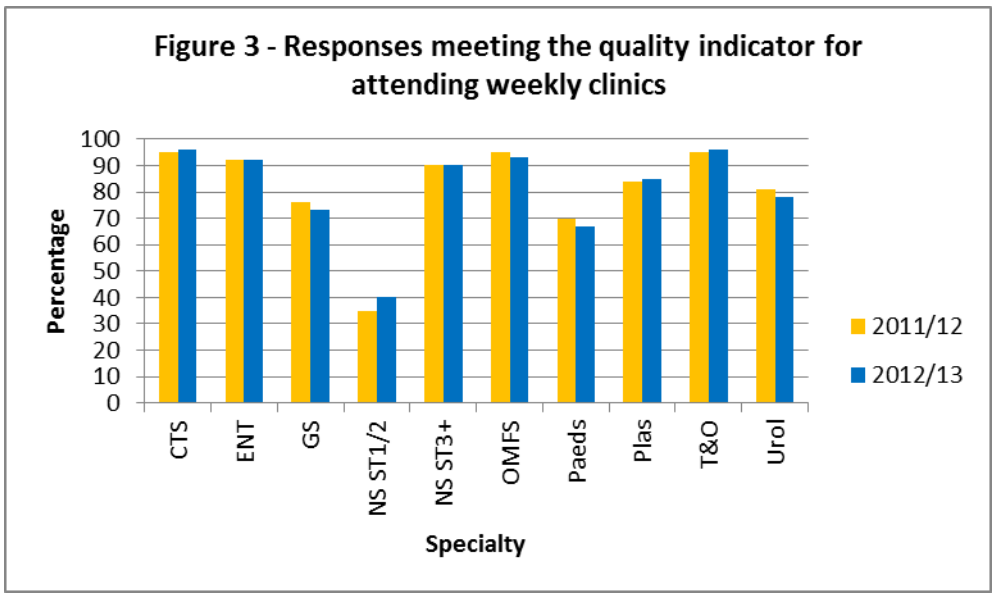


Highlights

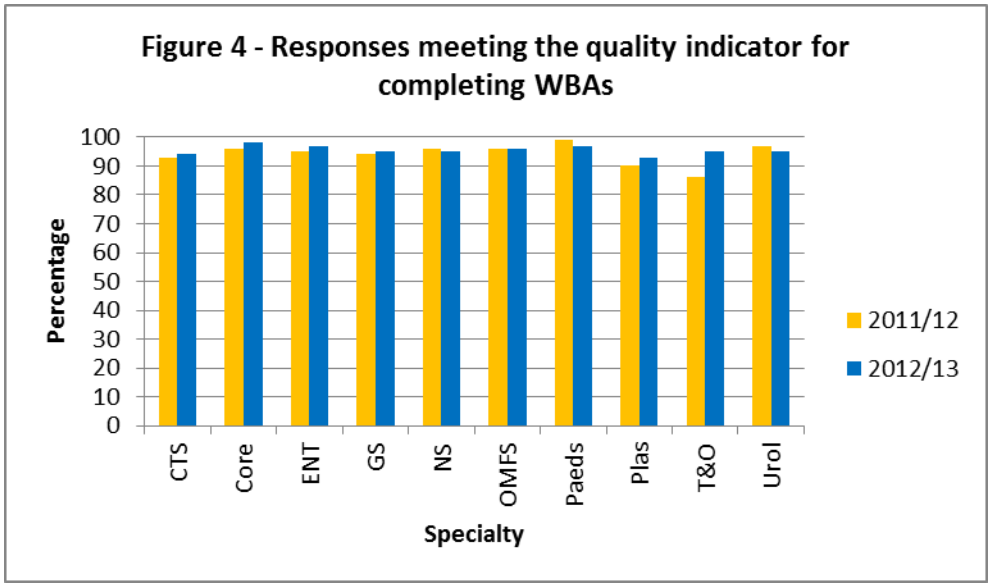
The survey results for the 2011/12 and 2012/13 training years showed that, generally, trainees received positive experiences in certain key areas of their training and were meeting the relevant QIs. The main points are as follows:

- The majority of responses indicated that higher surgical trainees were meeting the QIs for attending operating sessions and outpatient clinics, although there was some variation between specialties and training years. The results per specialty can be seen in Figures 2 and 3 below. There are 2 results for Neurosurgery as the QIs differ depending upon the level of the trainees.





- The majority of responses for all levels indicated that trainees were meeting the QI for completing an average of 1 workplace based assessment per week, thereby receiving regular structured feedback of their progress. The results per specialty can be seen in Figure 4 and should be considered in conjunction with the feedback figures in Table 1 below.



- Specific survey questions achieved a high rate of positive answers in one or both years of the survey and Table 1 below provides these responses by specialty. For each question, the answers relate to the 2011/12 and 2012/13 training years respectively:

Table 1 – Positive responses to other key questions

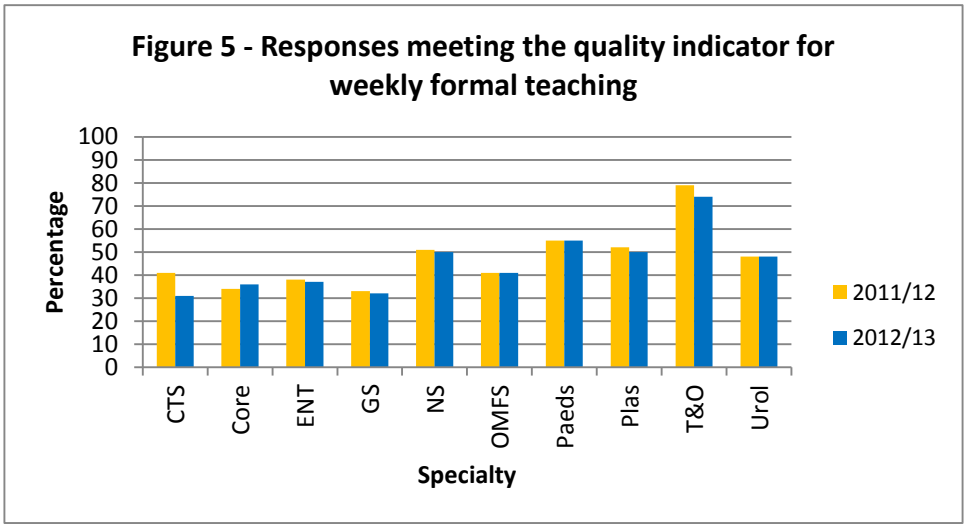
Survey question	CTS	Core	ENT	GS	NS ST1/2	NS ST3+	OMFS	Paeds	Plas	T&O	Urol
Did you receive regular feedback on your performance from your Clinical and Educational Supervisors?	Yes = 97% / 98%	Yes = 91% / 93%	Yes = 98% / 98%	Yes = 96% / 96%	Yes = 87% / 95%	Yes = 96% / 98%	Yes = 97% / 98%	Yes = 97% / 96%	Yes = 92% / 95%	Yes = 96% / 98%	Yes = 99% / 97%
Were you assigned an AES within six weeks of commencing this post?	Yes = 95% / 97%	Yes = 98% / 97%	Yes = 99% / 98%	Yes = 98% / 98%	Yes = 92% / 99%	Yes = 99% / 99%	Yes = 97% / 100%	Yes = 99% / 100%	Yes = 95% / 98%	Yes = 98% / 99%	Yes = 99% / 99%
Did you have any difficulty in negotiating your learning agreement for this post?	No = 92% / 98%	No = 97% / 98%	No = 97% / 98%	No = 97% / 97%	No = 96% / 98%	No = 98% / 95%	No = 99% / 98%	No = 99% / 98%	No = 94% / 98%	No = 97% / 98%	No = 97% / 98%
How would you rate the quality of consultant teaching & training in outpatients?	Good/Very Good = 61% / 75%	Good/Very Good = 60% / 64%	Good/Very Good = 68% / 72%	Good/Very Good = 60% / 67%	Good/Very Good = 48% / 47%	Good/Very Good = 66% / 59%	Good/Very Good = 64% / 72%	Good/Very Good = 61% / 70%	Good/Very Good = 74% / 80%	Good/Very Good = 77% / 78%	Good/Very Good = 67% / 72%
How would you rate the quality of consultant teaching & training in the operating theatre?	Good/Very Good = 75% / 85%	Good/Very Good = 72% / 74%	Good/Very Good = 90% / 90%	Good/Very Good = 79% / 85%	Good/Very Good = 81% / 64%	Good/Very Good = 85% / 78%	Good/Very Good = 88% / 93%	Good/Very Good = 93% / 79%	Good/Very Good = 84% / 88%	Good/Very Good = 85% / 87%	Good/Very Good = 88% / 91%
Would you recommend this attachment to other trainees at the same level?	Yes = 88%/ 93%	Yes = 84% / 87%	Yes = 93% / 94%	Yes = 89% / 91%	Yes = 87% / 79%	Yes = 93% / 88%	Yes = 97% / 98%	Yes = 99% / 92%	Yes = 95% / 94%	Yes = 92% / 93%	Yes = 96% / 94%

- The responses relating to feedback support those relating to the completion of weekly workplace based assessments and indicate that, in the majority of cases, trainees received regular updates on their progress in training from their supervisors.
- The increase in the number of responses rating teaching in outpatients and theatre as good or very good between the two years is worth noting and represents an improvement in this area, with one exception, in all of the specialties.
- Despite some fluctuation between the years, the majority of trainees would recommend their placements to another trainee. However, core and ST1/2 level Neurosurgery trainees were generally less satisfied with the training they received than the higher trainees were.

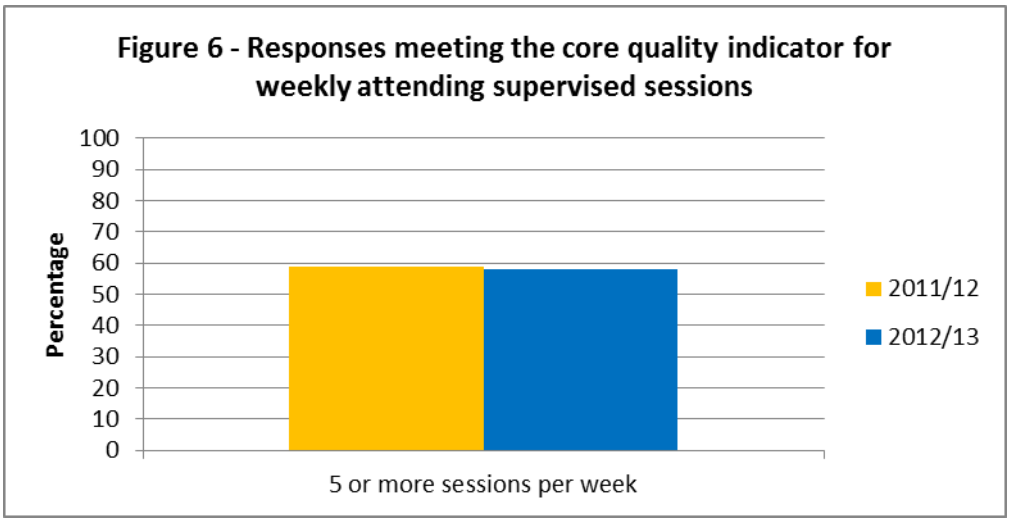
Concerns

The survey results have also highlighted common issues across the specialties, which the JCST, SACs and CSTC will continue to monitor going forward.

- Only a minority of trainees appeared to be meeting the QI for formal teaching, i.e. receiving an average of 2 hours per week. The results per specialty can be seen in Figure 5. However, the JCST recognises that the results might be due to a lack of clarity of what is meant by 'formal teaching' and the relevant survey question has been changed accordingly to include some examples.



- In the core QIs, the number of operating and clinic sessions trainees should attend varies depending upon the specialty of the training placement. However, a generic QI states that trainees should attend 5 consultant supervised sessions per week and the number of responses meeting this is shown in Figure 6.



- Although service is an integral part of training and is the best way for trainees to gain the required skills and competencies, a tension exists in many hospitals between training and service provision, with the latter impacting on the opportunities trainees have access to. Many responses indicated that trainees, particularly those at a lower level, had to undertake routine clinical work of little educational/training benefit, which prevented them from acquiring new skills. This seemed to be a particular problem when there was little/no ward cover from junior doctors.

- There were issues in the majority of the specialties with trainees missing training opportunities in order to provide cover for absent colleagues or fill rota gaps.

  Table 2 focuses on the specialties with the highest numbers of negative responses to these two survey questions. For each question, the answers relate to the 2011/12 and 2012/13 training years respectively:

Table 2 – Negative responses to service delivery questions

Survey question	Core	NS ST1/2	NS ST3+	Plas
Were you required to undertake routine clinical work that prevented the acquisition of new skills?	Yes = 35% / 29%	Yes = 38% / 40%	Yes = 23% / 15%	Yes = 13% / 15%
Did you miss any training opportunities due to providing cover for absent colleagues or filling rota gaps?	Yes = 31% / 27%	Yes = 35% / 36%	Yes = 25% / 22%	Yes = 21% / 22%

- In 2011/12, 23% of responses to the core survey and 35% of the ST1/2 Neurosurgery responses indicated an inability to regularly attend emergency theatre sessions, with figures of 21% and 44% respectively for 2012/13. In addition, a relatively high % of responses from Cardiothoracic Surgery, ENT and Urology trainees indicated that attendance at emergency theatre was not applicable, although it is recognised that emergency surgery might not be a requirement of these particular curricula.
- Some instances of bullying and undermining from colleagues, consultants and other medical staff have been reported. In the future, the GMC is planning to undertake a series of check visits to individual training units where bullying and undermining are/have been an issue. The JCST survey responses have been triangulated with those of the GMC survey and other forms of evidence in order to identify individual training units to potentially be checked as a part of this process.
- For ENT, 26% and 22% of the responses rated teaching and training on ward rounds as 'poor' or 'very poor' for 2011/12 and 2012/13 respectively, with figures of 24% and 17% for Plastic Surgery. These were higher than the other specialties.

Actions taken by the JCST

In general, SAC Liaison Members and Chairs are encouraged to consider the survey data while producing the annual report for their region / specialty respectively. Concerns and areas of good practice are shared with the GMC through the JCST's Annual Specialty Report, which is a summary of surgical training, and the survey data is also publicised through articles, for example, in the surgical colleges' magazines.

The JCST QA Group, at its meeting in December 2013, analysed the survey results for the 2012/13 training year as a result of which the QA Lead wrote to each of the SAC Chairs to highlight any concerns raised in the core and higher level survey results for the specialty. The SACs have since discussed the survey results and sense checked the data. At the time of writing this report, several specialties had submitted formal responses to the letter.

These responses addressed the specific issues raised in the survey results for the specialty and outlined the action the SAC has taken as a result. For example, the ENT TPDs have been asked to confirm the number of theatre sessions and clinics their trainees are timetabled for; the T&O Liaison Members have been tasked with reviewing trainee timetables at the next round of ARCPs; and where possible, ST1/2 level trainees in Neurosurgery will in future have an AES who is a Neurosurgeon even when they are undertaking placements in associated specialties. All of the responses have agreed that the survey results relating to formal teaching are likely due to a misunderstanding of the term and improvement should be evident in future surveys now clarification of what ‘formal teaching’ includes has been provided in the survey question.

The responses also expressed concern that core placements in the relevant specialties are consistently not meeting the QIs that the SACs set for attendance at theatre sessions and clinics, but have recognised that the delivery of core training is beyond the SACs' remit. The QA Lead has therefore written to the Chair of the CSTC to highlight the concerns raised with core placements in each specialty, who will, in turn, cascade the information to the core TPDs so action may be taken as required.

Future changes

The SACs have the potential to develop questions for trainees in their specialties and, although only General Surgery has chosen to do so to date, ENT specific questions will be included in the survey from autumn 2014. At the request of the Heads of School, the survey's reporting mechanisms are being reviewed to enable users to drill down further into the data, for example to hospital level. Cumulative reports will also be made available to enable trends over the three-year period of the survey to be identified.

The JCST QA Group has drafted a Memorandum of Understanding for sharing the survey data with the trainee organisations and comments are awaited from the Association of Surgeons in Training (ASiT) and the British Orthopaedic Trainees Association (BOTA) before the agreement can be finalised. The JCST recognises that, in order for the survey to continue being a valuable means of collecting data on surgical training, trainee anonymity must be protected as far as possible, particularly in the smaller specialties and those training units which have few trainees.

In accordance with its strategy, the JCST aims to increase the response rate of its survey to over 90% by 2014, in order to develop a clear picture of the strengths and weaknesses of surgical training in the UK, and would like to encourage all trainees to complete the survey for each training placement they undertake. Going forward, the JCST, SACs and the CSTC will continue to work with the Schools of Surgery to ensure that training deficiencies highlighted by the survey are dealt with effectively and that trainees are afforded appropriate opportunities during their surgical training placements.

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Appendix 1

Specialty survey - 2011/12 & 2012/13

1. Were you asked to obtain consent for procedures beyond your own operative competency?

2. Were you required to undertake routine clinical work that prevented the acquisition of new skills?

3. Did you miss any training opportunities due to providing cover for absent colleagues or filling rota gaps?

4. Did the clinical work intensity allow sufficient time for consultant teaching and training?

5. Did you receive regular feedback on your performance from your Clinical and Educational Supervisors?

6. Were you released for a centralised surgical teaching programme and were you able to attend >70%?

7. Was there enough clinical work in the unit to support the number of trainees working there?

8. 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
   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?

9. Were you able to attend emergency theatre regularly (e.g. CEPOD, trauma lists)?

10. How would you rate the quality of consultant teaching & training on ward rounds?

11. How would you rate the quality of consultant teaching & training in outpatients?

12. How would you rate the quality of consultant teaching & training in the operating theatre?

13. In outpatients did you regularly see new patients?

14. If you saw new patients, did your consultant (or a senior trainee) always review these with you after your initial consultation?

15. Would you recommend this attachment to other trainees at the same level?

Appendix 2

Core & Paediatric Surgery surveys (generic questions) - 2011/12 & 2012/13

Domain 1 – Patient safety

1. Were you adequately supervised by senior colleagues during this attachment?
2. Was there usually a post-acute consultant ward round?
3. Did patient handover at shift change take place safely and reliably?
4. Were you asked to obtain consent for procedures beyond your own operative competency?
5. Did you routinely participate in pre-operative briefings with use of the WHO checklist or equivalent?
6. Were you only asked to undertake unsupervised procedures in which you had been trained?
7. Were you given appropriate responsibility for your level of training?
8. Did you have access to relevant guidelines / protocols for both the unit and Trust?
9. Was there a culture of critically appraising systems following an adverse incident?

Domain 2 – Quality management, review and evaluation

10. Did the hours of work and on call rota conform to the New Deal and EWTD?
11. Did you normally only work your contracted hours?
12. In this post, were you involved in the management of patients presenting as an emergency on at least one day a week (on average)?
13. Were you free from elective daytime commitments when on-call for emergencies?
14. Was out of hours cover provided by cross-cover between specialties?
15. Were you required to undertake routine clinical work that prevented the acquisition of new skills?
16. Did you miss any training opportunities due to providing cover for absent colleagues or filling rota gaps?

Domain 3 – Equality, diversity and opportunity

17. Were there any personal security issues at the hospital?
18. Were you aware of how to access confidential advice and occupational health services?

Domain 5 – Delivery of approved curriculum including assessment

19. Did you have exposure to an appropriate case load and case mix?
20. Did you improve your clinical skills?
21. Did the clinical work intensity allow sufficient time for consultant teaching and training?
22. Was your AES familiar with the ISCP system and competent at using the ISCP website?
23. Did your AES undertake the required appraisal meetings (goal setting, mid-point, final)?
24. At meetings with your AES, were your portfolio and assessments reviewed?
25. Did you receive regular feedback on your performance from your Clinical and Educational Supervisors?
26. Was a local teaching programme/clinical meeting held in the department or Trust? If yes, how often did it occur?
27. How would you rate the quality of teaching you received?

Domain 6 – Support and development of trainees, trainers and local faculty

28. Did induction to the training programme by the Deanery take place when you first started?
29. Were induction and orientation sessions into the Trust satisfactory?
30. Were induction and orientation sessions into the Department satisfactory?
31. Did you feel a valued team member and have the opportunity to express your opinion in different clinical settings?
32. In this post, were you personally subjected to persistent behaviour by others that undermined your professional confidence or self esteem?

33. Did you complete at least one audit project per 12 months?
34. Did you present/teach at departmental/Trust clinical meetings/Audit/M&M meetings?
35. Were you able to attend the Multi-disciplinary team meetings (MDT)?
36. Were you released for a centralised surgical teaching programme and were you able to attend >70%?
37. Was study leave with expenses or funding available and were details for application clear?
38. Were there opportunities/encouragement for research or journal publication (e.g. case report)?

Domain 7 – Management of education and training

39. Did you know who your Training Programme Director was?
40. Did you feel that you worked in an environment where personal difficulties and concerns were taken seriously?

Domain 8 – Educational resources and capacity

41. Was there enough clinical work in the unit to support the number of trainees working there?
42. Was there easy access to educational facilities including library, IT facilities (including internet) for private study, audit and research?

Domain 9 – Outcomes

43. Did you achieve your educational goals during this placement?

SMART standards

44. 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?
    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?
45. Were you able to attend emergency theatre regularly (e.g. CEPOD, trauma lists)?
46. How would you rate the quality of consultant teaching & training on ward rounds?
47. How would you rate the quality of consultant teaching & training in outpatients?
48. How would you rate the quality of consultant teaching & training in the operating theatre?
49. In outpatients did you regularly see new patients?
50. If you saw new patients, did your consultant (or a senior trainee) always review these with you after your initial consultation?

General comments

51. Overall, did this post offer clinical and operative experience commensurate with your level of training?
52. Overall, was the teaching and education offered by the attachment satisfactory?
53. Overall, was the emergency experience offered by this attachment satisfactory?
54. Would you recommend this attachment to other trainees at the same level?
55. What was the best thing about this post?
56. What was the worst thing about this post?
57. How could this post be improved?

Appendix 3

Survey questions 2013/14

Generic Questions

1. Were you adequately supervised by senior colleagues during this attachment?
2. Was there usually a post-acute consultant ward round?
3. Did patient handover at shift change take place safely and reliably?
4. Were you asked to obtain consent for procedures beyond your own operative competency or clinical experience?
5. Did you routinely participate in pre-operative briefings with use of the WHO checklist or equivalent?
6. Were you only asked to undertake unsupervised procedures in which you had been trained?
7. Were you given appropriate responsibility for your level of training?
8. Did you have access to relevant guidelines / protocols for both the unit and hospital?
9. Was there a culture of critically appraising systems following an adverse incident?
10. Are any elective sessions combined with on call commitment such that the elective sessions are frequently compromised?
11. Were you required to undertake routine clinical work that prevented the acquisition of new skills?
12. Did you regularly miss training opportunities in order to provide cover for absent colleagues or fill rota gaps?
13. Did the clinical work intensity allow sufficient time for consultant teaching and training?
14. Did you receive regular feedback on your performance from your Clinical and Educational Supervisors?
15. In this post, were you personally subjected to persistent behaviour by others that undermined your professional confidence or self esteem?
16. Were you released for a centralised surgical teaching programme and were you able to attend >70%?
17. Was there enough clinical work in the unit to support the number of trainees working there?
18. Please indicate the number of surgical staff in this department (including yourself).
    Core Surgical Trainees:
    ST3/4:
    ST5/6:
    ST7/8:
    Staff grade/trust doctor/associate specialist or similar:
    Nationally appointed fellow:
    Other type of fellow:
    Consultants
    Other (specify):
19. 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?
20. Were you able to attend emergency theatre regularly (e.g. CEPOD, trauma lists)?
21. Did the presence of another fellow or trainee frequently compromise/compete for your learning opportunities in this post?

22. In this post, did you receive simulation and clinical skills training?
23. If yes to Question 22, was this through:
    a) A formal programme organised by the training programme?
    b) Locally organised training within the hospital?
24. Did you have access to a skills centre for practice:
    a) During normal working hours?
    b) Outside of normal working hours?
25. If yes to either part of Question 24 above, did you have a mentor to cover induction on equipment and to monitor progress?
26. How would you rate the quality of consultant teaching & training on ward rounds?
27. How would you rate the quality of consultant teaching & training in outpatients?
28. How would you rate the quality of consultant teaching & training in the operating theatre?
29. In outpatients did you regularly see new patients?
30. Did you experience any difficulties relating to the geographical location of this training post?
31. Would you recommend this attachment to other trainees at the same level?

Questions for General Surgery trainees

The following questions relate to your current placement:

Special Interest
1. What is your special interest within General Surgery?
2. Do you have an additional interest?

Hospital Facilities
3. Are the following available 24/7 with real time reporting:
    (a) CT scanning?
    (b) Interventional radiology?
4. How many days per week is there a CEPOD list?
5. How many other specialties share this list (counting Vascular Surgery as a separate specialty)?

Accommodation and IT
6. Do you have office accommodation?
7. Do you have appropriate IT access for literature searches and on line journals?

Timetable
8. How many consultant ward rounds per week do you have?
9. Do you perform a daily business round of your team's patients?
10. Do you attend at least 1 MDT per week?
11. Do you have timetabled time for research or audit projects during the working week?
12. Are you timetabled to regularly deliver teaching in this post?

Management
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?

Study Leave
14. Have you had difficulty obtaining study leave?

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. Did you receive endovascular training in this post?
16. Did you receive cross-sectional imaging training for:

(a) Diagnosis
(b) Treatment planning (e.g. EVAR, TEVAR)

Question 17 is only for trainees with a special interest in colorectal or upper gastrointestinal surgery:

17. Are you given endoscopy training in this post?

Questions for less than full-time (LTFT) trainees

The initial questions provide background information that may not have changed since you completed this questionnaire previously. Please answer anyway.

1. In which year were you appointed to this training programme?
2. In which year did you become a LTFT trainee?
3. How long did it take to obtain a LTFT training slot?
4. Do you consider that this was prolonged?
5. Does your LETB or training programme have an identified person who is responsible for LTFT training?
6. Do you believe that your training programme director understands and is sympathetic to the needs of a LTFT trainee?
7. Do you consider that training less than fulltime may affect your future career prospects?

The following questions are specific to your current placement.

8. Please indicate the proportion of time that you currently work:
9. Who determined the proportion of time that you work?
10. If this was not determined by you, are you happy with the training time that you have been given?
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 supernumerary member of your surgical team (not in a job share, not in an established but vacant training post)?
12. Have you experienced problems accessing any of the following sessions?
    Consultant ward rounds
    Outpatient clinics
    Operating lists
    MDT or equivalent
    Research / audit
13. Have you needed to work additional (non-paid) sessions to achieve specific clinical aims (e.g. endoscopy training, special interest training)?
14. Are your fixed sessions all undertaken with the same consultant? If No, how many different consultants do you work with?
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?
16. Is the level of your on call commitment sufficient to retain your on call competencies?
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

18. Please indicate anything that your LETB/current attachment has done which has enhanced the quality of your LTFT training.

19. Please indicate anything that your LETB/current attachment has done which has detracted from the quality of your LTFT training.

Questions for Academic trainees

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