

Your Training Counts

***Trainee Experiences of
Clinical Learning Environments
in Ireland 2015***



**Comhairle na nDochtúirí Leighis
Medical Council**

ACKNOWLEDGEMENTS

Your Training Counts (YTC), the annual National Trainee Experience Survey is designed, managed and analysed by Simon O'Hare, Research, Monitoring and Evaluation Manager at the Medical Council of Ireland. At the Medical Council, a team of people made different contributions to YTC and their assistance is gratefully acknowledged: Dr Paul Kavanagh for direction and support; Grainne Behan for ICT/survey development; Rasha Elnimeiry for conducting a literature review to inform what new items we could include in the 2015 survey; Michelle Navan for proof reading; and, the Communications team for guidance and launching the report. Thank you all.

Your Training Counts was overseen by the Education, Training and Professional Development Committee of the Medical Council, and the advice and support provided by its chair, Prof Colm O'Herlihy, and its members is acknowledged.

We continue to be grateful to Dr Klarke Boor and Prof Fedde Scheele (VU University Medical Centre, Amsterdam) for generously sharing their experience and expertise in the development and use of D-RECT, the Dutch Residency Educational Climate Test, which was used in *Your Training Counts*.

Recognition also goes to:

- The General Medical Council – a variety of questions from the GMC's National Trainee Experience Survey were added to *Your Training Counts* and provide a basis for comparison between the UK and Ireland;
- Trevor Lambert, University Research Lecturer/Statistician at the Medical Careers Research Group (led by Prof Michael Goldacre at the Unit of Health-Care Epidemiology, Nuffield Department of Population Health) – for sharing questions on preparedness which have been used by the Group in the UK for over a decade;
- Stephen Joseph, Professor in Psychology, Health and Social Care at the University of Nottingham - for giving us permission to replicate the Short Depression-Happiness Scale questionnaire in *Your Training Counts*; and,
- Carol Thrush, Professor in Surgery and GME, University of Arkansas for Medical Sciences - for allowing us to replicate the 'Learning Environment for Professionalism' survey in *Your Training Counts*.

The Medical Council continues to enjoy collaborating with Prof Ruairi Brugha, Dr Niamh Humphries and the Doctor Emigration Project Team at the Royal College of Surgeons in Ireland to support them with their Health Research Board funded project designed to explore medical graduate retention in Ireland (which uses data from *Your Training Counts* as a source of information).

Finally, we are grateful to the 1,035 trainees across Ireland who took part in *Your Training Counts*. Each trainee who participated took time to share information on their training experience and without their contribution *Your Training Counts* would not be a success; we are incredibly thankful to everyone who took part.

PRESIDENT'S AND VICE PRESIDENT'S FOREWORD

We are very pleased to publish the 2015 *Your Training Counts* report which marks the second year of data collection on trainees' perceptions of the clinical learning environment in Ireland.

At the Medical Council, one of our main objectives for this term is to create a supportive learning environment to enable good professional practice, and we believe there is no better way to support trainee doctors than by speaking directly to them while creating an evidence-base to enhance and improve the quality of their training environments. We want to ensure that their environments are at the highest possible standard for the benefit of both the trainees' themselves and members of the public availing of their care. We would like to thank all of the trainees who took part in this survey in which they gave their frank and honest feedback, as we feel it will genuinely bring about change for the health system as a whole.

Although it is notable that in some areas there wasn't significant change this year, it is important not to forget the positive findings which emerged from the report. Like last year, trainees rated the quality of care being provided at clinical sites very highly. This is definitely encouraging and we were delighted to see this reaffirmed this year. In saying that, it is apparent from this year's report that some trainees are still experiencing bullying and undermining within the learning environment and this is clearly something that needs to be addressed. Induction and preparedness for transitions was once again rated poorly by trainees and although some actions have been taken to try and change these aspects of the clinical environment, this has not yet been observed in our findings. We will continue to share this data and work with our partner organisations to inform policy decisions for the benefit of these trainees and, of course, their patients.

We are absolutely committed to supporting doctors to make safe and effective transitions along the continuum of medical education and on foot of specific challenges we heard from interns last year, we have been undertaking a review of the intern year. We have also published a roadmap titled ["Doctors' Education, Training and Lifelong Learning in 21st Century Ireland"](#). The aim of this roadmap is to guide the Medical Council's role in overseeing doctors' education and training across the continuum from undergraduate to retirement.

We will keep a focus in this area until we see the fruit of our work, and the work of the medical training bodies, come through in the experience of trainees. We will continue to encourage all the organisations we work with to improve the experiences for the trainees who are the future for our profession.

Freddie Wood.

Prof Freddie Wood
President



Audrey Dillon

Dr Audrey Dillon
Vice-President



CHIEF EXECUTIVE'S FOREWORD

I am pleased to be with the Medical Council to share the findings from the second-ever *Your Training Counts* report.

In any profession, trainees are the lifeblood of its future; so too with medicine. Patients want the best doctors possible and so does the profession and the Medical Council. Trainees, though, say in these surveys that some of their experiences within the training environment are not particularly positive and it is vital that we listen and act on these findings. These *Your Training Counts* surveys, of which this is just the second, rightly make the trainees the central focus as they are vital to the country's future. My intention is continue to shine a light on these issues for our trainees and hopefully in time, we will see the appropriate results.

In any highly complex system as healthcare is, it takes time for progress to show. So it is with the results of this survey. Compared to the last survey, they show little difference. I'm aware that there may be some reasons for this, including the time gap between the surveys in terms of changes trickling through, however, the slow nature of progress does not reflect the importance which the Medical Council is attaching to this issue; nor does it reflect the commitments made by some of the training bodies to the Medical Council to take action on the survey results.

I urge all the decision makers of our partner organisations in the health sector to embrace the findings of these surveys and act on them. I hope the results will be the instigators of change for the benefit of trainees here in Ireland.

The development and enhancement of medical education and training in Ireland is in all of our interests and I look forward to next year's report findings where hopefully we will begin to see improvements coming through in some of the more problematic areas.



Mr William Prasifka
Chief Executive



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ABOUT THE MEDICAL COUNCIL

Through the regulation of doctors, the Medical Council enhances patient safety in Ireland. In operation since 1979, it is an independent statutory organisation, charged with fostering and ensuring good medical practice. It ensures high standards of education, training and practice among doctors, and acts in the public interest at all times. The Medical Council is noteworthy among medical regulators worldwide in having a non-medical majority. It comprises of 13 non-medical members and 12 medical members, and has a staff of approximately 70.

The Medical Council's role focuses on four areas:



MAINTAINING THE REGISTER OF DOCTORS

The Medical Council reviews the qualifications and good standing of all doctors and makes decisions about who can enter the Register of medical practitioners. In December 2014, approximately 19,000 doctors were registered, allowing them to practise medicine in Ireland.

SAFEGUARDING EDUCATION QUALITY FOR DOCTORS

The Medical Council is responsible for setting and monitoring standards for education and training throughout the professional life of a doctor: undergraduate medical education, intern and postgraduate training and lifelong learning. It can take action to safeguard quality where standards are not met.

SETTING STANDARDS FOR DOCTORS' PRACTICE

The Medical Council is the independent body responsible for setting the standards for doctors on matters related to professional conduct and ethics. These standards are the basis to good professional practice and ensure a strong and effective patient-doctor relationship.

RESPONDING TO CONCERNS ABOUT DOCTORS

Where a patient, their family, employer, team member or any other person has a concern about a doctors' practice, the Medical Council can investigate a complaint. When necessary, it can take appropriate action following its investigation to safeguard the public and support the doctor in maintaining good practice. Through its work across these four areas, the Medical Council provides leadership to doctors in enhancing good professional practice in the interests of patient safety. You can find out more about the Medical Council at

www.medicalcouncil.ie

WHY DO WE DO “YOUR TRAINING COUNTS”?

While the Medical Council is well known for our role in responding to concerns about doctors, we are also responsible for safeguarding the quality of doctors’ education, training and lifelong learning in Ireland. In this way, it ensures high standards among doctors in the public interest.

The Medical Council ensures that medical education and training programmes, the bodies that deliver them and clinical sites where learning takes place are fit-for-purpose. It has powers to hold educational and training bodies and management of clinical sites accountable, to ensure that the medical education and training they deliver is designed and delivered to standards defined by the Medical Council.

You can read more about our standards for medical education and training here: <http://www.medicalcouncil.ie/Education/>

Your Training Counts, the Annual National Trainee Experience Survey, aims to support the continuing improvement of the quality of postgraduate medical training in Ireland.

Specifically, the objectives of *Your Training Counts* are to:

- Monitor trainee views on the quality of clinical learning environments in Ireland;
- Monitor trainee views of other aspects of postgraduate medical education and training including preparedness for transitions, retention and career plans, health and wellbeing, and trainee perceptions of safety at clinical sites;
- Inform the role of the Medical Council in safeguarding the quality of medical education and training through identifying opportunities for strengthening standards and guidance, and through focussing its quality assessment role; and,
- Inform dialogue and collaboration between all individuals and bodies involved in medical education and training in Ireland so as to continually improve the experience and outcomes of trainees in Ireland.

METHODS

So as to ensure comparability and enable us to track changes in indicators, we followed a similar method for *Your Training Counts* in 2015, as previously described. You can read more about the design and development of *Your Training Counts* [here](#) and more about the first National Trainee Experience Survey in 2014 [here](#).

This year *Your Training Counts* collected feedback from over 1,000 doctors in training. The survey was hosted online (May to July 2015) and trainees were sent reminders to participate over the 12-week survey window.

The Dutch Residency Educational Climate Test (D-RECT) was used to collect trainee experiences of clinical learning environments. D-RECT contains 50 questions which, when added together, provide a rating for clinical learning environment on a scale of 50 – 250 (with higher scores indicating higher quality learning environments). D-RECT also enables trainee views to be examined across attributes of the clinical learning environment through arranging the 50 items into 11 subscales (e.g. Feedback, Supervision, Teamwork). For each attribute, trainee views are measured on a scale of 1-5 (with higher scores indicating better trainee experiences of that attribute of clinical learning environments).

In 2014, we conducted a psychometric evaluation to establish the utility of D-RECT as an instrument to measure trainee experience of the clinical learning environment in Ireland. You can read the results of the process [here](#).

To complement D-RECT almost 60 additional questions on induction and orientation, bullying and harassment, professionalism, wellbeing, health and quality of life, and career intentions were included in *Your Training Counts*. In general, questions were repeated from 2014 so that we can track changes; some new questions were added.

In terms of statistical procedures, all those reported were conducted with an alpha level of 0.05. The dataset contained a mix of continuous and categorical variables and these were, in general, handled in those formats. The distribution of continuous data was examined and parametric or non-parametric procedures were used as appropriate. In the cases of some categorical data, aggregation of levels was undertaken where this enabled easier communication of findings (for example, in some analysis, 5-point Likert scales of agreement were re-coded into 2 or 3 level categories). Hypothesis testing was conducted to examine relationships between variables. Bivariate correlation tests were conducted to examine relationships between continuous variables, with Pearson correlation coefficients being reported. When examining relationships between categorical variables and continuous variables, independent t-Tests and one-way ANOVAs were used. Appropriate equality of variance and post-hoc tests were applied to describe how variables interacted with each other. Chi-squared tests were used to examine relationships between categorical/ordinal variables. For 2x2 tables Continuity Correction values were reported, for larger tables, Pearson Chi-Square values were reported. Where hypothesis testing was conducted, the report contains reference to the type of test, number of respondents, the degree of freedom, the test statistic and the p-value.

Some comparison with 2014 data is included in this report – using the appropriate tests as described above to show if any year on year change was statistically significant or not.

RESPONSE RATE FOR YOUR TRAINING COUNTS 2015

Not all questions in YTC 2015 were answered by all participants. At most 1035 doctor took part, representing a response rate of 37% (resulting in a margin of error of $\pm 2\%$ for national level statistics).

Trainee population demographics were well-represented in the sample (as per **Table 1**), meaning we can be quite sure that results can be generalised to the national level.

Table 1: About the trainee population and respondents to YTC 2015

Characteristic	Trainee population 2015	YTC respondents 2015
Age (mean)	30.1 years	30.3 years
Males	45%	44%
Females	55%	56%
Graduates of Irish medical schools	85%	83%
Graduates of other medical schools	15%	17%
Interns	28%	26%
Trainee Specialists	72%	74%

SUMMARY OF FINDINGS FROM YTC 2015

This report presents the second year of findings from *Your Training Counts*, the Medical Council's annual trainee experience survey. A comparison of key indicators between 2014 and 2015 is shown.

TRACKING VIEWS AND MONITORING PROGRESS

Having established a baseline in 2014, *Your Training Counts* now provides a robust and comprehensive framework for tracking progress and measuring the impact of changes in medical education and training in Ireland. It would be too early to expect dramatic change in findings between 2014 and 2015. However, it is positive to note that the position described in 2014 has not deteriorated and some encouraging trends are discernible. Trainees find that teamwork and peer collaboration – essential elements of safe patient care – are working well. The contribution of clinical teachers remains positively recognised. Tracking and publicly reporting indicators through *Your Training Counts* will support change.

WIDE VARIATION IN LEARNING AT CLINICAL SITES MUST BE REDUCED

It is unsurprising to note that the wide variation in trainee experience of learning at clinical sites has not reduced, but it is disappointing to find that this has widened from 2014 to 2015. Educational governance at clinical sites must be prioritised.

DEFENSIBLE GAPS IN TRAINEE INDUCTION AND ORIENTATION?

We first highlighted gaps in trainee induction and orientation in 2014. Given the implications for patient care and for trainee learning experience, these gaps must be addressed by clinical sites and training organisations. Is it defensible that 2-in-10 trainees report no induction and 1-in-10 trainees report missing out on induction because of competing demands on their time?

MORE SUPPORT FOR SAFER AND SMOOTHER TRANSITIONS

Transitions in doctors' professional development demand particular attention. We have already begun to tackle some of the issues reported to us by interns in 2014. We will expect our work on Entrustable Professional Activities to be taken forward through collaboration between the Medical Schools, Intern Training Networks and the Health Service Executive.

RESPECTING TRAINEES AS VALUED TEAM MEMBERS

We opened debate on the difficult subject of bullying and undermining of trainees in 2014. Subsequent reports on trainee health and wellbeing and on migration intentions have confirmed the need to take this issue seriously. We've been encouraged by the sensitive and constructive discussion that has followed. This year we have collected further information to better inform everyone's understanding of this complex issue. The leadership and commitment shown to ensure trainees are respected as valued team members will need to translate into measurable improvement in reported experience.

GOOD PLACES TO LEARN, TO WORK AND TO CARE

Some clinical sites are better places for trainees to work and learn than others. While initiatives are underway, more can be done to bring about measurable improvements in trainee experience. These improvements will benefit patient care today and into the future.

KEY INDICATORS

Indicator (scoring range) ¹		2014	2015
THE CLINICAL LEARNING ENVIRONMENT			
1	Overall experience of clinical learning environments (50-250)	170.8	172.4
2	Feedback (1-5)	2.64	2.70
3	Coaching and assessment (1-5)	3.22	3.23
4	Professional relations between consultants (1-5)	3.23	3.25
5	Role of the educational supervisor (1-5)	3.26	3.29
6	Role of Patient-handover (1-5)	3.29	3.36
7	Work being adapted to trainees' competence (1-5)	3.40	3.42
8	Formal education (1-5)	3.46	3.44
9	Supervision (1-5)	3.64	3.66
10	Consultant's role (1-5)	3.78	3.77
11	Teamwork (1-5)	3.83	3.90
12	Peer collaboration (1-5)	3.87	3.95
13	% of trainees that would recommend their site as a place to train	-	62%
BULLYING AND UNDERMINING BEHAVIOURS			
14	% of trainees who were bullied in post	34%	35%
15	% of trainees who were undermined by a Consultant or GP in post	44%	46%
INDUCTION AND ORIENTATION			
16	% of trainees who received all the information they needed about their workplace through induction to their post	53%	50%
17	% of trainees who had their role and responsibilities explained to them through induction to their post	66%	66%
18	% of trainees who sat down with their educational supervisor and discussed educational objectives for their post	52%	51%
PREPAREDNESS FOR TRANSITIONS			
19	% interns who felt previous medical education and training prepared them well for intern year	48%	53%
20	% doctors completing higher specialist training who felt prepared for their next role	87%	83%
TRAINEE SAFETY			
21	% of all trainees who felt physically safe at their clinical site	86%	83%
TRAINEE PERCEPTION OF THE QUALITY OF CARE			
22	% of trainees that rated the quality of care provided to patients in their site as "good or very good"	85%	86%
23	% of trainees who agree they are satisfied with the care they provide patients in their post	71%	70%
24	% of trainees that would recommend their site as a place to receive care	-	70%

¹ All scales and subscales are scored positively, with higher ratings meaning better trainee experiences

TRAINEE EXPERIENCE OF CLINICAL LEARNING ENVIRONMENTS IN IRELAND 2015

Key Points:

- The national mean D-RECT score, which measures the quality of trainees' learning environments, across all trainees in Ireland was 172.4, a slight (but not statistically significant) increase from ratings given in 2014;
- Despite this improvement, there remains a sizeable gap between what experts feel trainees should be experiencing in their learning environments and what trainees are reporting as their experience;
- There is evidence that the wide variation in trainees' experience of clinical learning environments noted in *Your Training Counts* 2014, increased in 2015;
- Two attributes of clinical learning environments, "Peer collaboration" and "Teamwork", were rated significantly higher by trainees in 2015 than in 2014;
- No attribute of clinical learning environments were rated significantly lower by trainees in 2015 than in 2014;
- Trainees who took direct entry routes to medical school rated their learning environments significantly more highly than graduate entry trainees. Trainees who gained their basic medical qualification outside Ireland rated learning environments significantly more highly than graduates of Irish medical schools – as in 2014;
- Intern trainees rated the quality of learning environments significantly lower than all other trainees;
- Age was associated with views on the quality of learning environments, with trainees aged 20-24 reporting significantly lower quality experiences than other trainees; and,
- Trainees in hospitals (larger and smaller) rated their learning environments as significantly lower in quality than trainees in GP practices and Mental Health Services.

VIEWS ON CLINICAL LEARNING ENVIRONMENTS

The Dutch Residency Educational Climate Test (D-RECT) was used to collect trainees' experiences of clinical learning environments. D-RECT contains 50 questions which, when added together, provide a rating for clinical learning environment on a scale of 50 – 250 (with higher scores indicating perceived higher quality learning environments).

In 2015, the national mean D-RECT score for all trainees was 172.4 (95% CI 169.9 - 174.8); representing a small, but not statistically significant, increase from the mean D-RECT score for 2014 (170.8). The standard deviation for scores increased from 31.97 in 2014 to 35.32 in 2015. This spread of scores, illustrated in **Figure 1**, indicates wide variation in trainee experiences of clinical learning environments in Ireland.

Figure 1: Summary of trainee views of the clinical learning environment

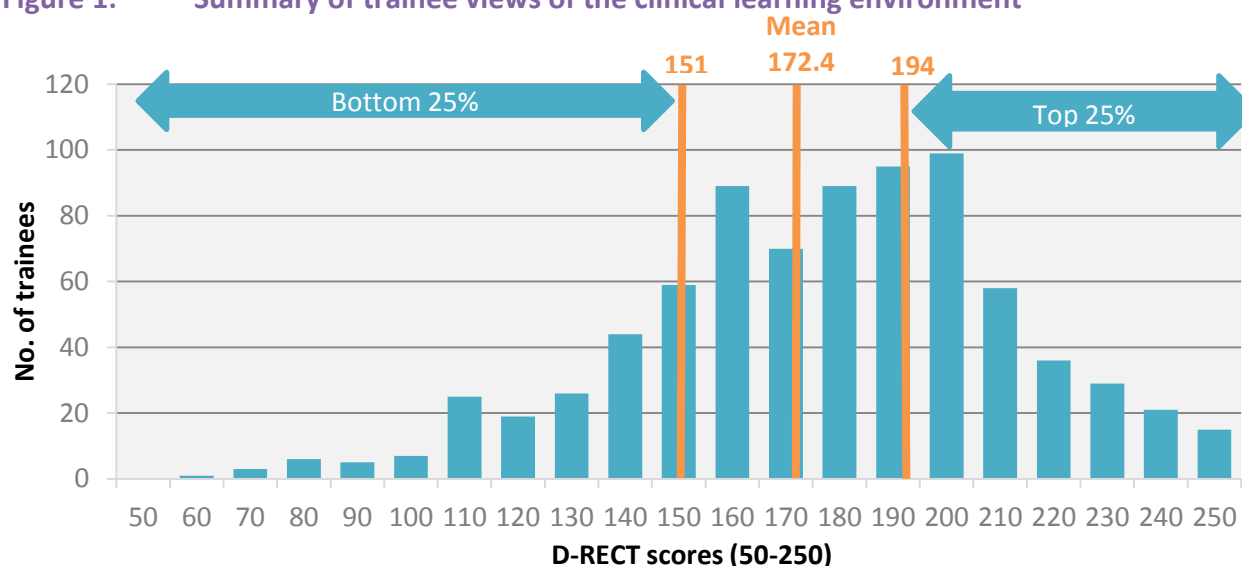
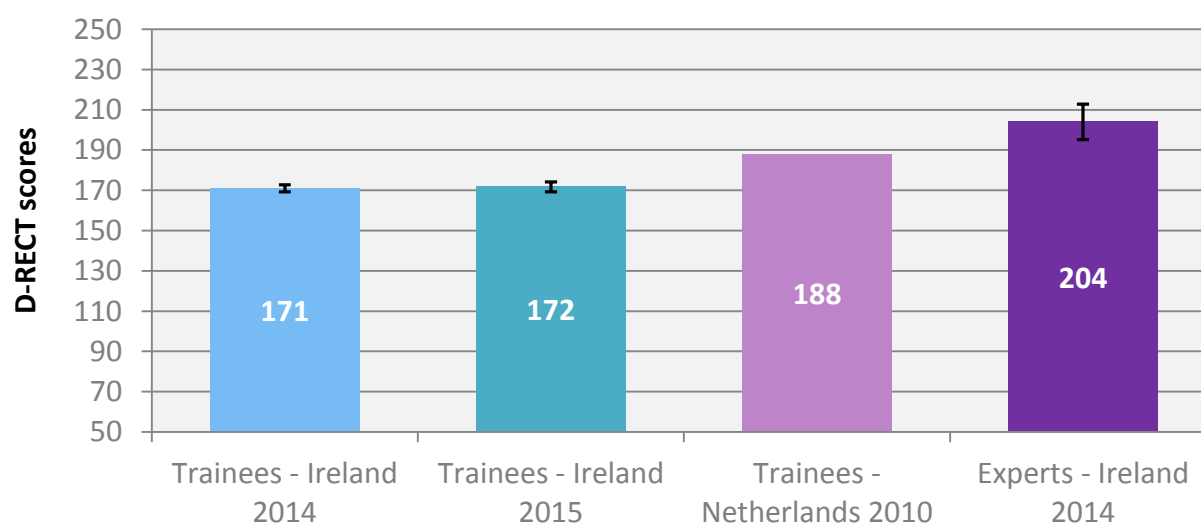


Figure 2, below, provides benchmarking information for D-RECT scores. Despite the small increase in the mean D-RECT score for trainees in Ireland in 2015, there is still some distance between the trainee experience and that envisioned by experts (as what trainees should be experiencing) in 2014.

Figure 2: Benchmarking D-RECT scores



STRENGTHS AND WEAKNESSES OF CLINICAL LEARNING ENVIRONMENTS

The D-RECT instrument enables trainee views of the overall clinical learning environment to be examined across 11 specific attributes. Attribute scores range from 1 to 5; with higher scores indicating more positive views of that component of clinical learning environments.

Table 2 summarises how trainees rated each of the 11 subscales in 2015, compares that rating with data from 2014, and highlights where any change in the last year was statistically significant.

Table 2: D-RECT subscale scores

Attribute of the learning environment	2015 scores	2014 scores	Change in scores	Statistically significant change?
Feedback	2.70	2.64	0.06	No
Coaching and assessment	3.23	3.22	0.01	No
Professional relations between consultants	3.25	3.23	0.02	No
Role of the educational supervisor	3.29	3.26	0.03	No
Role of Patient-handover	3.36	3.29	0.07	No
Work being adapted to trainees' competence	3.42	3.40	0.01	No
Formal education	3.44	3.46	-0.02	No
Supervision	3.66	3.64	0.02	No
Consultant's role	3.77	3.78	-0.01	No
Teamwork	3.90	3.83	0.07	Yes - Improved
Peer collaboration	3.95	3.87	0.08	Yes - Improved

There was no change in the order of how trainees ranked attributes between 2014 and 2015; e.g. 'Feedback' was the lowest, and 'Peer collaboration' the highest, rated attribute in both years.

Two attributes, 'Teamwork' and 'Peer collaboration', showed statistically significant (albeit slight) improvement in 2015 (although both were already the two most highly regarded attributes of learning environments). Although there was a slight lowering of trainee scores regarding the attributes 'Formal education' and 'Consultant's role', no attribute was rated significantly lower in 2015 than in 2014.

VARIATIONS IN TRAINEE PERCEPTIONS OF LEARNING ENVIRONMENTS

D-RECT scores were analysed by different doctor characteristics (e.g. age, gender) and contextual factors (e.g. type of site, stage of training) to see if these factors were significantly associated with trainees' experiences of learning environments. There were significant associations between views on the quality of learning environments and trainees' region of qualification, entry routes to medical school, age, stage of training and the type of site in which trainees were learning. These significant links were also present in 2014 data.

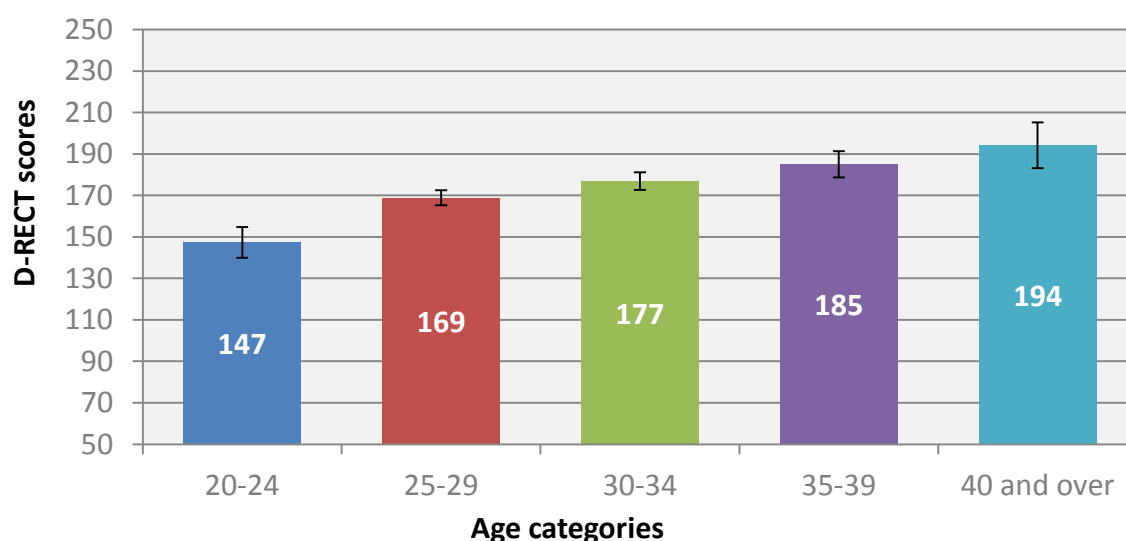
Did views vary by gender?

The mean D-RECT score for female trainees was 173.5 (95% CI 170.2-176.9) and for male trainees 171.0 (95% CI 167.4 - 174.7); there was not a significant difference in D-RECT scores between these groups ($t(792)=0.997$, $p = .319$).

Did views vary by age?

There were significant differences in how trainees of different ages rated their learning environments. In general, the older the trainee the higher they valued their learning environment (as illustrated in **Figure 3**). Trainees in the 20-24 age category reported significantly lower D-RECT scores than all other trainees ($F(4,789) = 22.36$, $p < 0.001$).

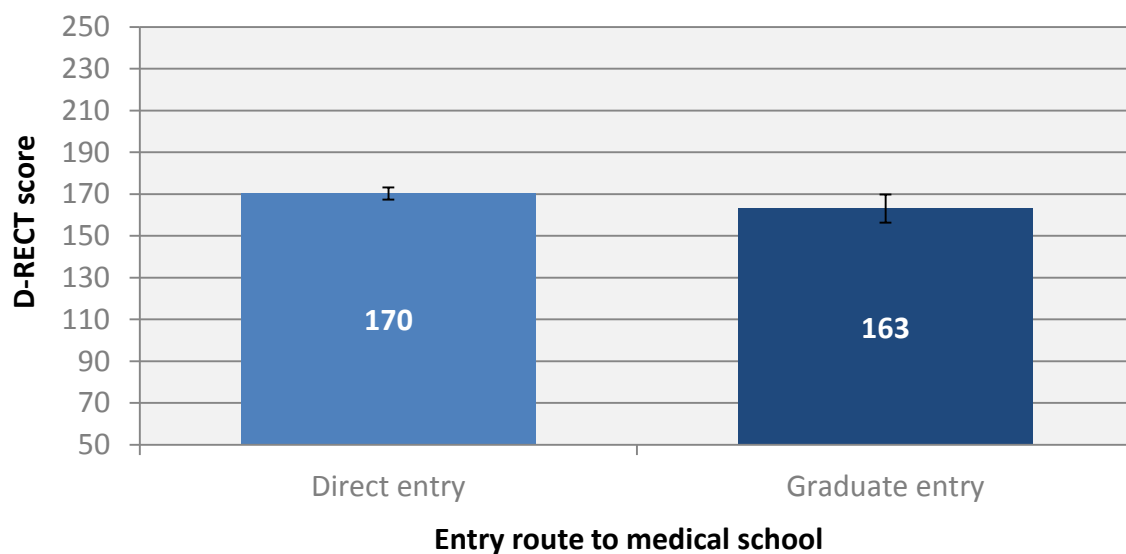
Figure 3: Trainee views on clinical learning environments, by age



Did views vary by entry routes to medical school?

There was a small, statistically significant, difference in how trainees who entered medical school through different routes rated their learning environments. Trainees who took direct entry routes into medical school rated their learning environments significantly higher ($M=170$) than graduate entry trainees ($M=163$), ($t(662)=1.967$, $p = .05$).

Figure 4: Trainee views on clinical learning environments, by entry route to medical school

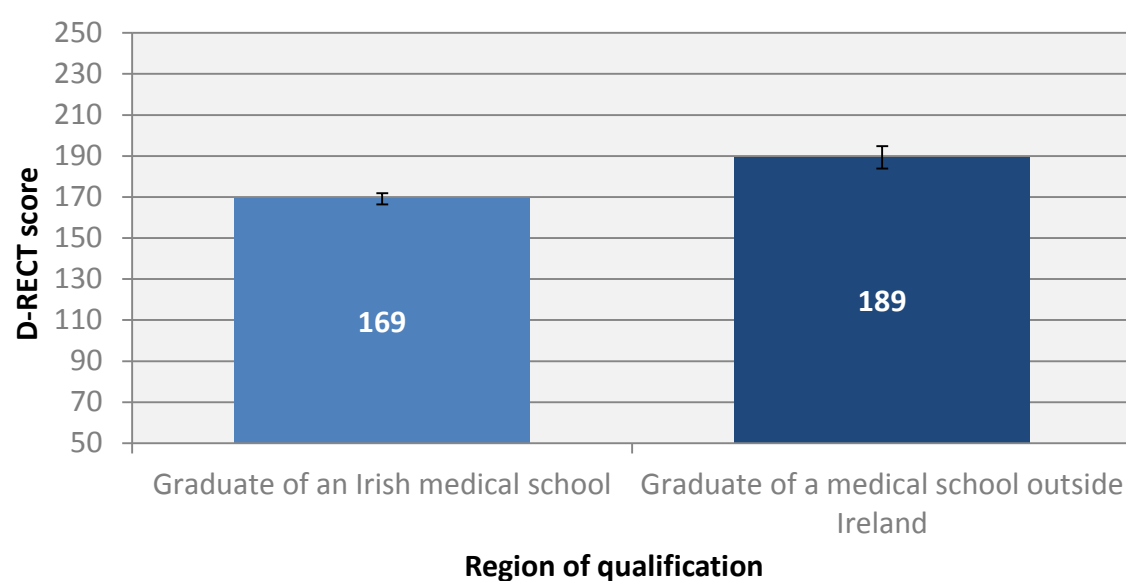


To explore whether the differences in total D-RECT scores from trainees who took different routes to medical school was, in fact, due to age differences between these groups, a stratified analysis was conducted. Lower D-RECT scores were observed among trainees who were graduate entry medical students (M=155) compared to direct entry trainees (M=180) in the 30-34 year age group ($t(191)=4.442$, $p<.001$).

Did views vary by where trainees gained their Basic Medical Qualification (BMQ)?

There was a statistically significant difference in D-RECT ratings between trainees who graduated in an Irish medical school and trainees who graduated outside Ireland. Graduates of Irish medical schools gave significantly lower D-RECT scores (M=169) than trainees who qualified elsewhere (M=189), $t(193.6)=6.040$, $p<.001$.

Figure 5: Trainee views of clinical learning environments, by region of qualification

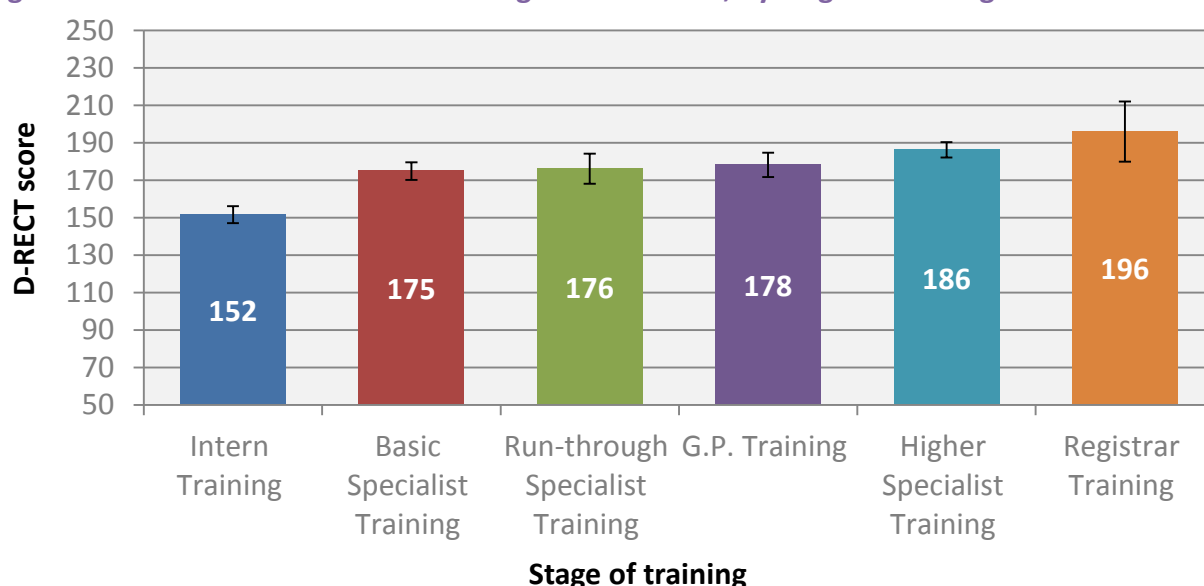


Significantly lower D-RECT scores were observed among graduates of Irish medical schools (compared to graduates of other medical schools) in both the 25-29 and 30-34 age groups.

Did views vary by trainees' stage of training?

There were statistically significant differences in D-RECT scores from trainees at different stages of training. Trainees on intern programmes gave significantly lower D-RECT scores than all other trainees, ($F(5,785) = 27.84, p < 0.001$).

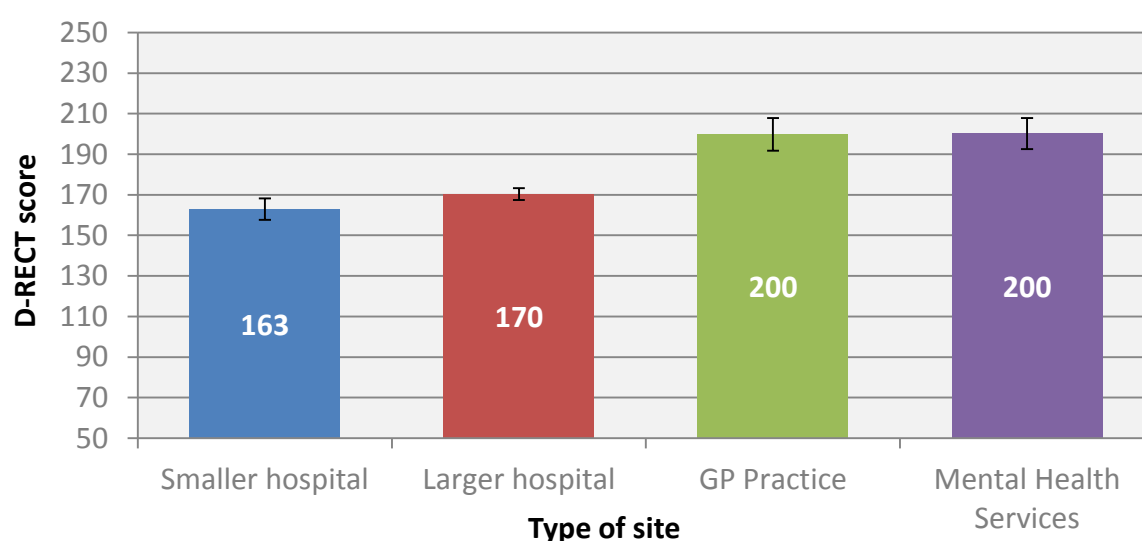
Figure 6: Trainee views of clinical learning environments, by stage of training



Did views vary by the type of site in which trainees were located?

There were significant differences in D-RECT scores from trainees located in different types of learning environments. Trainees in smaller ($M=163$) and larger hospitals ($M=170$) reported significantly lower D-RECT scores than trainees in GP practices ($M=200$) and Mental Health Services ($M=200$), ($F(3,780) = 26.91, p < 0.001$).

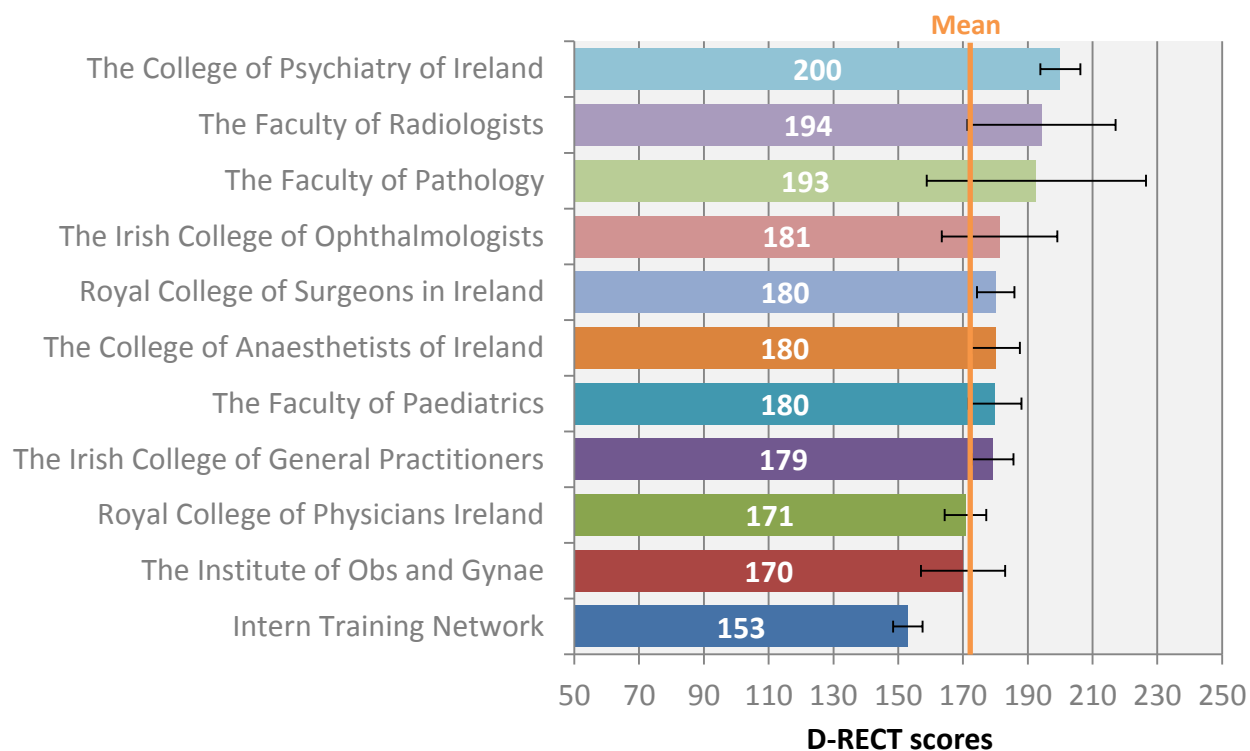
Figure 7: Trainee views of clinical learning environments, by type of site



Did views vary by trainees' overseeing training body?

The variations in how trainees, associated with different training bodies, rated their learning environments is summarised below.

Figure 8: Trainee perceptions of learning environments, by overseeing training body



Did views vary by the speciality of the post in which trainees were training?

The variations in how specialist trainees and interns, in different speciality posts, rated their learning environments are summarised below.

Figure 9: Trainee perceptions of learning environments, by specialty of post – specialist trainees

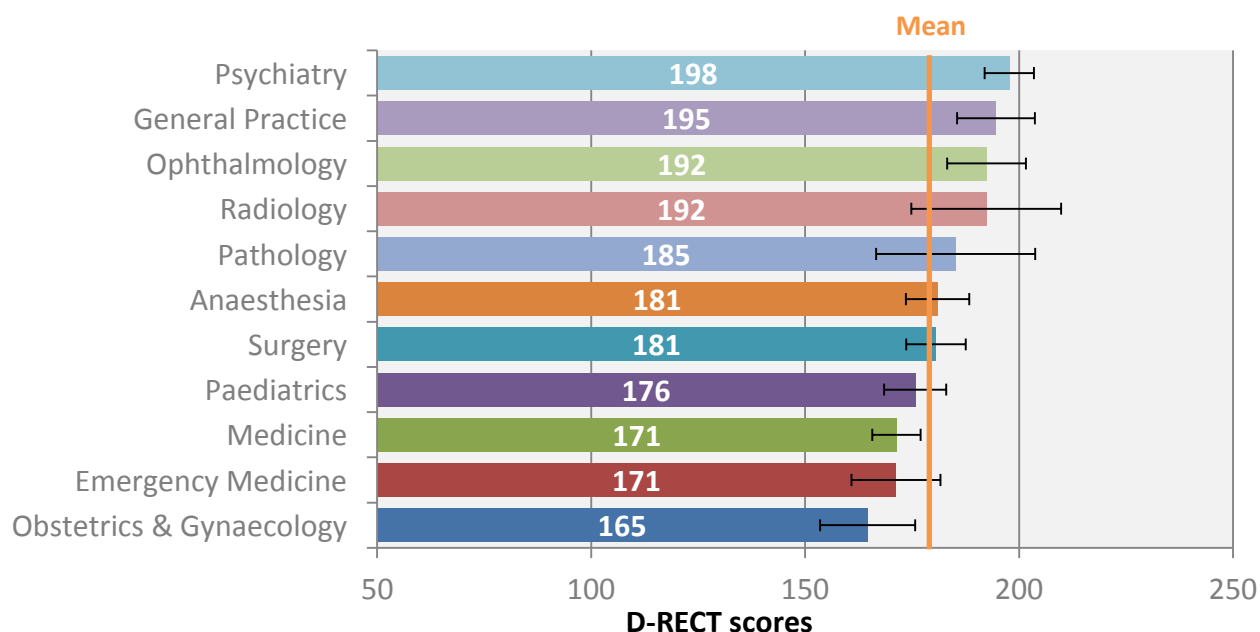
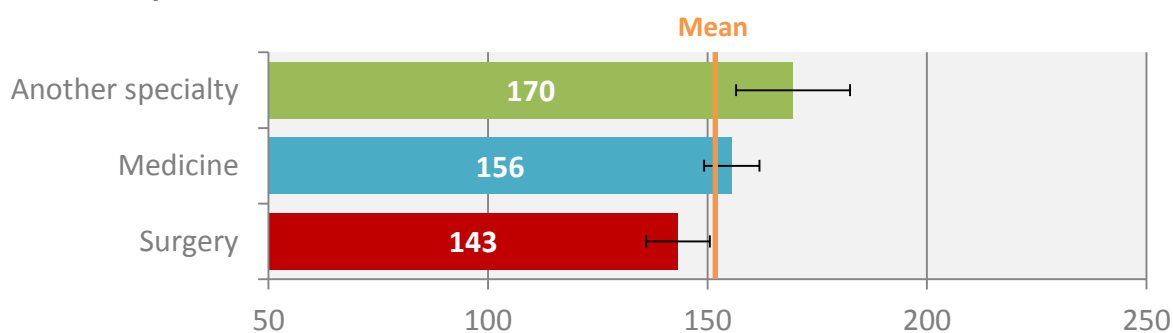


Figure 10: Trainee perceptions of learning environments, by specialty of post – interns only

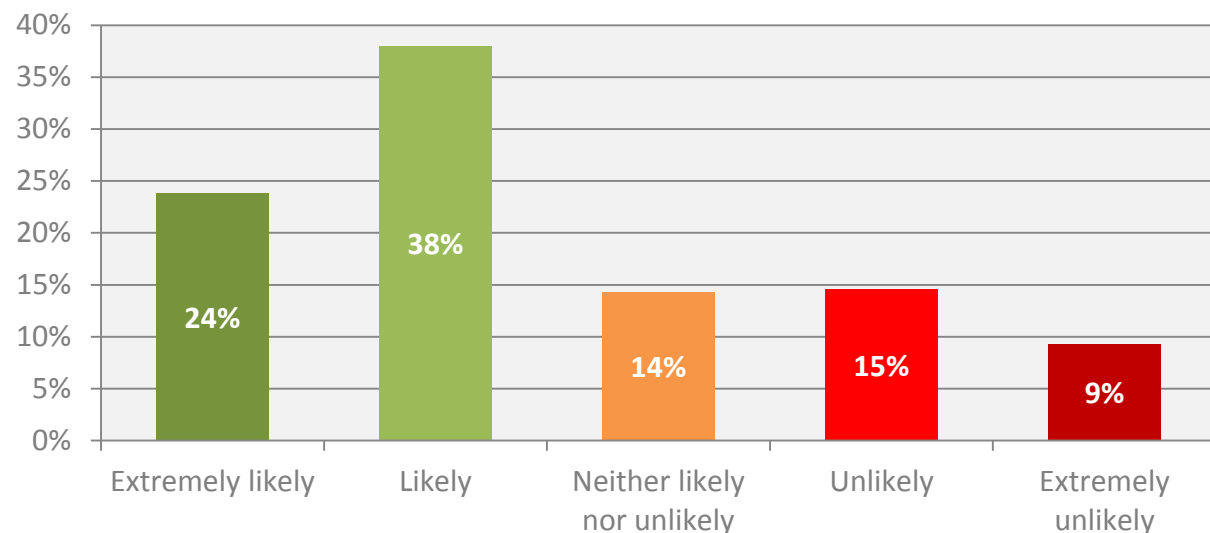


Interns in training posts that were not surgery or medicine specific gave significantly higher D-RECT scores ($M=170$) than trainees in surgery posts ($M=143$), ($F(2,217) = 7.38$, $p = 0.001$)².

² Due to the small numbers of intern trainees in specialty posts other than medicine or surgery, responses from these trainees were grouped together into one category – “Another specialty”.

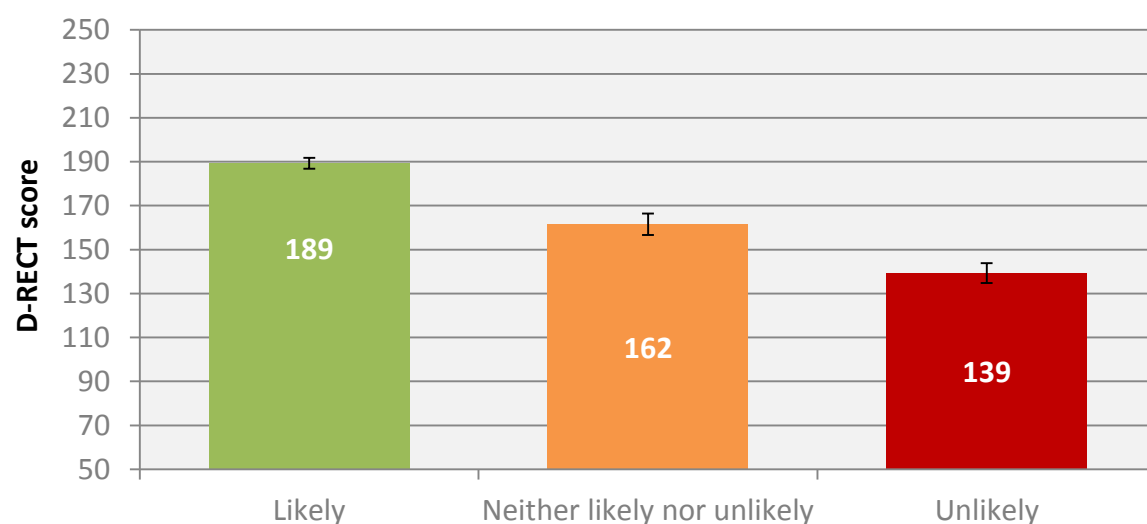
We also asked trainees to tell us how likely they were to recommend their site to friends and family as a place to train. 62% of trainees were likely, or extremely likely, to recommend this site as a place to train, as per **Figure 11**.

Figure 11: “How likely are you to recommend your training site to friends and family as a place to train?”- All trainees



Responses were significantly associated with D-RECT scores, as per **Figure 12**. Trainees who were likely to recommend their site gave significantly higher D-RECT scores ($M=189$) than trainees who were neutral ($M=162$) or unlikely to recommend their site ($M=139$), ($F(2,742) = 221.44$, $p < 0.001$).

Figure 12: Trainee likelihood of recommending site to friends or family as a place to train, by D-RECT scores³



³ We have included this item on recommending a site as a place to train as it is a useful global indicator, but it lacks the construct validity and diagnostic value of D-RECT.

INDUCTION TO TRAINING POSTS

KEY POINTS

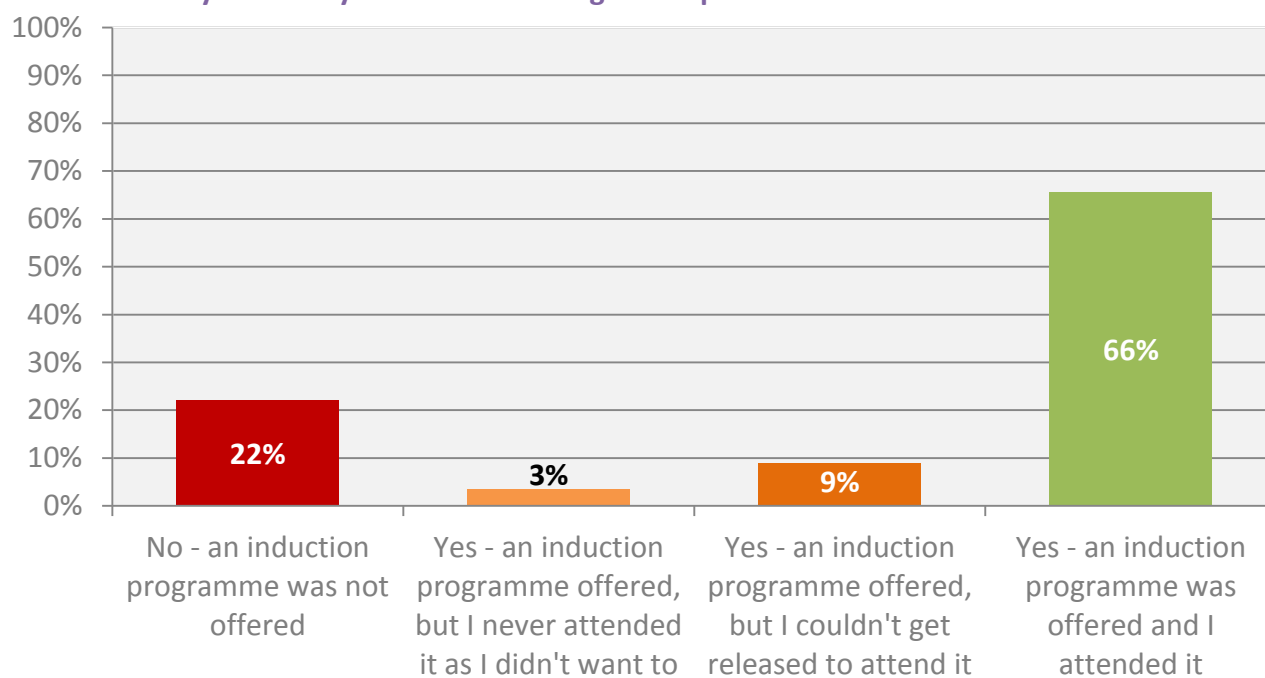
- 3 different aspects of induction were explored with trainees. Data shows that trainee experiences of induction had not improved within the last year and fall short of what trainees in the UK report as their experiences;
- 2 in 3 trainees attended an induction programme when they began working in their post;
- 22% of all trainees said they were not offered a programme of induction when they began working in their post and a further 9% said that, although they were offered a programme, they could not get released to attend it;
- 2015's results confirm the statistically significant link, made in 2014, between trainees' perceptions of the quality of learning environments and their experiences of induction – trainees that attended induction programmes considered their learning environments to be significantly higher in quality than trainees who did not;
- Trainees on intern training programmes were significantly less likely to say they received all the information they needed about their workplace when starting their post (35%) than HST trainees (63%); and,
- Trainees in larger hospitals (64%) and smaller hospitals (58%) were less significantly less likely to say they had their role and responsibilities explained to them at the start of their post than trainees in GP practices (86%) or Mental Health Services (79%).

TRAINEE VIEWS ON INDUCTION TO CLINICAL LEARNING ENVIRONMENTS

Postgraduate training is workplace-based. For trainees the clinical site is both a place of learning and a place of work. It is fundamental for every trainee – in their dual and equally important roles as learner and worker – that they experience comprehensive and effective induction and orientation. Each role needs to be addressed through formal, structured induction so as to support trainees to fulfil their potential both in terms of achieving defined learning outcomes and in contributing to safe, good quality patient care.

We asked trainees about their experience of induction through a number of items in *Your Training Counts*. The following describes their experiences.

Figure 13: Trainee experience of induction: Was a programme of induction offered to you when you started working in this post?

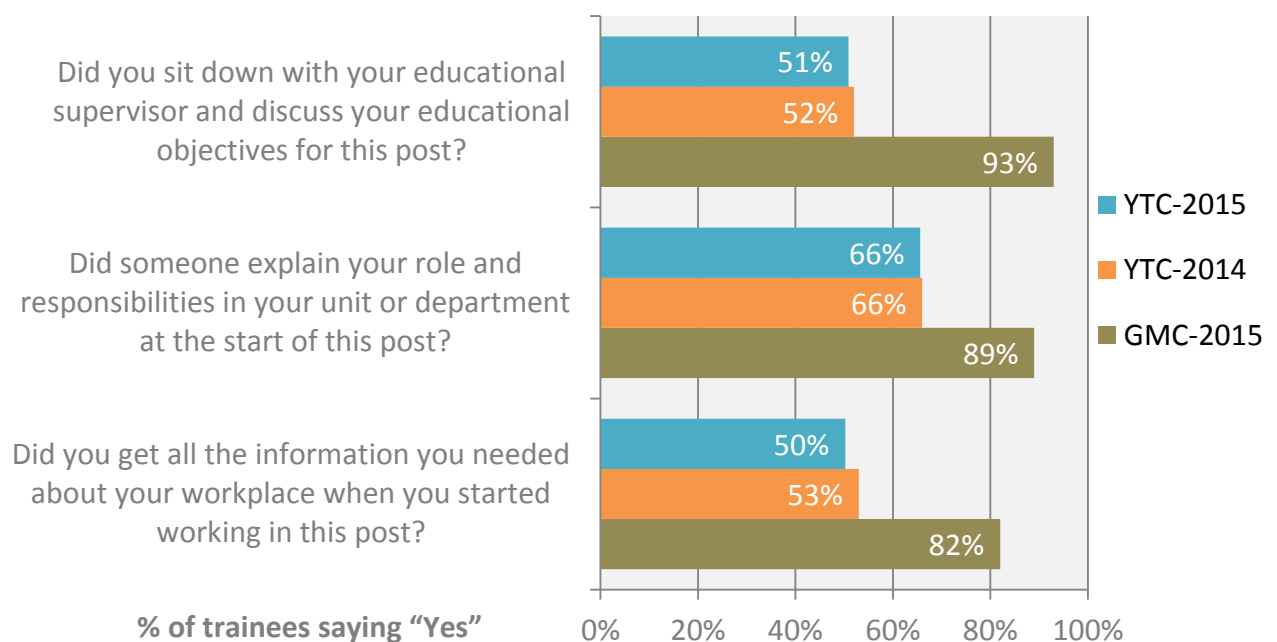


2 in 3 trainees attended an induction programme when they began working in their post. 22% of trainees said they were not offered a programme of induction and a further 9% said that, although they were offered a programme, they could not get released to attend it.

3 different aspects of induction were explored with trainees. Data from those responses, responses given by trainees in *Your Training Counts* in 2014, and comparable information from the UK (as collected by the GMC in their National Trainee Experience Survey 2015) is presented in **Figure 14**.

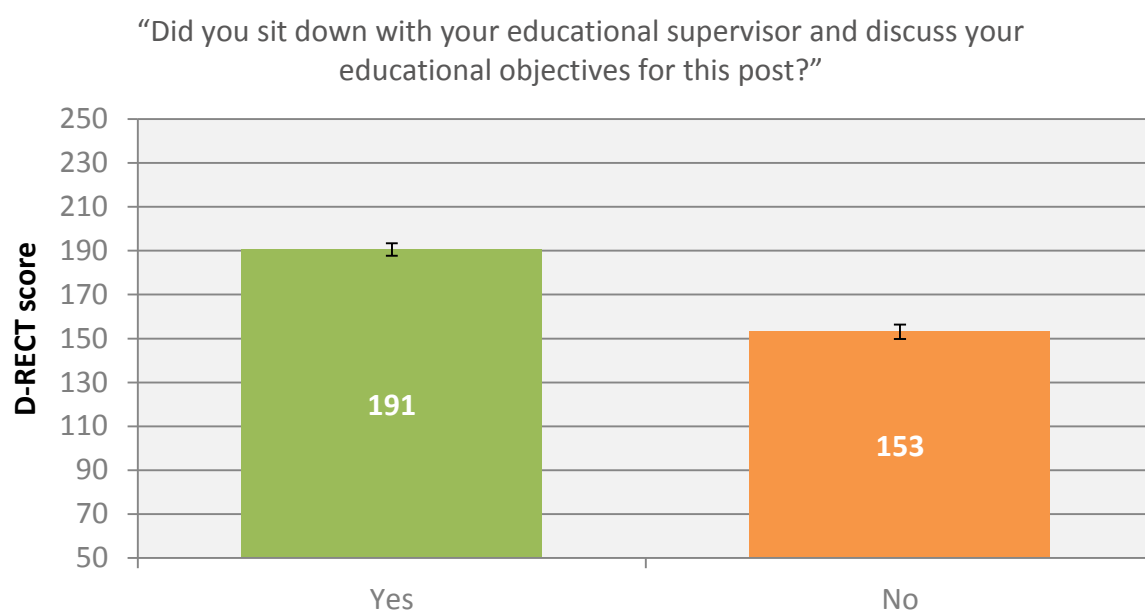
Data shows that the experiences of induction, for trainees in Ireland, did not improve within the last year and fall short of what trainees in the UK report as their experience.

Figure 14: Trainee views of specific aspects of induction to the clinical environment



Data from *Your Training Counts* 2015 confirms the statistically significant link, made in 2014, between trainee experience of induction and their perceptions of the quality of learning environments. Trainees who discussed educational objectives for their post with their educational supervisor gave significantly higher D-RECT scores ($M=191$) than trainees who did not have those discussions, ($M=153$), $t(736.3)=16.93$, $p<.001$.

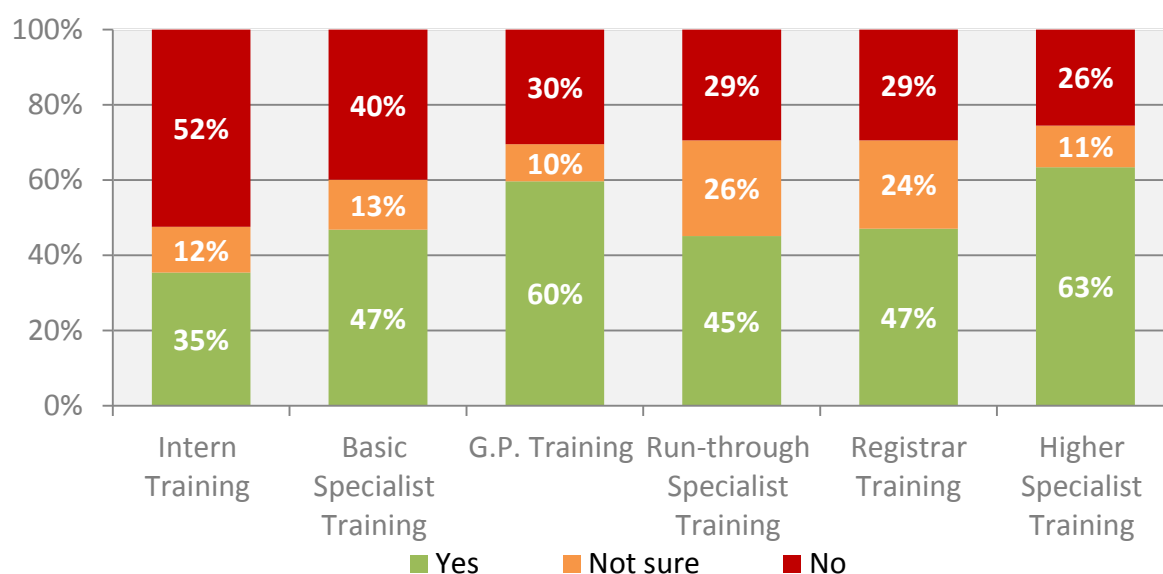
Figure 15: Trainee views of the clinical learning environment, comparison by reported experience of discussing educational objectives with an educational supervisor



Did views vary by stage of training?

2015 data confirms the significant, and moderately strong, association between trainees' experiences of induction and their stage of training. Trainees on intern training programmes were significantly less likely to say they received all the information they needed about their workplace when starting their post (35%) than HST trainees (63%), $\chi^2(10, N = 944) = 60.97, p < 0.001$.

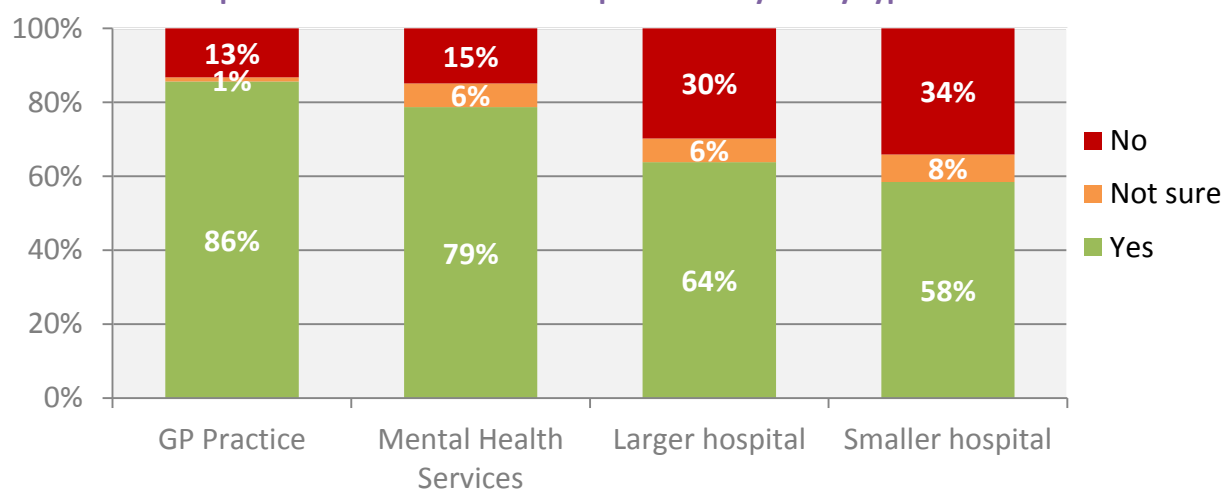
Figure 16: "Did you get all the information you needed about your workplace when you started working in this post?" Analysed by stage of training



Did views vary by type of site?

Trainees in larger hospitals (64%) and smaller hospitals (58%) were significantly less likely than trainees in GP practices (86%) or mental health services (79%) to have had their role and responsibilities explained to them at the start of their post ($\chi^2(6, N = 942) = 26.15, p < 0.001$). This is illustrated in Figure 17.

Figure 17: "Did someone explain your role and responsibilities in your unit or department at the start of this post?" Analysed by type of clinical site



TRAINEE PREPAREDNESS

KEY POINTS

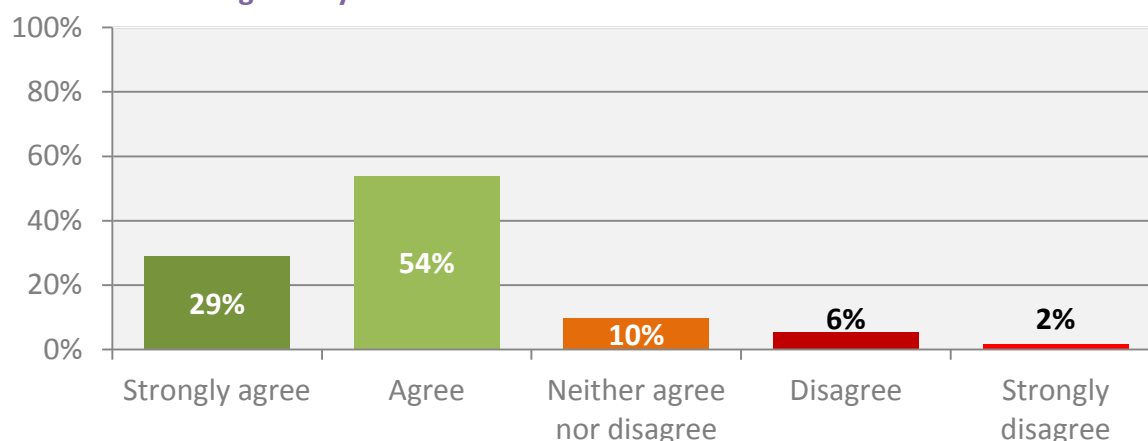
- The majority (83%) of trainees who were about to complete specialist training agreed they were well-prepared for the next stage of their career;
- A small minority (8%) of trainees who were about to complete specialist training disagreed that they felt ready for the next stage of their career;
- 53% of interns agreed that their previous medical education and training had prepared them well for the jobs they had undertaken as an intern – up from 48% in 2014;
- Trainees who felt well-prepared for the intern year rated their learning environments significantly more highly than trainee who did not feel the same;
- 64% of interns who did not feel well-prepared for the intern year said their lack of preparedness was a ‘medium-sized’ or a ‘serious’ problem;
- Interns who reported their under preparedness as a serious problem had significantly poorer views of the clinical learning environment than other intern trainees;
- While a high proportion of interns agreed that they were well prepared in terms of having the clinical knowledge (78%) and interpersonal skills (71%) they needed for the intern year, a minority of interns agreed that they were well prepared for the clinical procedures (43%), physical, emotional and mental demands (28%) and administrative tasks (18%) of the intern year.

FOR TRAINEES ABOUT TO COMPLETE SPECIALIST TRAINING

Trainees who were due to shortly complete specialist training were asked how well prepared they felt to take up their next role. Most trainees agreed or strongly agreed (83%) that specialist training had prepared them well for the next stage of their career; however, a small minority disagreed or strongly disagreed (8%). In 2014, 87% of trainees completing specialist training felt well-prepared for their next role.

The views of trainees completing specialist training on preparedness are shown in **Figure 18**.

Figure 18: “My experience of specialist training has prepared me well for the next stage in my career”

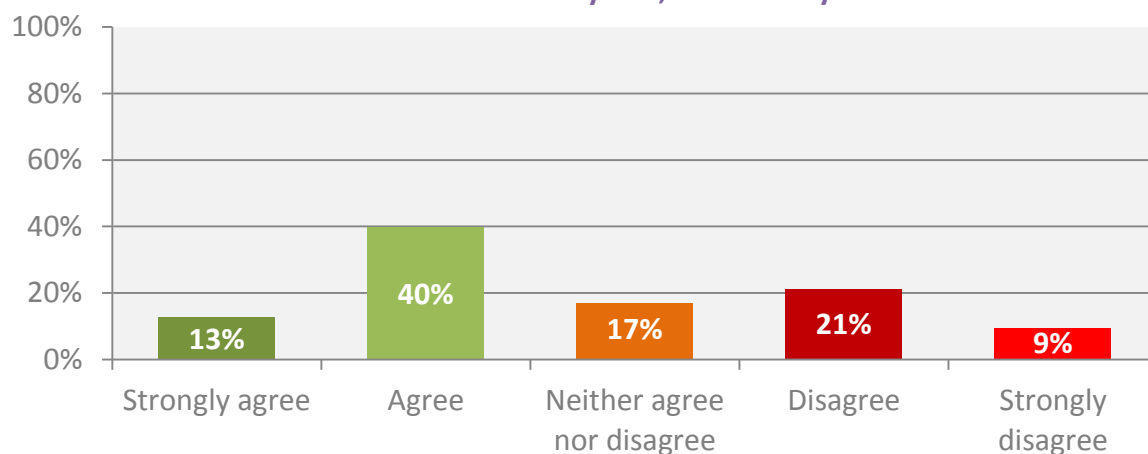


Specialist trainees' feelings about being prepared for the next stage in their career varied significantly between different supervising bodies. While the average agreement about feeling prepared for the next stage in careers was 83%, in fact there was variation from 100% to 73%. The numbers of respondents to this question remains small. However, it will be possible to group responses over a number of years so we can examine and report on this variation in greater detail.

INTERN PREPAREDNESS

Interns were invited to share views regarding how well, in retrospect, they felt their education and training at medical school had prepared for the jobs they undertook during intern training.

Figure 19: “My previous medical education and training prepared me well for the jobs I have undertaken so far this year”, interns only

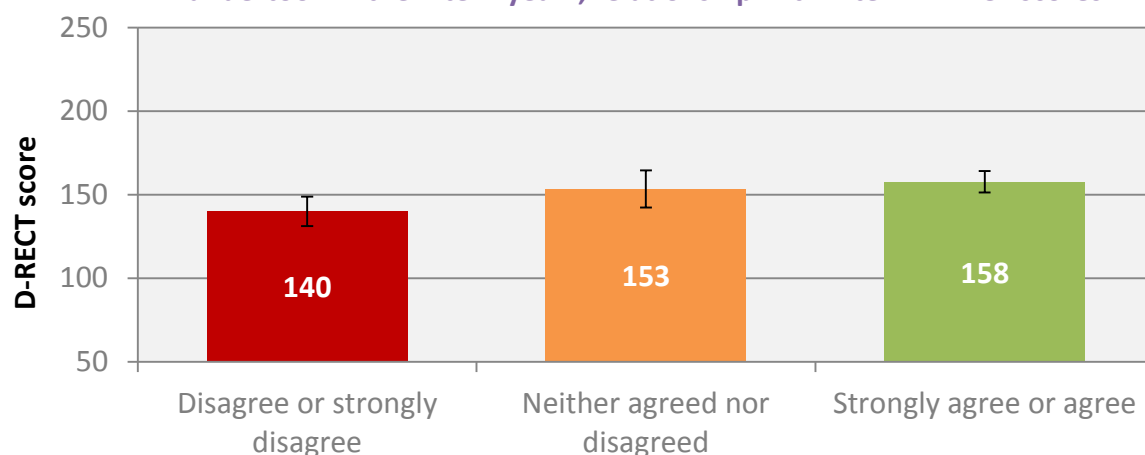


Overall, 53% of interns agreed that their previous medical education and training prepared them well for the jobs they had undertaken as an intern; however, 30% did not feel well prepared. In 2014, 48% of interns agreed that their previous medical education and training prepared them well for intern training.

A number of different trainee and contextual characteristics were examined to see if they had significant relationships with trainee views on preparedness for intern training. There were no significant associations with how prepared trainees felt for the intern year and, gender, age, routes to medical school, or the medical schools from which interns graduated.

Interns' views on preparedness were examined with their views on the quality of learning environments.

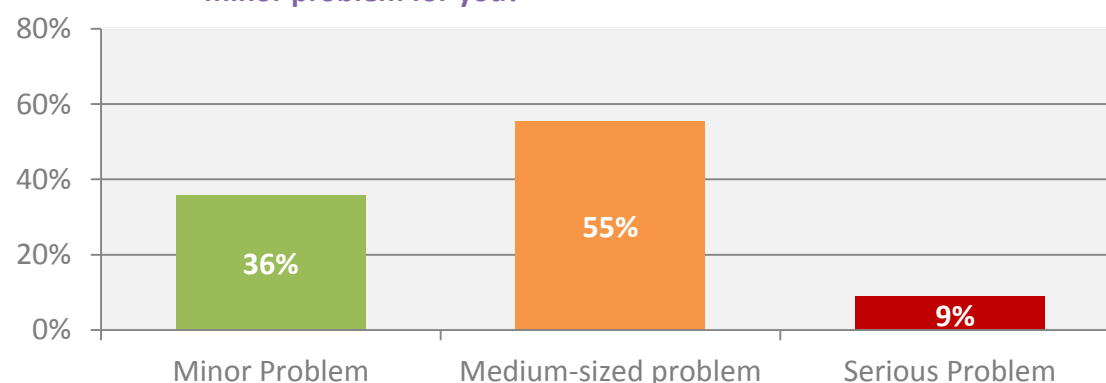
Figure 20: “My previous medical education and training prepared me well for the jobs I undertook in the intern year”, relationship with intern D-RECT scores



There was a statistically significant difference in trainees' experience of learning environments between trainees who felt well prepared for the intern year ($M=158$) and those that did not ($M=140$), ($F(2,201) = 5.523$, $p = 0.005$).

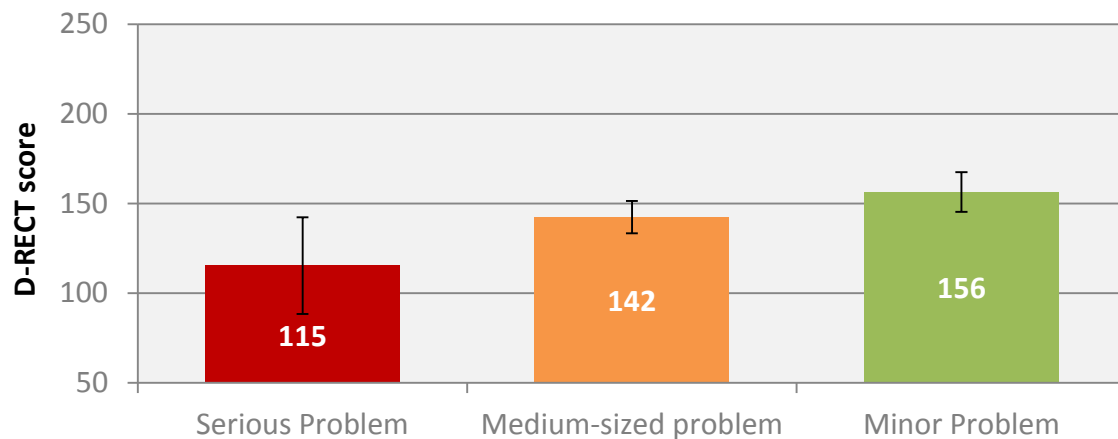
Interns who did not agree that their previous medical education and training had prepared them well for the jobs they had undertaken during their intern year were asked to say how problematic this sense of being underprepared was for them. 36% reported that lack of preparedness was a 'minor problem', for 55% the problem was 'medium-sized' and for a further 9% the problem was 'serious', as illustrated in Figure 21.

Figure 21: “Was a lack of preparation for the intern year a serious, medium-sized or minor problem for you?”



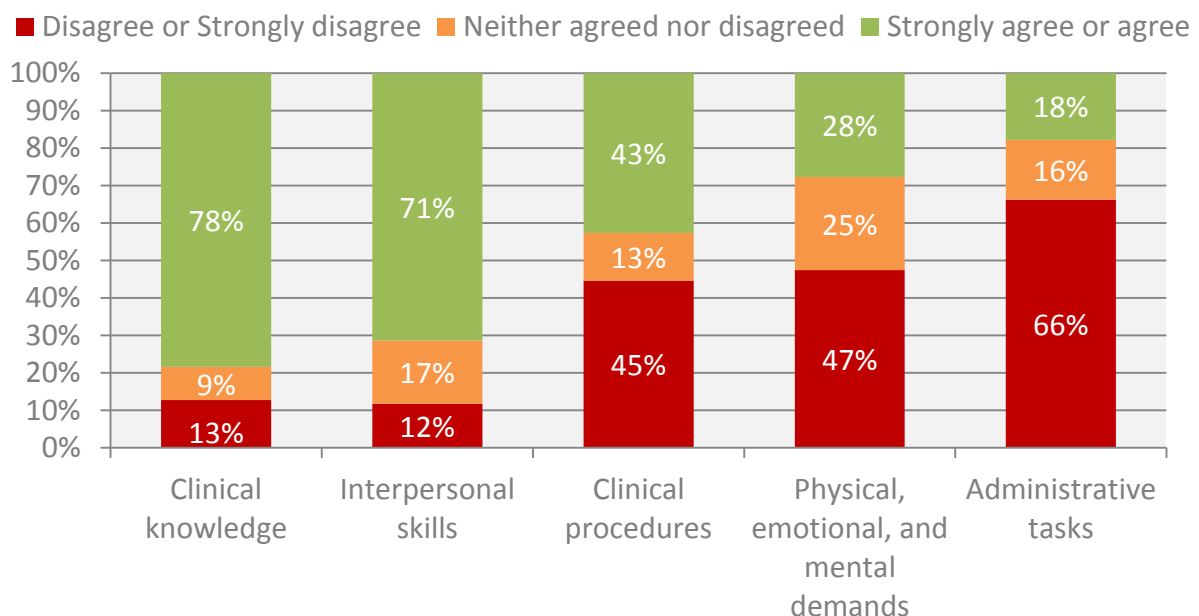
For trainees who felt unprepared for the intern year, those who reported this as a ‘serious problem’ had significantly poorer views of clinical learning environments ($M=115$) than those who considered their under-preparedness to be a medium-sized ($M=142$) or minor problem ($M=156$), ($F(2,94) = 5.89$, $p = 0.004$).

Figure 22: “Was a lack of preparation for the intern year a serious, medium-sized or minor problem for you?” Relationship with intern D-RECT scores



Interns were also asked to provide their views on how well their previous medical education and training had prepared them with necessary skills across a number of different domains. The results are illustrated in **Figure 23**, below.

Figure 23: “My previous medical education and training prepared me well for the .. I needed for the intern year” - domain specific responses from interns



While a high proportion of trainees agreed that they were well prepared for the intern year in terms of having the right clinical knowledge (78%) and interpersonal skills (71%), in the domains of meeting the physical, emotional and mental demands of the intern year (28%) and completing the necessary administrative tasks (18%), only a minority of interns agreed that they were well-prepared.

TRAINEE VIEWS ON BULLYING AND UNDERMINING BEHAVIOUR

KEY POINTS

- 35% of trainees said they had experienced bullying and harassment in post;
- 56% of trainees said they had witnessed someone else being bullied and harassed in post;
- 46% of trainees said they felt they had experienced undermining behaviour from a Consultant or GP in post;
- There were no significant associations between the prevalence of bullying experienced by trainees and gender, the region in which trainees gained their Basic Medical Qualification, or entry routes taken by trainees to medical school;
- The prevalence of bullying was significantly higher among interns (48%), and lower among trainees in Higher Specialist Training (28%) and GP training programmes (23%);
- Trainees in GP practices (4%) and Mental Health Services (7%) were significantly less likely to have been bullied frequently than trainees in larger hospitals (16%) and smaller hospitals (24%);
- Trainees who were bullied reported significantly lower ratings regarding the quality of their learning environments than trainees who were never bullied;
- Doctors were identified by trainees as the largest source of bullying in training environments (with 49% of all sources of perceived bullying being doctors);
- Sources of bullying varied for trainees at different stages of training, for example, although bullying from Consultants/GPs was reported as the main source of bullying in 24% of all cases, for trainees in Run-through training programmes 48% of bullying came from this source;
- Almost 7 in 10 trainees who experienced bullying in their learning environment did not report their experience to someone in authority;
- Of those trainees that reported their experience of bullying to someone in authority, almost 40% perceived nothing to have happened about it;
- Trainees who felt action was taken when they reported their experience of bullying gave significantly higher ratings for their learning environments than trainees who perceived nothing to have happened when they reported their experience.

PREVALENCE OF TRAINEE BULLYING AND UNDERMINING BEHAVIOURS

In *Your Training Counts* 2014 a third of trainees perceived themselves to have experienced bullying and harassment in their training post. We repeated items on bullying and undermining behaviour in 2015, and added a few new questions, to see if we could monitor and better understand trainees' experiences.

Trainees were invited to provide their views on bullying and undermining behaviours in the clinical environment. **Table 3** summarises responses.

Table 3: The prevalence of trainee-reported bullying and undermining behaviour in the clinical environment, all trainees

	How often, if at all, have you been the victim of bullying and harassment in this post?	How often, if at all, have you witnessed someone else being the victim of bullying and harassment in this post?	In this post, how often if at all, have you experienced behaviour from a consultant/GP that undermined your professional confidence and/or self-esteem?
Never	65%	44%	54%
At least once	35%	56%	46%
Every day	1%	3%	1%
At least once per week	7%	10%	4%
At least once per fortnight	3%	6%	3%
At least once per month	6%	11%	6%
Less often than once per month ⁴	19%	26%	31%

2015's results show no significant changes in the prevalence of trainee-reported bullying since 2014, with slight increases in the prevalence of personal experience of bullying (2%), witnessing someone else being bullied (4%) and experiencing undermining behaviour by a consultant or GP (3%).

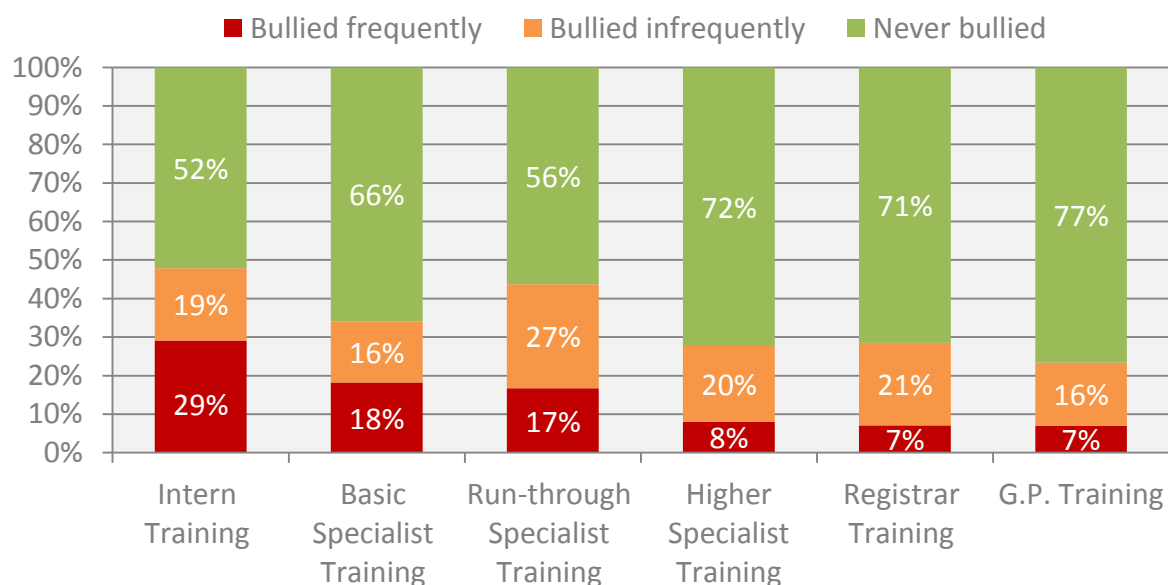
Variation in trainee views of bullying and undermining behaviours

There were no significant associations between the prevalence of bullying experienced by trainees and trainee gender, the region in which trainees gained their Basic Medical Qualification, or with entry routes trainees took to medical school.

There were significant associations between the prevalence of bullying experienced by trainees and stage of training and the type of clinical site in which they were located.

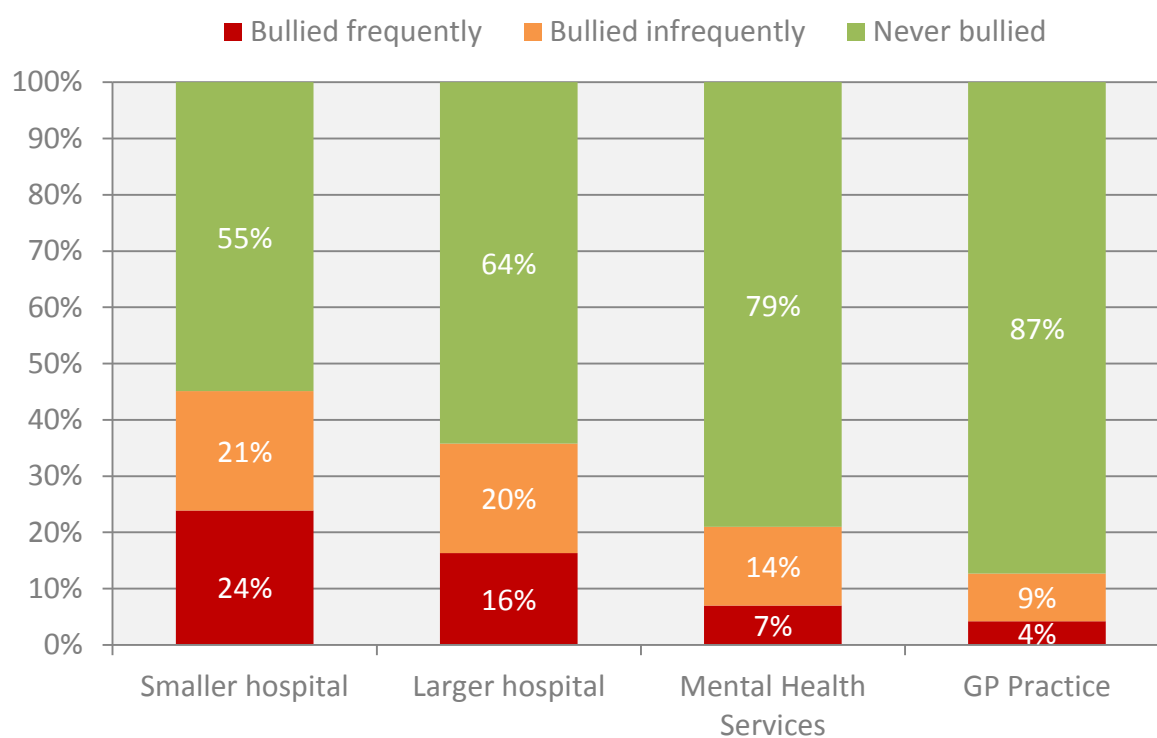
⁴ In the subsequent analyses, frequency was re-categorised. "Never" was converted to "never bullied"; "Less often than once per month" was converted to "infrequently bullied" and "At least once per month", "At least once per fortnight", "At least once per week", and "Every day" were converted to "frequently bullied".

Figure 24: Prevalence of trainee experience of bullying, compared across stage of training



The prevalence of bullying was higher among interns, and lower among trainees in GP training and Higher Specialist Training programmes; these associations were statistically significant and moderately strong ($X^2(10, N = 792) = 51.92, p < 0.001$).

Figure 25: Prevalence of trainee experience of bullying, compared across type of clinical site

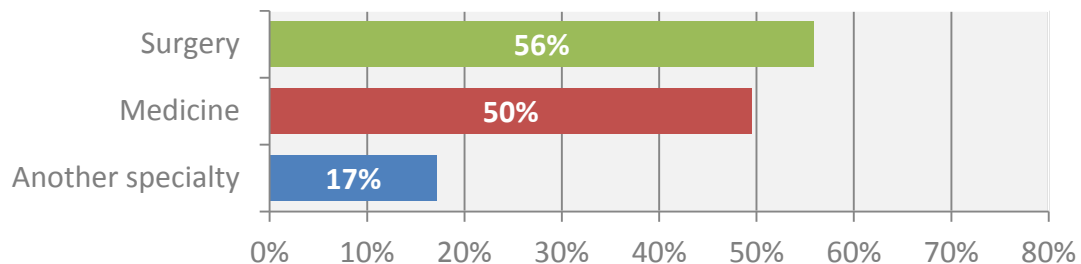


Trainees in GP practices (4%) and mental health services (7%) were significantly less likely to have been bullied frequently than trainees in larger hospitals (16%) and smaller hospitals (24%), ($X^2(6, N = 784) = 30.06, p < 0.001$).

Below, we show the prevalence of trainee experience of bullying for intern trainees (**Figure 26**) and for specialist trainees (**Figure 27**), in different speciality posts.

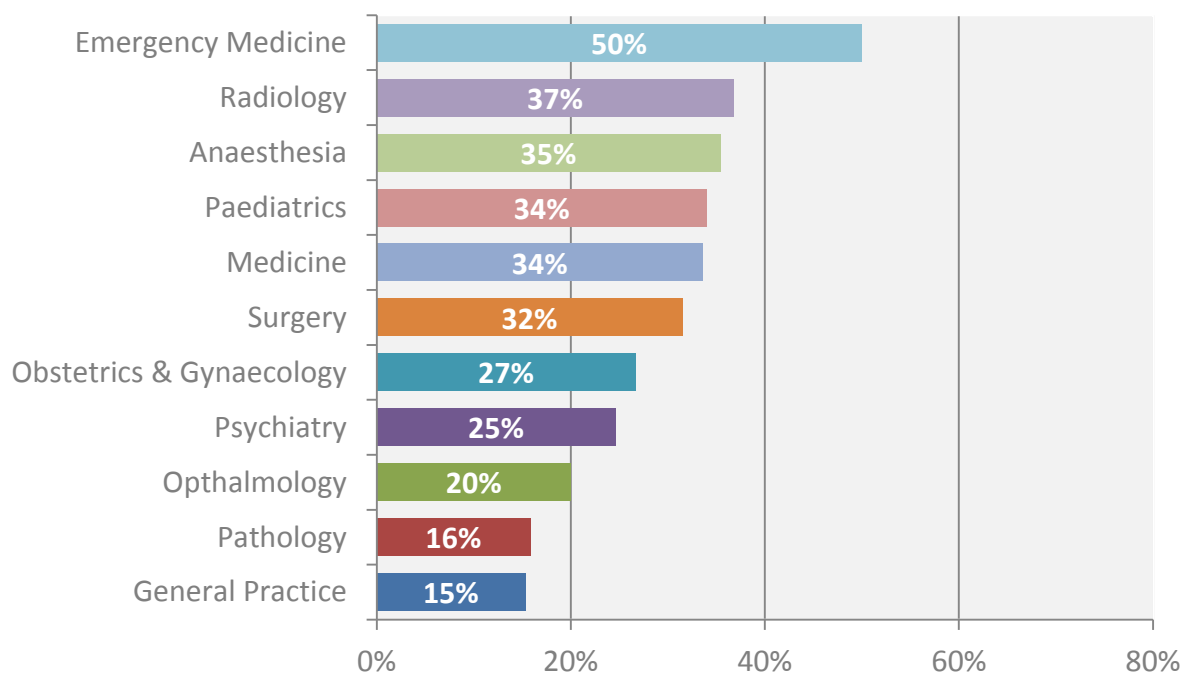
Intern trainees in surgery posts were significantly more likely (56%) than trainees in “another specialty” posts (17%) to have experienced bullying, $X^2(2, N = 213) = 13.4$, $p = 0.001$).

Figure 26: % of intern trainees who experienced bullying in post, by specialty of post



Specialist trainees in General Practice posts (15%) were significantly less likely than other trainees to say they had experienced bullying in post, and specialist trainees in Emergency Medicine posts (50%) were significantly more likely than others to say they experienced bullying ($X^2(10, N = 578) = 18.83$, $p = 0.042$).

Figure 27: % of specialist trainees who experienced bullying in post, by specialty of post

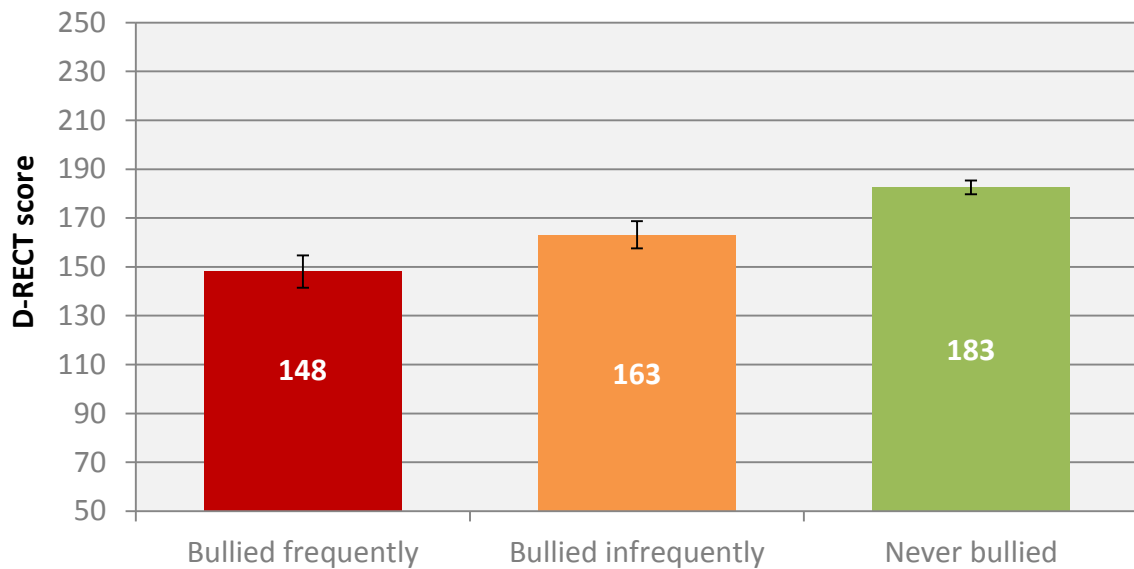


Trainee views on bullying and the overall clinical learning environment

The relationship between trainee experience of bullying and trainee views on clinical learning environments was examined.

As illustrated in **Figure 28**, trainees who experienced frequent bullying (M=148) or infrequent bullying (M=163) reported significantly lower total D-RECT scores than trainees who were never bullied (M=183), ($F(2,734) = 62.713$, $p < 0.001$).

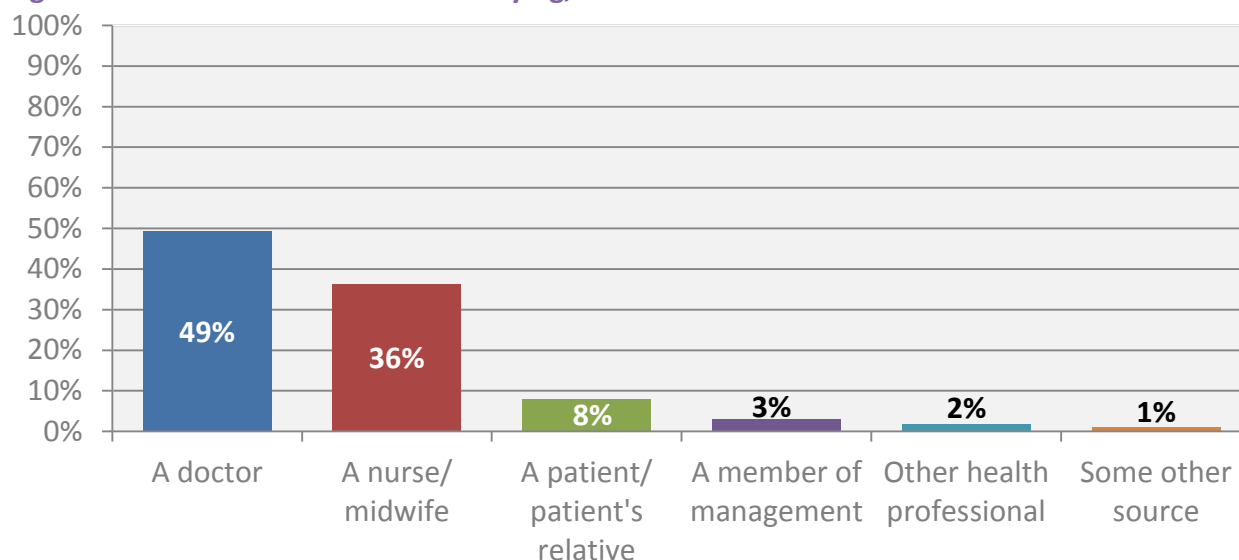
Figure 28: Trainee views of the clinical learning environment, compared by frequency of bullying



SOURCES OF BULLYING

To get a clearer focus on the issue of bullying in learning environments we asked trainees to identify the main source of the bullying they experienced. Results are summarised in **Figure 29**.

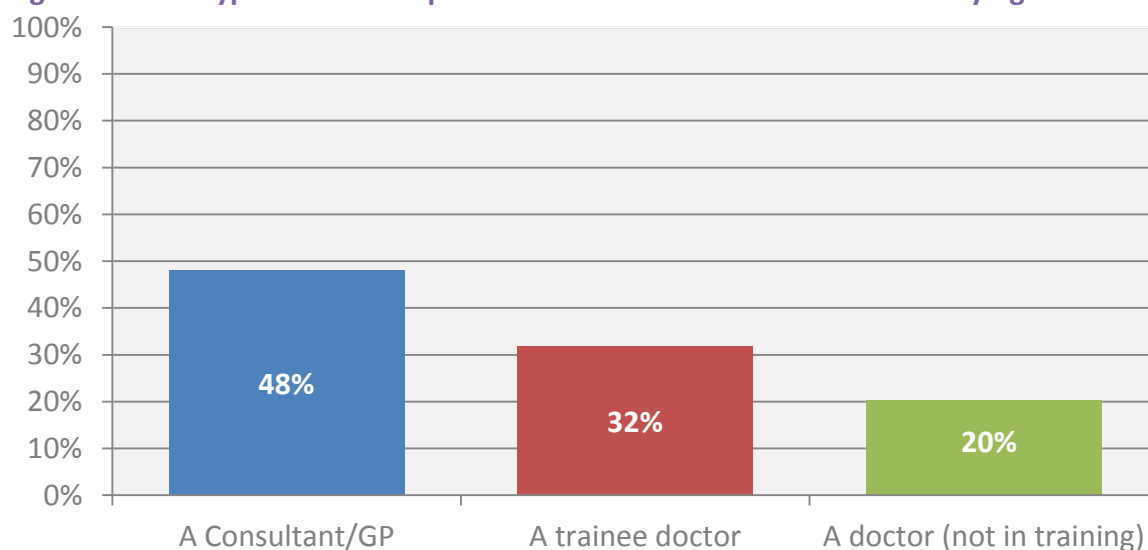
Figure 29: The main source of bullying, all trainees



Doctors were identified by trainees as the largest sources of bullying in training environments (with 49% of all perceived bullying coming from doctors).

Focussing only on doctors as sources of bullying, Consultants and GPs accounted for 48% of trainee bullying, with other trainees accounting for 32%, and doctors not in training accounting for 20% (as per **Figure 30**).

Figure 30: Type of doctor reported as the main source of trainee bullying



Variations in sources of bullying

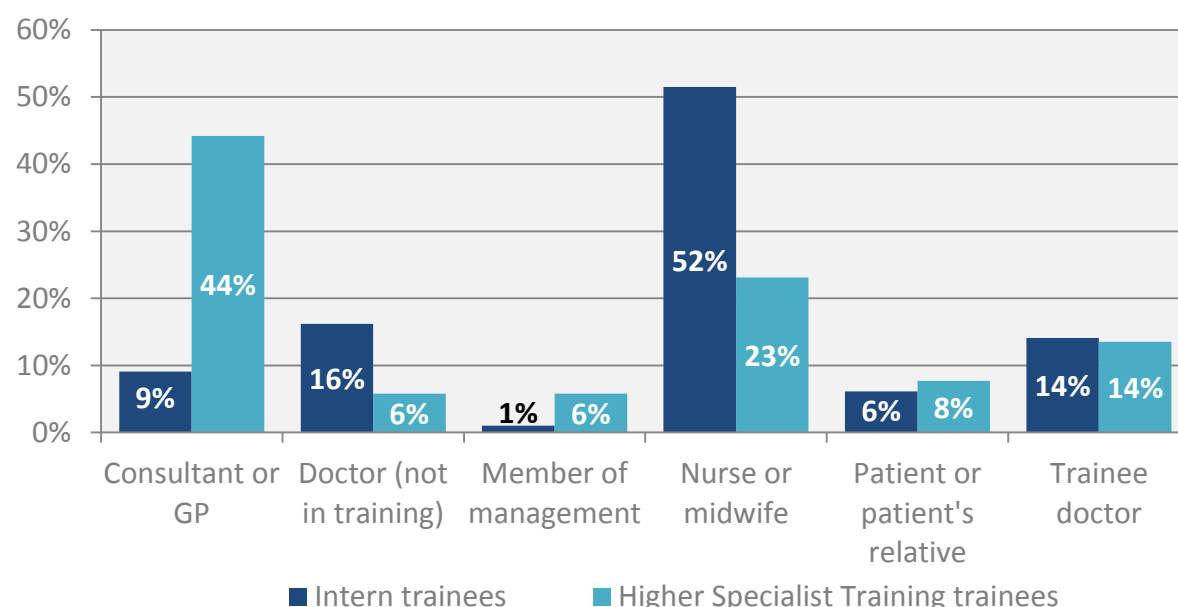
Data suggests that sources of bullying vary for trainees at different stages of training⁵. For example, although bullying from Consultants/GPs accounted for 24% of all trainee bullying, for trainees in Run-through training programmes this source accounted for 48% of bullying. Similarly, while bullying from patients/patients' relatives accounted for 8% of all trainee experiences of bullying, for trainees in GP training this source accounted for 21% of bullying.

Figure 31: Sources of bullying, by Stage of training

Main source of bullying	Which of the following best describes your training programme?					
	Intern Training	Basic Specialist Training	G.P. Training	Run-through Training	Registrar Training	Higher Specialist Training
A Consultant/GP	9%	25%	17%	48%	33%	44%
A doctor (not in training)	16%	5%	10%	5%	-	6%
A member of management	1%	4%	7%	-	-	6%
A nurse/midwife	52%	29%	31%	33%	-	23%
A patient/patient's relative	6%	7%	21%	-	33%	8%
A trainee doctor	14%	23%	7%	14%	33%	14%
Some other health professional	2%	4%	3%	-	-	-
Some other source	-	4%	3%	-	-	-

Figure 32, below contrasts sources of bullying for Intern trainees and for trainees on Higher Specialist Training programmes.

Figure 32: Sources of bullying, comparing Intern and HST experiences

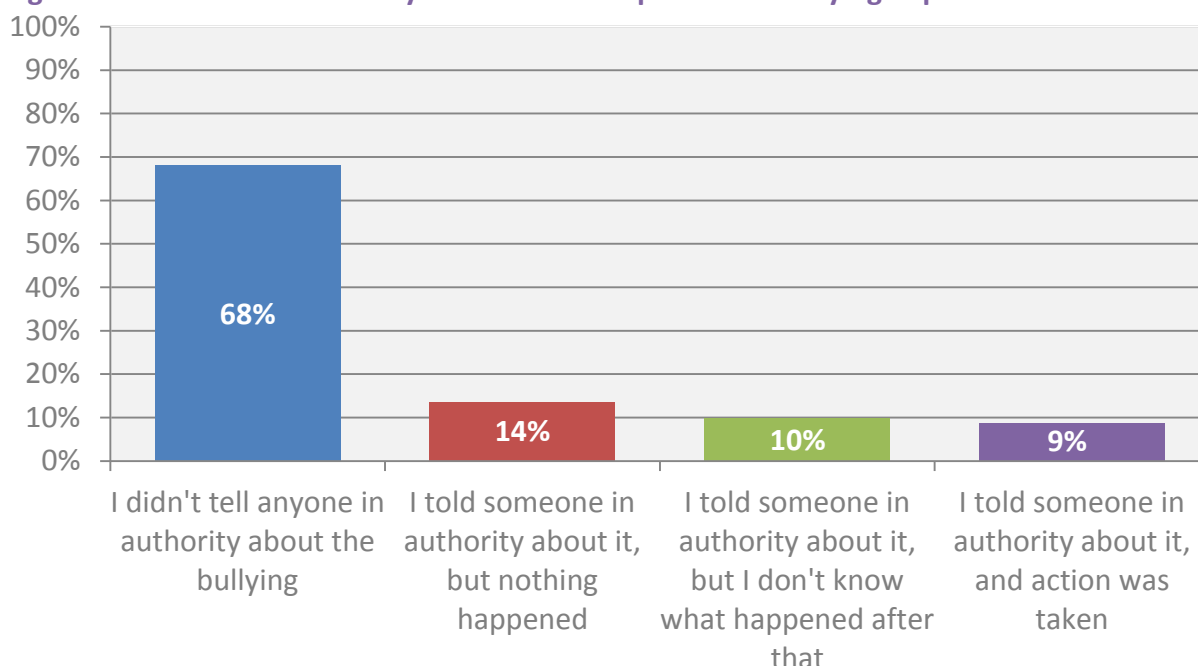


⁵ Although there were not enough cases to produce a statistically robust finding, the variance in sources of bullying for different types of trainee is something to monitor

REPORTING EXPERIENCES OF BULLYING TO SOMEONE IN AUTHORITY

Your Training Counts 2015 asked trainees to say what action, if any, they took when they experienced bullying in their training environment. The results are summarised in **Figure 33**.

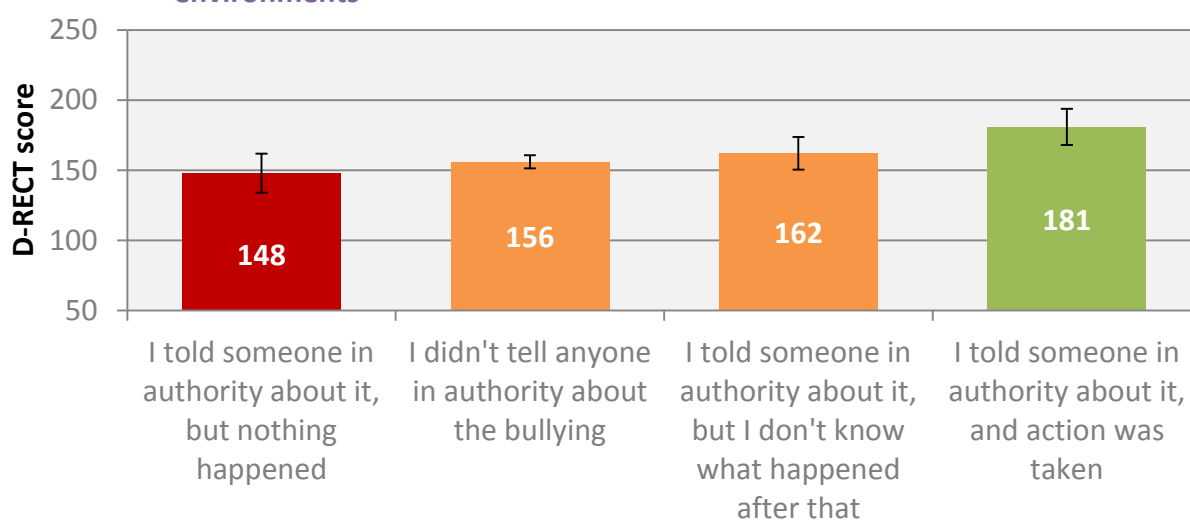
Figure 33: Actions taken by trainees who experienced bullying in post



Almost 7 in 10 trainees who experienced bullying in their learning environment did not report their experience to someone in authority. Of those trainees that reported their experience of bullying to someone in authority, almost 40% said that nothing happened.

What happens when trainees report bullying is important. **Figure 34** shows that trainees who felt action was taken, when they reported their experience of bullying, rated their learning environment significantly higher in quality ($M=181$) than trainees who perceived nothing to have happened when they reported their experience of being bullied ($M=148$), ($F(3,287) = 5.087$, $p = 0.002$).

Figure 34: What happened when trainees were bullied, by overall views on learning environments



TRAINEE SAFETY AT CLINICAL SITES

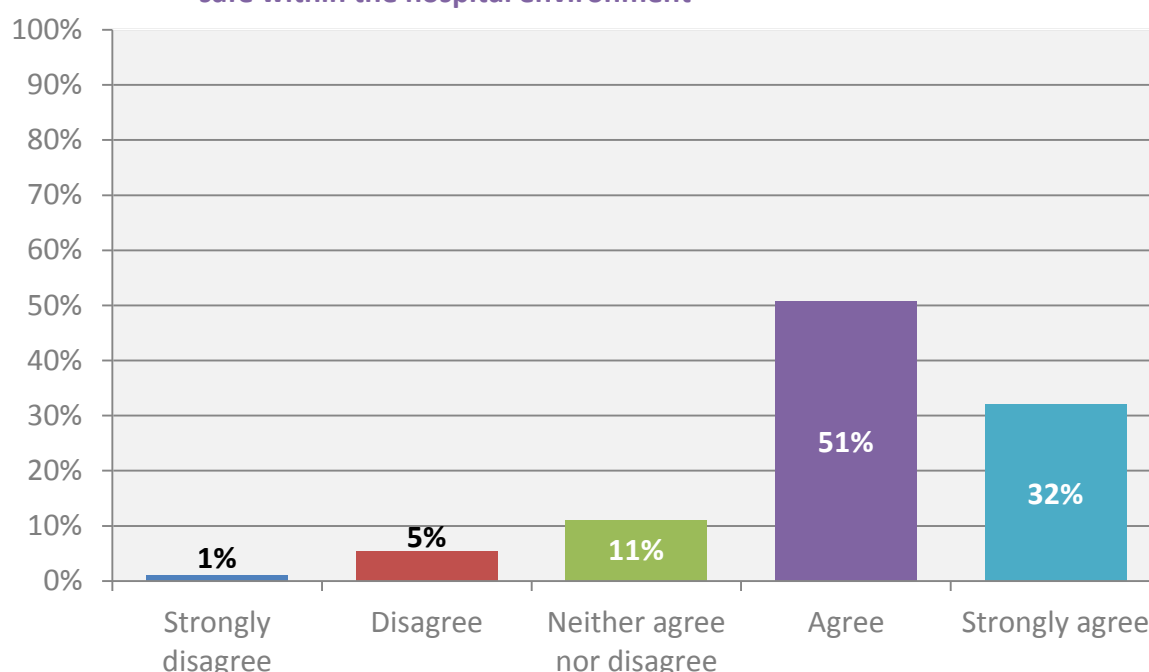
KEY POINTS

- 83% of trainees agreed that they felt physically safe in their clinical learning environment - this was 3% lower than ratings given by trainees in 2014;
- There were no significant differences in how safe trainees felt in their learning environments associated with age, gender, entry routes to medical school, region of qualification, or the type of site in which trainees were located;
- Trainees in GP Training programmes (89%) were significantly less likely than other trainees (94%) to agree that they felt physically safe at their clinical site;
- Trainees who were never bullied were significantly more likely, than trainees who were bullied, to agree that they felt safe at their clinical site;
- Trainees who agreed that they felt physically safe at their clinical site reported significantly higher views on the quality of learning environments than trainees who did not.

TRAINEE VIEWS ON SAFETY AT CLINICAL SITE

Trainees were asked to consider whether or not they felt physically safe within the environment in which they worked and learned. Responses are summarised below.

Figure 35: Trainee views of their physical safety at the clinical site - "I feel physically safe within the hospital environment"



In total, 83% of trainees agreed or strongly agreed that they felt physically safe in their clinical learning environment; down from 86% in 2014.

Views on physical safety at clinical sites were assessed across a number of trainee characteristics and contextual factors. There were no significant differences in how safe trainees felt in learning environments due to age, gender, entry routes to medical school, region of qualification, or the type of site in which trainees were located.

However, stage of training, experience of being bullied in post and overall views of the learning environment were significantly associated with trainees' feelings about being safe in their environment.

Figure 36: Trainee views on their physical safety at the clinical site, by stage of training

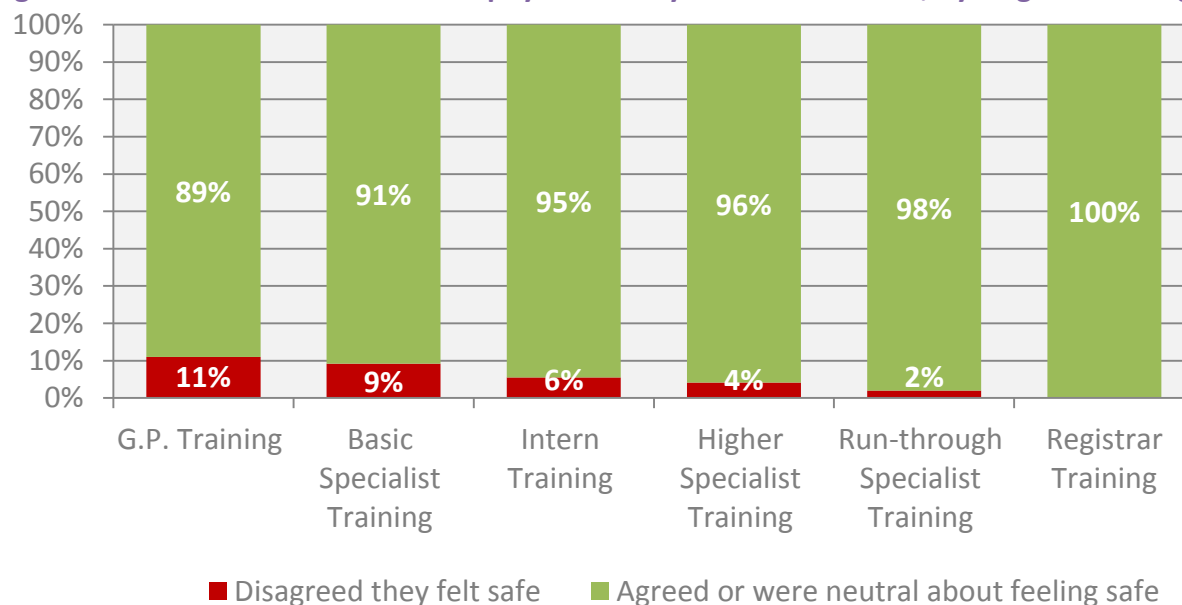


Figure 36, above, shows that trainees in GP Training programmes (89%) were significantly less likely than other trainees to agree that they felt physically safe at their clinical site, ($\chi^2(5, N = 789) = 11.061, p = .05$).

Figure 37: Trainee views on their physical safety at the clinical site, by experience of being bullied in post

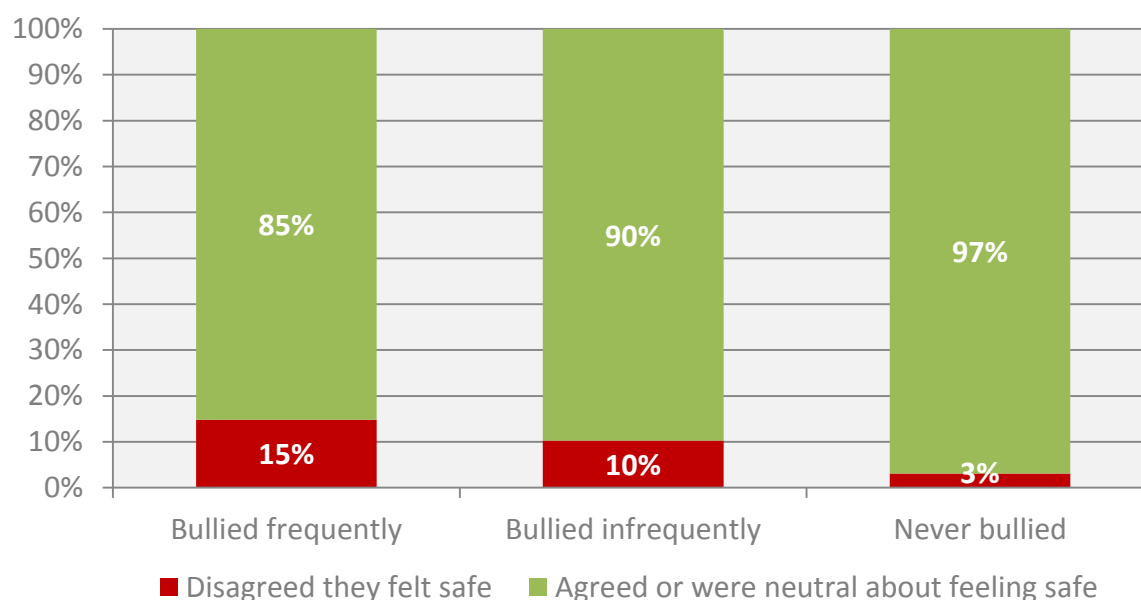
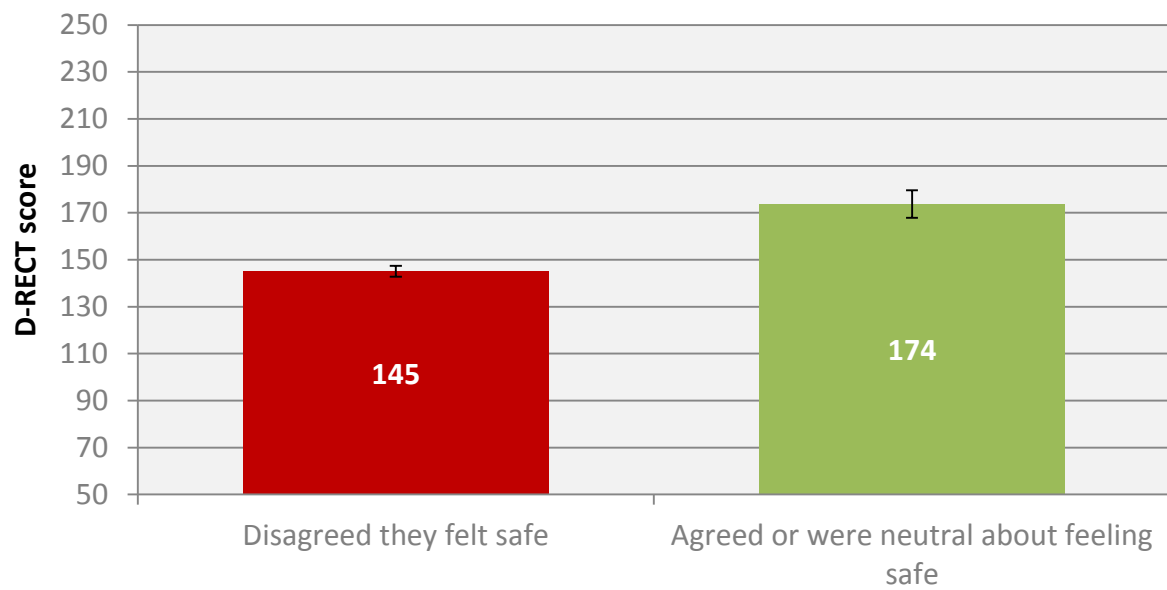


Figure 37, above, shows that trainees who were bullied frequently (15%), or infrequently (10%), were significantly less likely than trainees who were never bullied (3%) to agree that they felt safe at their clinical site, ($\chi^2(2, N = 757) = 27.346, p < .001$).

Figure 38: Trainee views on clinical learning environments, by views on physical safety



Trainee views on the quality of clinical learning environments were significantly associated with how safe trainees felt at clinical sites.

Trainees who agreed that they felt physically safe at their clinical site reported significantly higher views on the quality of learning environments ($M=174$), than those who did not agree ($M=145$), $t(748)=5.585$, $p<.001$.

TRAINEE VIEWS ON QUALITY OF PATIENT CARE

KEY POINTS

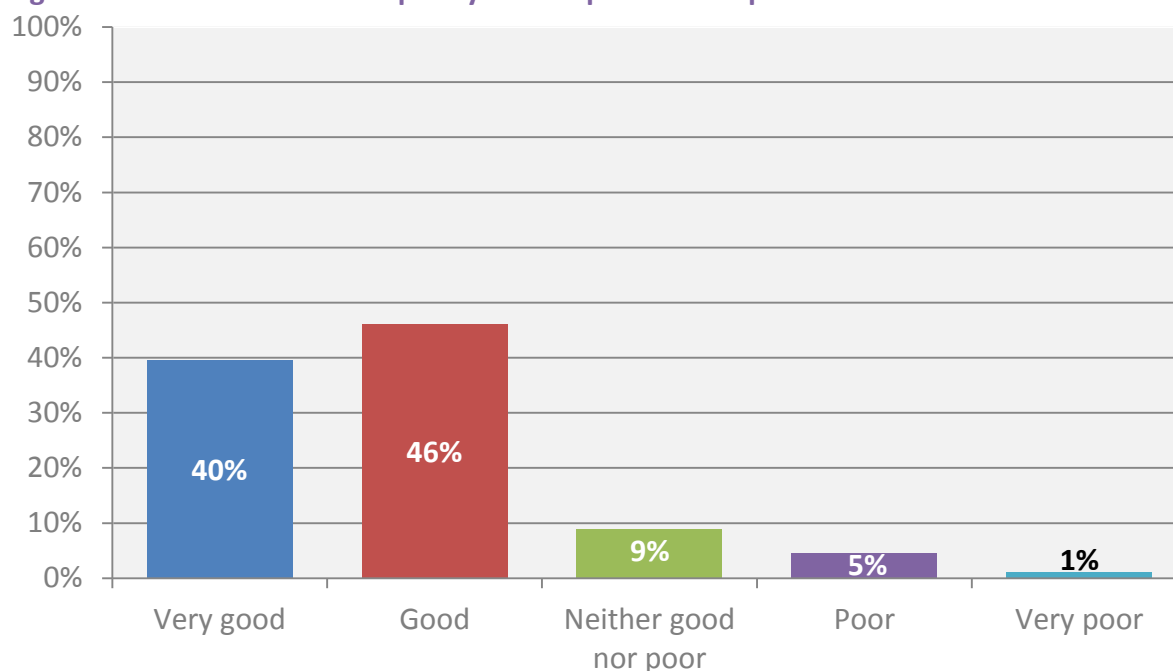
- 86% of trainees rated the quality of care provided to patients at their clinical site as 'good' or 'very good'; a marginal increase compared to 2014;
- There were no significant variations in trainees' views on the quality of care provided at clinical sites due to gender or entry routes to medical school;
- Interns were significantly less likely than all other trainees to rate the quality of care provided to patients as 'good' or 'very good';
- Trainees in larger hospitals (12.5%) and smaller hospitals (26.2%) were significantly more likely than trainees in GP practices (4%) and Mental Health Services (7%) to rate the quality of care provided to patients as 'less than good';
- Trainees who were bullied frequently were significantly less likely to rate the quality of care provided to patients at their site as 'good' or 'very good' (63%) than trainees who were never bullied (91%); and,
- Trainees who rated the quality of care at the clinical site as 'good or better' had significantly more positive views of clinical learning environments than trainees who rated the quality of care at clinical sites as 'less than good'.

TRAINEE VIEWS OF THE QUALITY OF PATIENT CARE AT CLINICAL SITES

Trainees were asked for their views on the quality of care provided to patients at the clinical sites in which they worked and learned.

In total, 86% of trainees rated the quality of care provided to patients at their clinical site as 'good' or 'very good'; 5% reported it was 'poor' or 'very poor' (as per **Figure 39**). This is a very similar finding to that in 2014 in which 85% of trainees rated the quality of care provided to patients as "good" or "very good".

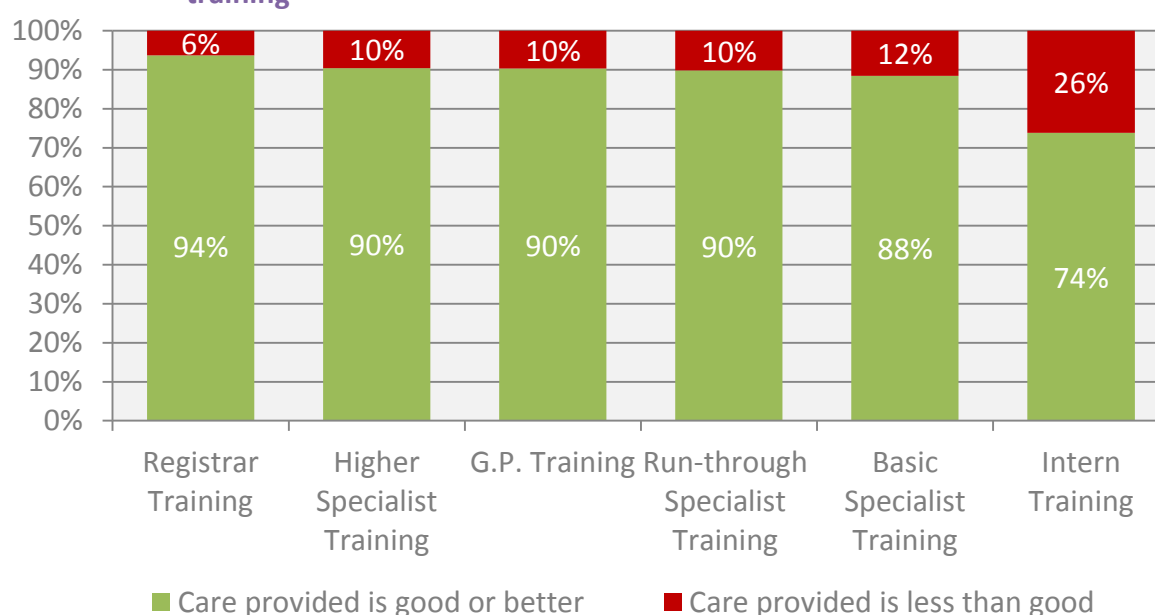
Figure 39: Trainee-rated quality of care provided to patients



There was no significant variation in trainees' views on the quality of care provided at clinical sites across gender or routes to medical school.

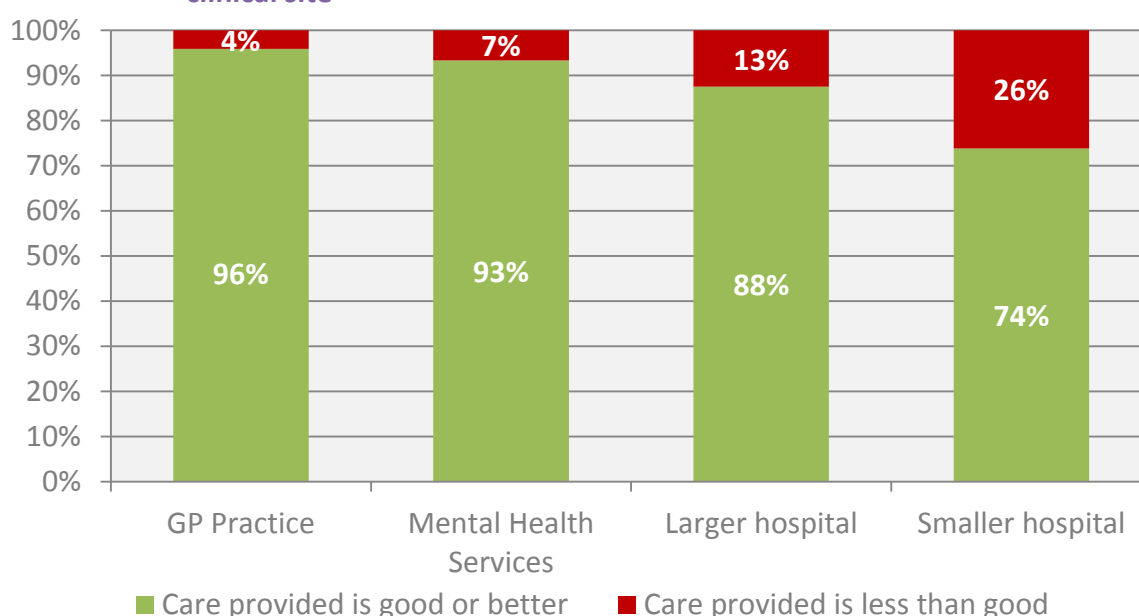
Trainees' age, stage of training, the type of site in which they were located, the region of qualification, their experience of being bullied and overall views on the quality of learning environments were significantly associated with trainee views on the quality of care provided to patients.

Figure 40: Trainee-rated quality of care provided to patients, variation across stage of training



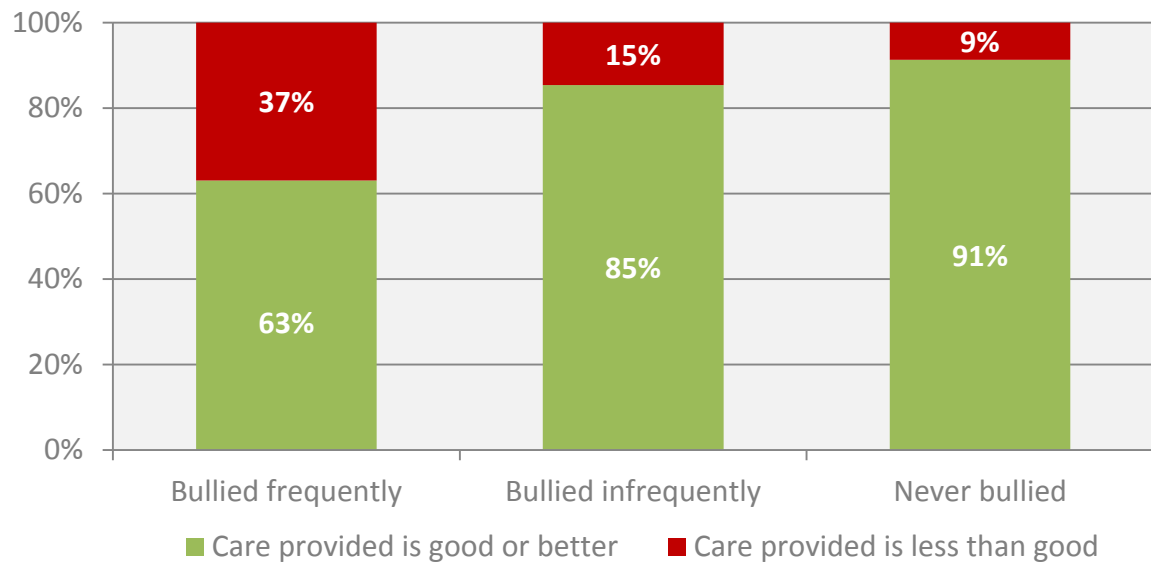
There was a significant, moderate, association between stage of training and views on the quality of care provided to patients – as per **Figure 40**. Interns were significantly more likely than other trainees to rate the quality of care provided to patients as ‘less than good’, $\chi^2(5, N = 813) = 32.28, p < 0.001$.

Figure 41: Trainee-rated quality of care provided to patients, variation across type of clinical site



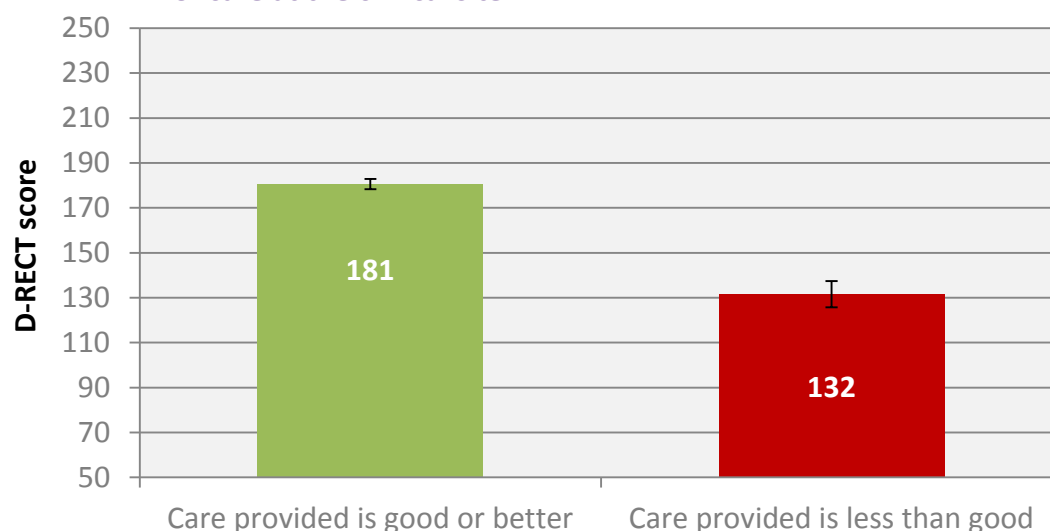
As **Figure 41** suggests, there was a significant, weak, association between trainees’ views on the quality of care provided to patients and the type of site in which they were learning and working. Trainees in larger (12.5%) and smaller hospitals (26.2%) were significantly more likely than trainees in GP practices (4%) and Mental Health Services (7%) to rate the quality of care provided to patients as ‘less than good’, $\chi^2(3, N = 805) = 31.01, p < 0.001$.

Figure 42: Trainee-rated quality of care provided to patients, by experience of bullying



There was a significant, and moderately strong, association between views on the quality of patient care and trainees' experience of bullying, as highlighted in **Figure 42**. Trainees who were bullied frequently were significantly more likely to rate the quality of care provided to patients as 'less than good' (37%) compared to trainees who were never bullied (9%), $\chi^2(2, N = 781) = 64.11, p < 0.001$.

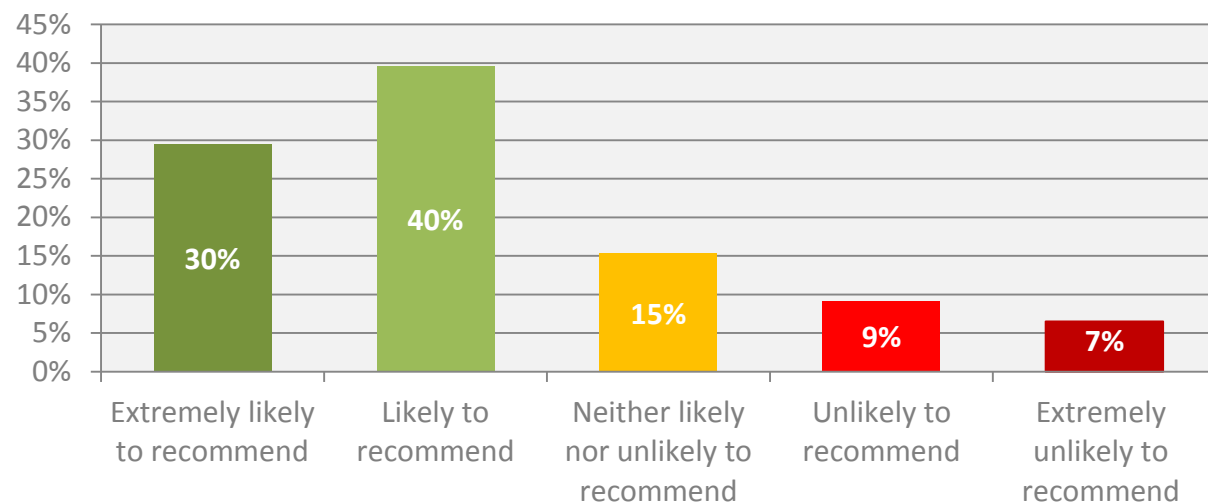
Figure 43: Trainee views of the clinical learning environment, by rating of the quality of care at the clinical site.



There was a strong association between trainees' views on the quality of care provided to patients and overall views on the quality of learning environments. Trainees who rated the quality of care at the clinical site as 'good or better' had significantly more positive views of clinical learning environments ($M=181$) than trainees who rated the quality of care at the clinical site as 'less than good' ($M=132$), $t(152.15) = 15.97, p < 0.001$.

We also asked trainees how likely it was that they would recommend the site in which they worked to friends or family if they needed care. 70% of trainees were likely, or extremely likely, to recommend their training site to friends and family if they needed care.

Figure 44: “How likely are you to recommend your training site to friends and family if they needed care or treatment?”



Responses, to the question regarding how likely trainees were to recommend their site as a place of care, were significantly associated with: trainees stage of training (with interns being least likely to recommend their site); type of site in which trainees were learning (trainees were significantly less likely to recommend smaller hospitals than any other type of site); region of qualification (with doctors who qualified outside of Ireland being more likely to recommend sites); bullying (with doctors who were never bullied being more likely to recommend sites); and, D-RECT scores (with trainees who recommended their training site giving significantly higher D-rect scores than other trainees).





Comhairle na nDochtúirí Leighis
Medical Council